

# LEGISLATIVE AUDIT COMMISSION



Review of  
Department of Human Services  
Two Years Ended June 30, 2023  
622 Stratton Office Building  
Springfield, Illinois 62706  
217/782-7097

**REVIEW: #4587  
DEPARTMENT OF HUMAN SERVICES  
TWO YEARS ENDED JUNE 30, 2023**

**RECOMMENDATIONS – 32**

**IMPLEMENTED/PARTIALLY IMPLEMENTED – 32**

**REPEATED RECOMMENDATIONS – 25**

**PRIOR AUDIT FINDINGS/RECOMMENDATIONS – 33**

This review summarizes the auditors' report of the Department of Human Services for the two years ended June 30, 2023, filed with the Legislative Audit Commission on May 29, 2025. The auditors conducted a compliance examination in accordance with state law and Government Auditing Standards.

This review summarizes the report on the Department of Human Services, which includes the facilities operated by DHS which includes:

- 6 Developmental Centers;
- 6 Mental Health Centers; and
- 1 combined Mental Health and Developmental Center;

DHS has 6 Divisions:

- Developmental Disabilities
- Mental Health
- Early Childhood
- Rehabilitation Services
- Family & Community Services
- Substance Use Prevention and Recover

The Illinois Department of Human Services (DHS) was created in 1997 by consolidating the Departments of Alcoholism and Substance Abuse, Mental Health, Developmental Disabilities and Rehabilitation Services, along with the client-centered services provided through the Departments of Children and Family Services, Healthcare and Family Services and Public Health. DHS established as its primary mission to provide the state's residents with streamlined access to integrated services, especially those who are striving for economic independence, and others who face multiple challenges to self-sufficiency.

**REVIEW: #4587 DEPARTMENT OF HUMAN SERVICES FY22-23 COMPLIANCE**

The Secretary of DHS during the audit period was Grace Hou. The current Secretary is Dulce Quintero who was appointed in September 2023. Dulce Quintero served as Assistant Secretary at DHS from 2019 until 2023.

**Appropriations and Expenditures**

Appropriations (\$ thousands)	FY22		FY23	
	Approp	Expend	Approp	Expend
<b>GENERAL FUNDS</b>				
Total Other Operations and Refunds	7.7	0.0	7.7	7.7
<b>Designated Purposes</b>				
Deposit to Off-Hours Child Care Prog. Fund	0.0	0.0	2,000.0	2,000.0
First Responders Behavioral Health Grant	0.0	0.0	10,000.0	10,000.0
First Responders Wellness Prog. Chicago	0.0	0.0	10,000.0	0.0
GATA Technical Asst. and Navigation	500.0	200.3	500.0	34.5
Indirect Cost Principles	0.1	0.0	0.1	0.0
Office of the Inspector General	9,072.3	8,460.1	9,987.2	8,937.9
Operational Expenses	702,952.2	651,041.2	762,344.7	757,451.9
Sexually Violent Persons Program	5,269.4	5,269.4	7,769.4	7,769.4
State Operated Developmental Centers	319,704.8	297,899.2	338,215.6	333,096.7
State Operated Mental Health Facilities	239,137.2	229,526.0	275,717.5	266,403.2
<b>Total Designated Purposes</b>	<b>1,276,636.0</b>	<b>1,192,396.2</b>	<b>1,416,534.5</b>	<b>1,385,693.6</b>
<b>Grants</b>				
A Safe Place Lake County	125.0	125.0	0.0	0.0
Access to Justice Grant Prog.-Resurrection	7,000.0	6,888.1	10,000.0	9,739.5
Access to Justice Grant Prog.-West Side Ctr	7,000.0	6,363.5	10,000.0	10,000.0
Ada S. McKinley Community Services	0.0	0.0	1,000.0	737.0
Addiction Prevention Related Services	1,263.8	1,205.4	1,674.0	1,046.3
Addiction Treatment - DCFS Clients	5,757.2	1,913.2	5,802.4	2,194.8
Addiction Treatment - Medicaid Eligible	11,316.4	8,310.8	15,521.1	8,074.3
Addiction Treatment - Special Population	6,106.7	3,534.3	6,098.2	4,862.2
Addiction Treatment Services	48,688.8	37,816.6	98,508.9	49,105.6
After School Youth Programs	14,522.0	13,492.5	16,812.4	13,012.1
Aid to Aged, Blind or Disabled	28,504.7	27,649.8	31,504.7	31,228.4
Alternative School Network	0.0	0.0	1,000.0	584.5
Alternatives	0.0	0.0	100.0	20.3
ARC of IL Life Span Project	471.4	471.4	471.4	471.4
ART Inc in Peoria - STEAM	300.0	300.0	300.0	300.0
ASI Homecare	300.0	287.9	0.0	0.0
Asian Human Services	0.0	0.0	100.0	4.2
Asthma & Allergy Found. Of Amer., St. Louis	0.0	0.0	2,400.0	432.7
Austin Childcare Provider's Network	250.0	169.7	250.0	237.4

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Becoming a Man	0.0	0.0	100.0	100.0
Best Buddies	977.5	977.5	977.5	977.5
Beyond Hunger (OPRF Food Pantry)	150.0	150.0	0.0	0.0
Black Ensemble Theater	0.0	0.0	100.0	52.8
Black Fire Brigade	50.0	50.0	0.0	0.0
Black Girls Break Bread	0.0	0.0	100.0	0.3
Black Men United to Fight Homelessness	250.0	250.0	250.0	249.9
Black Researchers Collective	0.0	0.0	700.0	0.0
Boys and Girls Club of Alton	125.0	77.8	0.0	0.0
Boys and Girls Clubs of Central IL	125.0	125.0	0.0	0.0
Boys and Girls Clubs of Decatur	125.0	119.1	0.0	0.0
Build	0.0	0.0	560.0	199.3
Calumet Memorial Park	0.0	0.0	300.0	91.2
Casa Central	500.0	500.0	0.0	0.0
Casa Michaoacan	300.0	81.0	0.0	0.0
Centro Romero	0.0	0.0	100.0	75.6
Chicago Chesed Fund	125.0	0.0	125.0	0.0
Chicago Police Dept. Mem. Foundation	2,000.0	0.0	2,000.0	0.0
Chicago Recovering Communities Coalition	0.0	0.0	1,000.0	0.0
Chicago Survivors	1,000.0	755.6	1,000.0	885.8
Chicago Westside Branch NAACP	250.0	145.7	250.0	249.8
Child Care Services	390,599.0	220,000.5	355,599.0	355,597.9
Children's Place	381.2	267.3	381.2	357.5
Chinese Mutual Aid Association	0.0	0.0	100.0	37.5
City of Brooklyn	0.0	0.0	1,000.0	0.0
City of Cahokia Heights	0.0	0.0	1,000.0	0.0
City of Chicago-Asylum Seekers	0.0	0.0	20,000.0	20,000.0
City of East St. Louis	0.0	0.0	1,000.0	0.0
City of Fairmont City	0.0	0.0	500.0	445.3
City of Madison	0.0	0.0	500.0	191.5
City of North Chicago	0.0	0.0	200.0	69.7
City of Peoria for Violence Prevention	0.0	0.0	500.0	0.0
City of Venice	0.0	0.0	500.0	204.5
City of Washington Park	0.0	0.0	500.0	0.0
City of Waukegan	0.0	0.0	200.0	116.0
Club of Apaseo el Alto	350.0	102.1	350.0	350.0
Communities United	300.0	300.0	0.0	0.0
Community Crisis Center	250.0	199.2	0.0	0.0
Community Services	7,366.4	6,398.8	7,513.8	6,477.4
Community Transitions and Syst. Rebalancing	51,964.2	49,655.7	52,651.4	50,195.9
Comm. Transitions and Syst. Rebal.-Colbert	50,587.3	45,062.3	51,118.2	46,026.4

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Community Works	0.0	0.0	200.0	156.5
Comprehensive Community Services	18,931.3	17,751.3	21,309.9	19,253.2
Cornerstone of Will County	300.0	300.0	0.0	0.0
CYN Counseling Center	0.0	0.0	310.0	37.5
DCFS Comm. Integrated Living Arrangements	2,471.6	2,471.6	2,471.6	2,471.6
DD Community & LTC Recruitment & Reten.	0.0	0.0	12,500.0	0.0
Dental Grants	986.0	373.2	995.9	721.0
Developmental Disabilities Grants	1,546,875.4	1,513,666.0	1,756,595.1	1,742,913.5
Developmental Disabilities Transitions	5,201.6	5,201.3	5,201.6	5,201.5
Domestic Violence Shelters	20,502.9	19,647.0	70,910.1	60,618.8
Early Intervention Program	108,891.9	108,891.9	115,891.9	100,350.0
East Side Health District	0.0	0.0	500.0	283.8
Eastern IL Foodbank	250.0	250.0	0.0	0.0
Ebenezer Community Outreach	250.0	250.0	0.0	0.0
Elyssa's Mission	0.0	0.0	50.0	45.7
Employability Development Services	6,145.7	3,962.1	6,199.5	5,225.6
Employee Connections	0.0	0.0	200.0	33.3
Enlace Chicago	500.0	447.7	0.0	0.0
Epilepsy Services	2,075.0	2,007.3	2,098.0	2,027.0
Ethiopian Community Association	0.0	0.0	100.0	73.4
Evaluation, Determin., Disposit. And Assess.	1,200.0	1,200.0	1,200.0	1,195.8
Eviction Mitigation Program	25,000.0	22,392.7	0.0	0.0
Family Cares Mission	250.0	247.5	1,000.0	948.9
Family Matters	0.0	0.0	100.0	90.0
Fathers Who Care	250.0	144.1	250.0	118.0
Fedecmi Casa Michoacan	0.0	0.0	500.0	0.0
Fellowship Housing	250.0	0.0	0.0	0.0
Food Stamp Employment & Training	3,651.0	1,050.4	3,651.0	1,851.1
For Case Services	0.0	0.0	11,450.9	11,384.1
Funeral & Burial Expense	5,000.0	4,420.5	5,000.0	4,973.1
Greater St. John Baptist Church	100.0	86.1	100.0	78.8
Guaranteed Income Pilot	0.0	0.0	3,570.0	0.0
Harvey Park District	0.0	0.0	400.0	180.1
Healthcare Alternatives	500.0	500.0	0.0	0.0
Healthy Families	10,040.0	9,376.9	0.0	0.0
Hephzibah House	100.0	100.0	0.0	0.0
Home & Community-Based Waiver	480.6	480.3	480.6	480.6
Home Illinois	0.0	0.0	25,000.0	21,233.0
Home Services Program	684,999.6	662,975.9	782,772.4	782,349.7
Homeless Youth Services	6,277.5	6,181.2	7,403.1	7,102.7
Homelessness Prevention	5,000.0	4,920.0	5,000.0	5,000.0

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Hope Community Church	100.0	0.0	0.0	0.0
Hope Fair Housing Center	300.0	211.4	0.0	0.0
Howard Area Community Center	0.0	0.0	100.0	46.9
Howard Brown Youth Center	0.0	0.0	100.0	30.0
ICNA Relief	125.0	125.0	0.0	0.0
Illinois Health Practice Alliance	0.0	0.0	2,000.0	0.0
Illinois Migrant Council	90.0	0.0	90.0	0.0
Immigrant Integration Services	33,200.0	32,837.4	38,000.0	36,809.4
Independent Living Centers	5,071.2	5,053.9	6,358.9	6,018.5
Independent Living Older Blind	146.1	129.9	146.1	146.1
Infant Mortality	29,665.0	25,141.2	29,722.9	25,937.8
Infant Welfare Society	100.0	100.0	0.0	0.0
Joliet Hospice House	250.0	250.0	0.0	0.0
Joliet United Cerebral Palsy Center	0.0	0.0	200.0	0.0
Josselyn Center	625.0	623.9	0.0	0.0
Journeys/The Road Home	250.0	0.0	0.0	0.0
Kennedy Forum	250.0	250.0	250.0	250.0
Kenwood Oakland Organization	0.0	0.0	700.0	148.7
Lake County United 211 Program	175.0	175.0	0.0	0.0
Loaves and Fishes Community Services	0.0	0.0	300.0	300.0
Local Healthy Foods Incentive	500.0	475.4	500.0	303.8
Logan Square Neighborhood Association	500.0	323.1	0.0	0.0
LUV Institute	0.0	0.0	700.0	647.4
Maryville Center for Children	250.0	218.8	0.0	0.0
Maternal & Child Home Visiting Program	0.0	0.0	17,926.3	16,738.4
Medforce Aeromedical Transport	250.0	0.0	0.0	0.0
Mental Health Grants, Child & Adolescent	125,827.1	116,851.1	168,251.3	140,871.6
Mental Health Psychotropic Medications	1,381.8	977.0	1,381.8	548.3
Mental Health Supportive Housing	22,407.2	15,342.5	22,713.8	19,416.4
Metropolitan Family Services	250.0	250.0	0.0	0.0
Metropolitan YMCA	125.0	74.8	0.0	0.0
National Alliance on Mental Illness - Services	180.0	180.0	180.0	180.0
National Alliance on Mental Illness - DuPage	250.0	249.3	0.0	0.0
Neighborhood Network Alliance	300.0	298.7	0.0	0.0
New Life Centers Chicagoland	300.0	223.3	0.0	0.0
New Life Centers of Chicagoland	125.0	125.0	0.0	0.0
New Moms	300.0	300.0	0.0	0.0
North Shore Legal Aid Clinic	250.0	250.0	0.0	0.0
Northshore Senior Center	250.0	250.0	0.0	0.0
Northwest Side Housing Center	250.0	250.0	0.0	0.0
Oak Leyden Developmental Services	100.0	100.0	0.0	0.0

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Oak Leyden Family Services	150.0	0.0	0.0	0.0
Oak Park River Forest Infant Welfare Society	0.0	0.0	100.0	100.0
Oral Health Forum	0.0	0.0	300.0	299.8
Parents Too Soon	6,870.3	6,870.3	0.0	0.0
Park Lawn Center	250.0	125.0	0.0	0.0
Peoria County Residential Safety Improvem.	0.0	0.0	50.0	0.0
Peoria Friendship House	0.0	0.0	400.0	365.9
Phalanx Family Services	1,000.0	826.7	2,000.0	597.4
Pilot Program Opioid Dependents	500.0	296.2	500.0	348.5
Pilsen Neighbors Community Council	250.0	183.0	0.0	0.0
PLOWS Council on Aging	250.0	250.0	0.0	0.0
Precious Blood Ministry Reconciliation	250.0	125.0	0.0	0.0
Prevention Partnership, Inc.	0.0	0.0	850.0	514.4
Project for Autism	4,800.0	4,320.4	4,800.0	4,721.5
Public Image Partnership	0.0	0.0	1,000.0	552.0
Rape Victims Prevention Act	7,659.7	7,659.7	7,659.7	7,659.7
Redeploy Illinois	6,373.6	4,772.2	14,373.6	5,499.3
Refugee One	250.0	245.8	0.0	0.0
Refugee Social Services	7,004.0	3,117.3	204.0	0.0
Refugees	1,126.7	1,053.8	1,126.7	767.7
Rehabilitation Serv. Federal Match	90.0	58.9	0.0	0.0
Reimagine Public Safety	0.0	0.0	5,000.0	1,100.8
Respite Services	6,677.5	5,550.5	6,744.3	5,626.1
Ricon Family Services	500.0	500.0	0.0	0.0
Rosecrance Inc.	0.0	0.0	1,000.0	979.9
Roseland Peace Center	0.0	0.0	1,500.0	1,064.7
Route History Institute	500.0	475.8	0.0	0.0
Sangamon County	0.0	0.0	1,000.0	122.8
Sarah's Inn	150.0	150.0	0.0	0.0
Segundo Ruiz Belvis Cultural Center	250.0	250.0	0.0	0.0
Silver Cross Hospital	500.0	500.0	0.0	0.0
South Central Community Services	125.0	96.2	0.0	0.0
SIU Rural Health for Mental Health Supp. Serv.	300.0	219.3	500.0	488.5
South Shore Works	0.0	0.0	700.0	0.0
Special Children's Charities	0.0	0.0	1,000.0	0.0
Special Services	7,667.1	6,761.4	7,675.8	7,048.9
St. Claire County	0.0	0.0	1,500.0	626.6
St. Mary's Hospital	1,500.0	0.0	1,500.0	667.0
St. Sabina Church	200.0	200.0	1,000.0	608.3
Supported Employment	0.0	0.0	90.0	62.1
Supportive Housing Services	16,166.7	16,166.7	16,490.1	16,207.7

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Temporary Assistance to Needy Families	160,000.0	154,273.2	205,000.0	203,362.6
The Answer Inc. for Autism & DD Programs	0.0	0.0	250.0	218.9
The City of Wood River	300.0	0.0	0.0	0.0
The House of James	250.0	250.0	0.0	0.0
Thornton Township	0.0	0.0	1,000.0	476.4
Tort Claims	475.0	397.5	475.0	362.1
Tort Claims Employees	10.9	1.9	10.9	0.5
Touched by an Angel Comm. Enrich. Center	0.0	0.0	350.0	313.6
Tri-Town YMCA	125.0	111.7	0.0	0.0
Trinity Services	250.0	250.0	0.0	0.0
United Cerebral Palsy Seguin of Gtr. Chicago	75.0	15.1	0.0	0.0
United Way of Greater St. Louis	0.0	0.0	1,000.0	1,000.0
Urban Autism Solutions - West Side Trans.	400.0	400.0	750.0	748.0
WDB Cares, NFP	0.0	0.0	300.0	0.0
Welcoming Centers	5,000.0	4,251.5	115,000.0	98,841.8
West Austin Development Center	0.0	0.0	620.0	486.0
West Cook County Youth Club	250.0	250.0	0.0	0.0
West Cook YMCA	100.0	100.0	0.0	0.0
Westside Health Authority Crisis Intervention	1,000.0	1,000.0	1,000.0	1,000.0
WINGS Program Inc	300.0	300.0	0.0	0.0
Wonderworks	100.0	100.0	100.0	21.0
Youth Build	0.0	0.0	200.0	33.6
Youth Employment Programs	19,000.0	15,419.4	19,000.0	13,440.5
Youth Guidance - Becoming a Man	0.0	0.0	3,000.0	2,854.6
Youth Guidance - Working on Womanhood	0.0	0.0	3,000.0	2,648.0
Youth Peace Center of Roseland	1,000.0	924.3	0.0	0.0
Youth Services of Glenview Northbrook	300.0	300.0	0.0	0.0
Youth Summer Job Programming	300.0	0.0	3,200.0	0.0
<b>Total Grants</b>	<b>3,580,601.6</b>	<b>3,263,796.3</b>	<b>4,269,072.0</b>	<b>4,021,631.3</b>
<b>TOTAL GENERAL FUNDS</b>	<b>4,857,245.3</b>	<b>4,456,192.5</b>	<b>5,685,614.2</b>	<b>5,407,332.6</b>
<b>OTHER STATE FUNDS</b>				
Total Contractual Services	300.0	298.5	300.0	299.5
Total Other Operations and Refunds	2,335.4	202.8	2,335.4	128.2
<b>Designated Purposes</b>				
Behavioral Health Special Projects	22,000.0	7,200.7	50,000.0	7,125.3
COVID-19 Related Expenses	100,000.0	94,025.7	130,000.0	105,645.8
DHS GATA Unit	5,000.0	1,412.5	5,000.0	1,450.9
DHS Interagency Support Services	3,000.0	2,005.4	3,000.0	2,764.3
DHS Recoveries Trust	22,263.0	8,787.4	22,263.0	5,250.9
Drugs & Costs Associated w/Pharmacy Serv.	12,300.0	5,419.5	12,300.0	5,244.4
Energy Conservation & Efficiency Program	500.0	6.3	500.0	10.0

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Framework Project Program	10,000.0	6,055.8	10,000.0	5,494.7
Illinois Broadband Adoption	0.0	0.0	100,000.0	0.0
Implement Firearm Conceal & Carry	2,500.0	338.8	2,500.0	449.1
Mgmt. Info. Serv. Tech. Assist. & Support	6,636.6	0.0	6,636.6	0.0
Medicare Part D	1,507.9	729.3	1,507.9	706.6
Off-Hours Child Care Program	0.0	0.0	2,000.0	0.0
Private Resources	200.0	145.6	200.0	165.1
Public Health Programs	368.0	0.0	368.0	0.0
Support Services	14,000.0	6,104.0	14,000.0	7,723.6
Total Designated Purposes	200,275.5	132,231.0	360,275.5	142,030.7
<b>Grants</b>				
9-8-8 Call Centers and Crisis Response	0.0	0.0	5,000.0	0.0
Addiction Prevention Related Services	2,050.0	1,234.8	2,050.0	1,200.0
Addiction Treatment & Related Services	3,742.2	1,149.8	3,742.2	1,168.9
Addiction Treatment Services	5,105.8	2,212.8	5,105.8	1,139.4
Assistance for Homeless	750.0	0.0	1,000.0	0.0
Autism Awareness	50.0	21.0	50.0	0.0
Autism Cares	50.0	0.0	50.0	0.0
Autism Research Checkoff	25.0	0.0	25.0	0.0
Cannabis Regulation & Tax Act	44,000.0	20,238.9	98,000.0	46,008.1
Children's Health Programs	1,138.8	0.0	1,138.8	0.0
Children's Wellness Charities	50.0	0.0	50.0	0.0
Coalition for Tech. Asst. & Training	250.0	0.0	250.0	0.0
Community Services & Volunteer Activities	0.0	0.0	15,000.0	6,286.5
Compulsive Gamblers Treatment	6,800.0	6,060.7	10,000.0	7,753.8
Developmental Disabilities Grants	52,000.0	0.0	52,000.0	0.0
Developmental Disabilities Legal Aid Grants	100.0	0.0	100.0	0.0
Developmental Disabilities Long Term Care	45,000.0	36,113.7	45,000.0	44,978.6
Developmental Disabilities Purchase of Care	9,965.6	0.0	9,965.6	0.0
DHS Community Services	15,000.0	71.0	15,000.0	13.3
Domestic Violence Programs	100.0	33.0	250.0	0.0
Domestic Violence Shelters	952.2	533.0	952.2	603.4
Early Intervention Program	200,000.0	159,609.6	200,000.0	188,613.7
Emergency and Transitional Housing	10,383.7	10,340.0	10,383.7	10,030.2
Emergency Rental Assistance Program	98,000.0	2,968.7	198,000.0	52,717.2
First Responders Behavioral Health Grant	0.0	0.0	10,000.0	0.0
Grants Supportive Housing Services	3,382.5	3,382.5	3,382.5	3,217.9
Group Home Loans	200.0	0.0	200.0	150.0
Health and Human Services Medicaid Trust	42,400.0	10,803.8	42,400.0	895.5
Home Services Program	256,000.0	244,027.3	256,000.0	230,206.7
Homeless Youth Services	1,000.0	709.8	1,000.0	581.8

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Homelessness Prevention	5,000.0	4,931.6	6,000.0	4,828.3
Housing for Families	50.0	0.0	50.0	0.0
Hunger Relief Checkoff	250.0	250.0	250.0	249.6
Medicaid-Mentally Ill/Kid Care	85,000.0	33,024.5	80,000.0	46,156.3
Mental Health Grants-Home-Based Program	1,300.0	1,190.2	1,300.0	1,137.7
Mental Health Treatment	5,000.0	3,047.5	5,000.0	4,244.4
National Opioid Settlement	0.0	0.0	108,000.0	3,863.6
Non-Medicaid Services for Comm. Youth Prog.	150.0	0.0	150.0	0.0
Opioid Overdose Prevention Program	300.0	284.2	300.0	0.0
Ronald McDonald House Charities Central IL	0.0	0.0	75.0	0.0
Ronald McDonald House Charities Chicago	0.0	0.0	75.0	0.0
Sexual Assault Services	100.0	0.0	200.0	0.0
Sexual Assault Services & Prevention	600.0	251.8	600.0	447.0
Special Children's Charities	0.0	0.0	500.0	370.8
Special Olympics IL & Children's Charities	2,000.0	2,000.0	1,500.0	1,112.3
Special Olympics IL Fund	50.0	13.7	50.0	14.6
Specialized Serv. For Human Traff. Survivors	100.0	0.0	100.0	0.0
State Match for Fed. Vocational Rehab. Prog.	16,690.3	13,943.4	6,882.9	4,537.5
Tobacco Enforcement Program	2,800.0	1,927.0	2,800.0	2,326.8
Welcoming Centers	80,000.0	0.0	80,000.0	37,884.2
Total Grants	997,886.1	560,374.3	1,279,928.7	702,738.1
<b>TOTAL OTHER STATE FUNDS</b>	<b>1,200,797.0</b>	<b>693,106.6</b>	<b>1,642,839.6</b>	<b>845,196.5</b>
<b>FEDERAL FUNDS</b>				
Total Personal Services & Fringe Benefits	185,339.5	118,323.2	185,318.5	119,171.7
Total Contractual Services	39,421.9	12,592.3	39,421.9	13,188.0
Total Other Operations and Refunds	13,668.8	1,436.3	13,668.8	1,420.7
<b>Designated Purposes</b>				
Alcohol & Substance Abuse Prevention	215.0	0.0	215.0	0.0
ARPA - Illinois Hospitals	0.0	0.0	7,000.0	0.0
Carter Temple Comm. Develop. Corporation	0.0	0.0	1,000.0	0.0
Community Services & Volunteer Activities	15,000.0	3,854.0	0.0	0.0
Federally Assisted Programs	7,388.3	2,078.7	8,004.2	2,555.0
COVID-19 Related Mental Health	0.0	0.0	40,000.0	40,000.0
DHS Expenses Related to COVID-19	60,000.0	60,000.0	50,000.0	50,000.0
Welcoming Centers	80,000.0	40,000.0	0.0	0.0
Maternal and Child Health Programs	458.1	0.0	458.1	0.0
Operation of Federal Employment	10,783.7	7,259.5	10,783.7	7,078.5
Vocational Programming	152.9	106.1	370.0	223.6
Total Designated Purposes	173,998.0	113,298.3	117,831.0	99,857.1
<b>Grants</b>				
Addiction Prevention Related Services	24,000.0	16,379.7	24,000.0	18,754.2

**REVIEW: #4587 DEPARTMENT OF HUMAN SERVICES FY22-23 COMPLIANCE**

Addiction Treatment & Related Services	71,500.0	49,580.0	71,500.0	52,160.0
Addiction Treatment Services	107,100.0	61,847.0	107,100.0	70,414.5
ARPA - Fifth Street Renaissance	100.0	100.0	100.0	78.5
ARPA - Homeless Youth Services	1,000.0	149.2	850.8	123.7
ARPA - Housing is Recovery Pilot	10,000.0	0.0	10,000.0	0.0
ARPA - IL Special Children's Charities	10,000.0	0.0	10,000.0	2,593.5
ARPA - IL Special Olympics	10,000.0	0.0	10,000.0	5,121.7
ARPA - Immigrant Integration Services	14,000.0	11,575.3	2,424.7	2,424.7
ARPA - It Takes a Village	100.0	100.0	0.0	0.0
ARPA - Legal Assistance to Migrants	4,200.0	0.0	4,200.0	3,622.8
ARPA - Living to Serve - Health Disparity Init.	100.0	51.3	48.7	48.7
ARPA - Mental Health Serv. To First Respond.	5,000.0	0.0	5,000.0	467.7
ARPA - Mental Health, Behavioral Health	50,000.0	38,197.8	11,802.2	4,707.9
ARPA - Parents Too Soon	12,000.0	0.0	12,000.0	3,271.1
ARPA - Peoria Friendship House	250.0	250.0	0.0	0.0
ARPA - Refugee Case Management	1,500.0	996.2	503.8	503.0
ARPA - Reimagine Public Safety	235,000.0	0.0	0.0	0.0
ARPA - Special Olympics IL	1,000.0	0.0	1,000.0	0.0
ARPA - Suicide Prevention	5,000.0	0.0	5,000.0	0.0
ARPA - Supportive Housing Services	28,054.0	270.7	27,783.3	8,650.1
ARPA - Teen Reach After-School Programs	10,000.0	1,123.6	8,876.4	4,960.7
ARPA - Tri-County Urban League	1,000.0	0.0	0.0	0.0
ARPA - United African Org. Welcome Centers	2,000.0	0.0	2,000.0	397.4
ARPA - United Power	10,000.0	0.0	10,000.0	1,425.0
ARPA - Welcoming Centers	5,000.0	208.7	4,791.3	2,761.7
ARPA - Well Kids Learning Hub	150.0	138.4	11.6	11.6
ARPA - Working on Womanhood	3,000.0	2,219.0	781.0	777.1
ARPA - Youth Employment Programs	60,000.0	2,349.4	57,650.6	18,667.8
ARPA - Youth Guidance-Becoming a Man	3,000.0	2,654.6	345.4	345.0
ARPA - Emergency & Transition Housing	0.0	0.0	1,038.4	0.0
ARPA - Homeless Prevention Recruitment	0.0	0.0	1,100.0	0.0
ARPA - Homeless Youth Program	0.0	0.0	840.3	394.2
ARPA - IHDA COVID-19 Afford. Housing Grant	0.0	0.0	20,000.0	30.3
ARPA - IHDA Permanent Supportive Housing	0.0	0.0	40,000.0	0.0
ARPA - Peoria County for Residential Safety	0.0	0.0	75.0	0.0
ARPA - Peoria County 10th Judicial Circuit Ct.	0.0	0.0	100.0	62.3
ARPA - Prevention of Abuse	0.0	0.0	200.0	200.0
ARPA - Reimagine Public Safety	0.0	0.0	235,000.0	30,818.2
ARPA - South Side Mission	0.0	0.0	100.0	96.6
ARPA - Supportive Housing Recruitment	0.0	0.0	1,987.3	0.0
ARPA - Supportive MI Housing Recruitment	0.0	0.0	2,271.4	0.0

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Business Enterprise Program for the Blind	3,527.3	1,419.4	3,700.0	1,808.7
Child Care Assistance Program	2,989,399.0	1,465,795.1	2,989,399.0	1,592,908.9
Child Care Service Great Start	5,200.0	5,200.0	6,200.0	5,200.0
Client Assistance Project	1,179.2	413.8	1,179.2	0.0
Community Grants	7,257.8	7,137.3	7,257.8	7,042.6
COVID-19 Prevention Programs	20,000.0	0.0	20,000.0	0.0
Developmental Disabilities Grants	90,000.0	35,961.3	90,000.0	64,124.1
DHS Federal Projects Fund	16,036.1	4,353.2	16,036.1	5,808.9
Donated Funds Initiative Program	22,729.4	16,232.8	22,729.4	17,960.2
Emergency Food Program	25,163.8	11,940.5	25,163.8	4,827.7
Emergency Solutions Grants Program	60,000.0	22,377.2	60,000.0	14,868.7
Employment & Training Program	35,000.0	25,525.4	35,000.0	12,453.2
Eviction Mitigation Program	120,000.0	82,898.5	120,000.0	15,864.2
Family Violence Programs	10,018.2	4,230.0	33,018.2	8,557.5
Farmer's Market Nutrition	500.0	242.6	500.0	240.7
Federal Assistive Tech. Act Services	1,050.0	812.2	8,000.0	7,345.0
Federal Vocational Rehabilitation Programs	65,000.0	47,742.3	65,000.0	43,049.9
Federal/State Employment Program	5,000.0	90.7	5,000.0	14.3
Free Distribution Food Supplies	230,000.0	144,974.4	230,000.0	170,211.0
Gear Up	3,516.8	3,329.8	3,516.8	1.3
Head Start State Collaboration	500.0	77.1	500.0	205.1
Independent Living Centers	5,807.2	3,995.0	5,807.2	4,531.0
Independent Living Older Blind	3,045.5	1,541.4	3,045.5	1,532.8
Juvenile Justice Planning & Action Grants	3,000.0	1,451.0	3,000.0	1,941.2
Maternal and Child Health Programs	2,000.0	0.0	2,000.0	0.0
Mental Health Block Grant	50,000.0	27,515.6	50,000.0	30,976.4
Mental Health Block Grant - ARPA	25,000.0	4,673.9	25,000.0	14,228.4
Mental Health Block Grant Children	4,341.8	3,163.1	4,341.8	3,222.6
MIEC Home Visiting Program	21,006.8	8,686.9	21,006.8	8,884.1
Migrant Day Care Services	4,422.4	2,723.6	4,422.4	3,790.9
Parents Too Soon	2,505.0	1,879.2	2,505.0	2,488.8
Partnership for Success Program	5,000.0	0.0	5,000.0	0.0
Prev. of Prescription Drug OD-Rel. Deaths	2,000.0	376.4	2,000.0	222.1
Public Assistance Grants for Priv. Non-Profits	50,000.0	4,692.8	50,000.0	16,600.2
Public Health Programs	10,742.3	2,596.8	10,742.3	2,378.1
Race to the Top	5,000.0	0.0	5,000.0	0.0
Refugee Settlement Services	30,611.2	7,154.6	50,611.2	13,647.4
Services to Disabled Individuals	25,000.0	11,726.7	25,000.0	14,092.7
SNAP 3-Year State Admin. Exp. Grant	40,000.0	21,916.9	40,000.0	20,041.5
SNAP Education	30,000.0	17,456.0	30,000.0	17,742.7
SNAP Outreach	5,000.0	2,076.9	5,000.0	2,345.9

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SNAP Pilot Employment & Training	5,000.0	0.0	5,000.0	0.0
SNAP to Success	3,000.0	1,979.0	3,000.0	2,165.8
SSI Advocacy Services	1,009.4	0.5	1,009.4	0.2
Subst. Abuse & Mental Health Serv. Admin.	5,000.0	1,646.5	5,000.0	1,061.4
Subst. Abuse Prev. & Treat. Block Grant	25,000.0	293.3	25,000.0	11,673.3
Supported Employment	1,900.0	696.3	3,500.0	2,558.6
Supportive Food Program - WIC	1,400.0	1,261.3	1,400.0	1,196.4
Tort Claims	10.0	0.0	10.0	0.0
WIC Program	75,049.0	53,069.3	75,049.0	57,491.5
Total Grants	4,836,982.2	2,251,517.5	4,896,133.1	2,441,196.0
<b>TOTAL FEDERAL FUNDS</b>	<b>5,249,410.4</b>	<b>2,497,167.6</b>	<b>5,252,373.3</b>	<b>2,674,833.5</b>
<b>TOTAL</b>	<b>11,307,452.7</b>	<b>7,646,466.7</b>	<b>12,580,827.1</b>	<b>8,927,362.6</b>

**Accountants' Findings and Recommendations**

Condensed below are the 33 findings and recommendations included in the audit report. Of these, 27 are repeated from the previous audit. The following recommendations are classified on the basis of information provided by the Department of, via electronic mail received September 29, 2022.

- 1. The auditors recommend the Department strengthen its internal control over preparing the SCO Forms by including a reconciliation of Federal grant receipts and expenditures by ALN included in each SCO Form to the general ledger for each fund (the ERP System). Deposits of federal draws should be recorded in the fund(s) that incurred the associated expenditures. Once prepared, balances reported in the SCO forms should be compared to the draft financial statements, by fund, to conclude if amounts are reasonable. Additionally, large balances in Due from Other Governments – Federal, Unearned Revenue and Unavailable Revenue should be investigated as they are unusual for reimbursement type grant awards in which the Department can generally draw funds monthly upon the incurrence of qualifying expenditures.**

**FINDING:** *Inadequate Internal Controls over Accounting for Federal Awards – First reported 2022, Last reported in 2023*

The Department of Human Services (Department) does not have sufficient internal control over accounting for grant transactions resulting in material misstatements to the draft financial statements.

The individuals at the Department responsible for drawing federal award monies did not track expenditures paid by fund and report this information to the Department's Office of Fiscal Services (Fiscal Services) which is responsible for recording grant transactions. In addition, the individuals depositing federal award draws did not always deposit the money

into the same funds in which the program expenditures were paid. This is more frequently an issue for Department programs funded by more than one fund, such as the Childcare and the Temporary Assistance for Needy Families (TANF) programs, or programs which receive cost allocations.

For financial reporting purposes, the Department (Fiscal Services) tracks grant data for purposes of accruing grant receivables, unearned revenue, unavailable revenue and payable balances, all of which impact Federal Operating Grant Revenue, using Office of Comptroller required SCO forms including SCO- 563 *Grant /Contract Analysis*, SCO-567, *Interfund Transfers – Grantee Agency*, and SCO-568 *Interfund Transactions – Grantor Agency*.

In preparing the SCO Forms, the Department made errors in reporting expenditure amounts, including expenditure adjustments, and cash receipts, including lapse period receipts, for its federal award programs, resulting in errors in the financial statements for grant transactions. Additionally, based on audit procedures performed, the SCO Forms required multiple revisions throughout calendar year 2024.

**Corrected Misstatements:**

- 1) In the General Revenue Fund (0001), expenditures were overstated by \$476 thousand and grant receipts were understated by \$2.7 million in the SCO-563 form. This resulted in an understatement of unearned revenue and overstatement of Federal Operating Grant Revenue by \$3.2 million. Further, certain opening balances in the SCO-563 form were not accurate, which resulted in an understatement of unearned revenue and overstatement of Federal Operating Grant Revenue of \$1.1 million.
- 2) In the General Revenue Fund (0001), assistance listing number (ALN) 10.561 included COVID- related funding with the non-COVID related funding. When working with the Department to split the activity between COVID-related funding and non-COVID related funding, an overstatement of Unearned Revenue and understatement of Federal Operating Grant Revenue of \$2.7 million was identified.
- 3) In the General Revenue Fund (0001), expenditures in the SCO-563 were understated by \$7.8 million for ALN 10.561C. This resulted in an understatement of Due from Other Governments – Federal and Unavailable Revenue by \$7.8 million.
- 4) In the General Revenue Fund (0001), a transfer in the amount of \$16.3 million was incorrectly recorded, resulting in an overstatement of Federal Operating Grant Revenue.
- 5) In the Employment and Training Fund (0347), expenditures in the SCO-563 form were overstated by \$94.5 million resulting in an overstatement of Federal

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Operating Grant Revenue, Unavailable Revenue and Due from Other Governments - Federal.

- 6) In the Employment and Training Fund (0347), certain opening balances in the SCO-563 form were not accurate, which resulted in an overstatement of Due from Other Governments – Federal and Unavailable Revenue in the amount of \$47.1 million.
- 7) A transfer was captured incorrectly between the Employment and Training Fund (0347) and the Special Purpose Trust Fund (Fund 0408), in the amount of \$5.2 million. Further, a transfer was captured incorrectly in the amount of \$16.3 million, resulting in an understatement of Federal Operating Grant Revenue.
- 8) In the Employment and Training Fund (0347), expenditures in the SCO-563 form were overstated by \$68.8 million due to inclusion of expenditures and grant receipts to be reported by the Department of Child and Family Services in Fund 0220. This resulted in an overstatement of Due from Other Governments – Federal by \$7.4 million and Federal Operating Grant Revenue by \$68.8 million, and an understatement of Unearned Revenue by \$61.4 million.
- 9) In the Food Stamp and Commodity Fund (1245), the SNAP major program expenditure report for ALNs 10.551 and 10.542 did not include June activity. This resulted in an understatement of Federal Operating Grants Revenue and Health and Social Services Expenses of \$376.8 million. Further, the activity recorded for fiscal year 2024 did not include emergency allotment funding. This resulted in an understatement of Federal Operating Grant Revenue and Health and Social Services expenditures of \$91 million.
- 10) In the Special Purpose Trust Fund (0408), certain opening balances in the SCO-563 form were not accurate, which resulted in an overstatement of Federal Operating Grant Revenue of \$357 thousand, overstatement of Due from Other Governments – Federal of \$461 thousand, overstatement of Unavailable Revenue of \$1.2 million, and an understatement of Unearned Revenue of \$1 million.
- 11) In the DHS Federal Projects Fund (0592), certain opening balances in the SCO-563 form were not accurate, which resulted in an understatement of Unearned Revenue and Due To by \$10.3 million.
- 12) In the Vocational Rehabilitation Fund (0081), certain opening balances in the SCO-563 form were not accurate, which resulted in an overstatement of Federal Operating Grant Revenue of \$7 million.

The errors reflected above were corrected in the final financial statements.

**Uncorrected Misstatements:**

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Uncorrected misstatements were identified as follows:

- 1) In the Vocational Rehabilitation Fund (0081), Federal Operating Grant Revenue was recognized in excess of eligible expenditures incurred which resulted in an uncorrected misstatement for an overstatement of Federal Operating Grant Revenue in the amount of \$6.3 million.
- 2) In the USDA Women, Infants and Children Fund (0700), the ending unearned revenue balance per the SCO-563 form did not agree to the trial balance. As a result, Federal Operating Grant Revenue was overstated and unearned revenue was understated by \$2.7 million.
- 3) In the DHS Special Purposes Trust Fund (0408), DHS Technology Initiative Fund (0211) and the Employment and Training Fund (0347), certain costs that were incurred in FY22 were included in total reimbursable costs in the SCO-563 in FY23 instead of in FY22, resulting in an understatement of prior year Federal Operating Grant Revenue and an overstatement of current year Federal Operating Grants Revenue of \$6 million, \$1 million, and \$1.7 million, respectively.

GASB Codification Section N50 provides the authoritative guidance for reporting nonexchange transactions. The majority of the Department's Federal awards are voluntary nonexchange transactions which are considered expenditure-driven or reimbursement-type grants. For these award types, the provider (Federal agency) stipulates that a recipient (the Department) cannot qualify for resources without first incurring allowable costs under the provider's program (eligibility requirement). Recipients of voluntary nonexchange transactions should recognize receivables (or a decrease in liabilities) and revenues (net of estimated uncollectible amounts), when all applicable eligibility requirements, including time requirements, are met.

Under a good system of internal control, detailed records of monthly grant transactions should be maintained for each Federal award, by fund, and reconciled to the general ledger by fund, to ensure amounts used to calculate receivables, unearned amounts, unavailable amounts and revenue are accurate in each Fund's SCO forms.

Department management indicated that several federal grant programs operated through more than one fund. For these programs, expenditures for each Federal award are tracked in total and provided to Fiscal Services in a report called a "bucket report." The bucket report does not indicate which funds the expenditures were paid from resulting in misallocations on the SCO-563 forms. Additionally, other errors resulted from additional COVID-19 related grant funding in FY23 which then had to be separated from ongoing programs. The June 2023 expenditure data was not made available in time to be included in the FY23 GAAP reporting.

As a result of errors in the SCO forms used as a basis for recording financial statement transactions, the draft financial statements were materially misstated as noted in the discussion above.

### **DEPARTMENT RESPONSE:**

**REVIEW: #4587 DEPARTMENT OF HUMAN SERVICES FY22-23 COMPLIANCE**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The expenditure and receipts data used to prepare the draft financial statements comes from the general ledger module in ERP. The Department prepared a reconciliation of ERP federal grant expenditures by ALN versus the buckets provided by the Federal Reporting area. Moving forward, the Department will also include ERP draw/receipt data. Additionally, the Department will compare expenditures against receipts by both fund and ALN to conclude whether the amounts are reasonable. Finally, the Department will investigate large balances shown as “Due from Other Governments” for those grants that are drawn on a reimbursement basis.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

- Revise SCO563/bucket reconciliation spreadsheet to include Receipts, and to include a tab with data grouped by ALN and a tab with data grouped by fund. (100% Complete)
- Compare expenditures to receipts for each ALN to identify any major differences, research differences. (100% Complete)
- Identify ALN’s with large balances in the “Due From other Governments” column. (100% Complete)

**Date of Completion: 01/31/2025**

**2. The auditors recommend the Department assume more responsibility for the transactions and balances reported in its financial statements that are initiated/estimated by other State agencies, including the following:**

- **The Department should enter into an interagency agreement (IA) with HFS that details the responsibilities of each agency with regards to initiating, processing and recording transactions, and how the sufficiency of internal control over Department transactions will be monitored (i.e. annual internal audit, SOC 1 Type 2 audit, or other).**
- **Once an IA is executed, on a regular basis, the Department should determine if the control system and related monitoring agreed to through the IA is sufficient to prevent and detect significant financial statement errors. The sufficiency of internal control should be monitored each time there is a major change to Federal MAP/CHIP programs or IT systems used for those programs.**
- **Expenditure and accrual amounts provided by HFS in connection with year-end reporting of Federal MAP receivables should be reconciled to ERP or agreed to reports and source data compiled by HFS.**

**FINDING: *Medical Assistance Program Financial Information – This finding has been repeated since 2017.***

The Department of Human Services (Department) does not have an adequate understanding of the suitability of the design of internal control or the operating effectiveness of internal control in place over all data recorded in its financial statements for transactions initiated by other State agencies and recorded in the Department's financial statements.

During their testing of the financial statements and supporting documentation, the auditors noted the following:

- The Department could not provide documentation of the preparation or the Department's review of expenditure reconciliations for Federal Medical Assistance Program (MAP) funds or the State Children's Health Insurance Program (CHIP) (Funds 0120, 0142, 0211, 0365, 0502, 0509, 0718) between amounts reported in the Department's general ledger system (ERP) and amounts reported in the Grant/Contract Analysis Forms (Form SCO-563s) provided to the Office of Comptroller (IOC) which support the receivable and revenue calculation for financial reporting. The amount per the Form SCO-563s (totaling approximately \$424 million for total reimbursable costs "TRC" for Assistance Listing Numbers (ALN) 93.767 and 93.778), is a computed amount (a formula), essentially the amount needed to achieve the reported receivable balance provided by the Department of Healthcare and Family Services (HFS), a separate State agency, or a maximum amount for funds which have a statutory deposit limit. The Department does not retain a reconciliation between what is reported on the Form SCO-563s (claimable expenditures) and within ERP (all expenditures) for each fund which identifies which expenditures were used for claiming the federal award. Additionally, there is no documentation maintained by the Department to support the calculation and methodology used by HFS in preparing the net federal receivable amount (approximately \$16.1 million for the two ALNs).
- During testing of expenditures and liabilities, they determined that the Department is not monitoring or reviewing the payments submitted by HFS, or the liabilities calculated by HFS, on behalf of the Department and reported in the Department's financial statements. When HFS submits a request for payment to the IOC, a summary file is also sent to the Department which goes through an interface and is recorded into ERP. An employee in the Department's Office of Fiscal Services reconciles the payments between ERP and the IOC before accepting them into ERP. Although the Department has documented their understanding of how transactions for DHS programs are processed within HFS, the Department was unable to provide auditors with documentation of their monitoring performed over the amounts reported in the Department's financial statements.
- Additionally, the Department is placing reliance on the internal control over the applicable HFS system without recent independent verification of the system. Currently, the Department receives summarized information from HFS and records the transactions into ERP and the SCO-563 forms without performing sufficient

procedures to determine the accuracy of the information.

A good system of internal control requires that management review all significant accounts and balances recorded in the financial statements for accuracy, which includes transactions initiated by other State agencies.

Internal controls over financial reporting for governmental entities should be designed to provide reasonable assurance of achieving effective and efficient operations, reliability of reporting for internal and external use, and/or compliance with provisions of applicable laws and regulations.

The Governmental Accounting Standards Board's *Codification of Governmental Financial and Reporting Standards*, Section 1100.101, provides that a governmental accounting system must make it possible both:

(a) to present fairly and with full disclosure the funds and activities of the governmental unit in conformity with generally accepted accounting principles, and (b) to determine and demonstrate compliance with finance-related legal and contractual provisions. This requires the financial statements to agree with and to be supported by the Department's underlying records to enable accurate financial statements to be prepared.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

This finding was first noted during the Department's financial audit of the year ended June 30, 2017. In subsequent years, the Department has been unable to fully implement its corrective action plan.

Department management indicated they rely on the HFS Bureau of Claims Processing and the controls in the Medicaid Management Information System (MMIS). Although management has outlined a corrective action plan to address the findings, Department management stated, the plan was not executed prior to June 30, 2023.

Lack of sufficient internal controls over transactions and balances recorded in the Department's financial statements increases the likelihood of misstatements.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department has begun drafting an interagency agreement with the Department of Healthcare and Family Services (HFS), which will outline the responsibilities of each agency regarding the reliability of HFS' MMIS data. The Department will also work with HFS to outline how the federal MAP receivables are supported by reports and source data compiled by HFS. Lastly, the Department will monitor the interagency agreement and make necessary modifications as needed.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

- Draft and implement an IGA between DHS and HFS indicating the responsibilities of each agency regarding MMIS data. (50% Complete)
- Meet with HFS to outline how the HFS MAP data is used to identify receivable amounts. (10% Complete)

**Estimated Date of Completion: 10/01/2025**

3. **The auditors recommend the Department utilize information provided by the Illinois Office of Comptroller (IOC) SCO- 565 Inter-Fund Payable/Receivable form in preparing and reviewing its final inter-fund balances.**

**FINDING: *Intergovernmental Expenses – New***

The Department of Human Services (Department) does not have sufficient internal control over accounting for intergovernmental expense transactions.

In contractual services expenditures for the General Revenue Fund (0001), three transactions totaling \$9 million out of 46 transactions totaling \$97.3 million tested that were recognized during the year ended June 30, 2023, were expenditures incurred in the year ended June 30, 2022 and should have been recognized for the year ended June 30, 2022. Of the three transactions, two were intergovernmental charges from the Department of Innovation and Technology (DoIT).

In equipment expenditures for the General Revenue Fund (0001), two transactions totaling \$6.2 million out of 12 transactions totaling \$13.6 million tested that were recognized during the year ended June 30, 2023, were expenditures incurred in the year ended June 30, 2022 and should have been recognized for the year ended June 30, 2022. Both transactions were intergovernmental charges from the DoIT.

Upon further investigation, it was determined there were approximately \$53.5 million of contractual services and other expenditures incurred by DoIT to be billed out to the Department, of which only approximately \$37.5 million had been recognized in accounts payable during fiscal year 2022. The Department reported nearly \$15.9 million in expenditures for the year ended June 30, 2023, that were incurred for data center charges, supplemental IT charges and communication charges in the year ended June 30, 2022.

GASB Codification Section 1600 provides the authoritative guidance for reporting expenditure transactions. Paragraph 119 states "In the absence of an explicit requirement

to do otherwise, a government should accrue a governmental fund liability and expenditure in the period in which the government incurs the liability. Governmental fund liabilities and expenditures that should be accrued include liabilities that, once incurred, normally are paid in a timely manner and in full from current financial resources—for example, salaries, professional services, supplies, utilities, and travel. To the extent not paid, such liabilities generally represent claims against current financial resources and should be reported as governmental fund liabilities.”

Department management indicated they used the amount of expenditures paid to the revolving fund during FY23 lapse period to identify the \$37.5 million that was owed to DoIT at June 30, 2022.

As a result of the errors noted above, expenditures in the prior year financial statements were understated and expenditures in the current year financial statements were overstated by \$15.9 million.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department will utilize the data on the SCO-565 provided by the Illinois Office of the Comptroller in preparing and reviewing inter-fund balances included in GAAP reports and financial statements.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

Utilize the SCO-565 provided by the IOC in the applicable GAAP packages.

**Date of Completion: 01/03/2025**

- 4. The auditors recommend the Department evaluate the policies and procedures in place related to fund balance review to ensure that categories are properly calculated, reviewed and reported.**

**FINDING:** *Classification of Fund Balance – New*

The Department of Human Services (Department) did not properly classify fund balance in the General Revenue Fund.

During their testing of fund balance classifications, the auditors noted that the Department inappropriately classified \$57,470,000 of fund balance in the General Revenue Fund. The \$57,470,000 of fund balance was reported as restricted fund balance but should have been reported as unassigned fund balance.

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GASB Codification Section 1800 provides the authoritative guidance for reporting fund balance in governmental funds. Paragraph 179 states “Fund balance classifications should depict the nature of the net resources that are reported in a governmental fund. An individual governmental fund could include no spendable resources and amounts that are restricted, committed, or assigned, or any combination of those classifications.” Further, paragraph 178 states “Unassigned fund balance is the residual classification for the general fund. This classification represents fund balance that has not been assigned to other funds and that has not been restricted, committed, or assigned to specific purposes within the general fund. The general fund should be the only fund that reports a positive unassigned fund balance amount.

Department management indicated the General Revenue fund balance included a no spendable portion relating to the balance of inventory, which led the Department to report the fund balance as restricted.

The improper classification of fund balance in the General Revenue Fund represents a failure in internal controls over financial reporting to identify an error with GASB reporting requirements.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department will continue to work with the Illinois Office of the Comptroller (IOC) on reviewing and updating the classification of Departmental fund balances.

### **UPDATED RESPONSE:**

**Implemented.**

### **Corrective Action Plan:**

Work with the IOC prior to completion of financial statements to ensure fund balance classifications are correct.

**Date of Completion: 01/03/2025**

- 5. The auditors recommend the Departments work with DoIT to allocate sufficient resources to enable a full recovery of IES in the event of a disaster and implement adequate disaster recovery controls over IES. Additionally, in the interim, they recommend the Departments work with DoIT to develop a prioritization plan and emergency operating procedures to allow IES to operate under reduced capacity in the event of a disaster.**

**The auditors further recommend management of the Departments enhance the Disaster Recovery Plan to include:**

- Detailed recovery scripts over the application and its data,**
- Detailed environment diagrams,**
- IES support staff and vendor contact information,**

- Documentation on the backup and responsibilities for recovery of IES, and
- Documentation of the current environment.

Finally, they recommend the Departments perform disaster recovery testing on a regular basis as defined in the plan.

**FINDING:** *Inadequate Disaster Recovery Controls over the Integrated Eligibility System (IES) – This finding has been repeated since 2019.*

The Department of Human Services and the Department of Healthcare and Family Services (collectively, the “Departments”) lacked adequate disaster recovery controls over the Integrated Eligibility System (IES).

Management of the Departments have a shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments’ IES is the automated system used by the Departments to intake, process (with the assistance of caseworkers), and approve assistance applications, maintenance items, Mid-Point Reports, and redeterminations of eligibility as well as to make payments for the State’s human service programs. Additionally, the Departments work with the Department of Innovation and Technology (DoIT) for information technology management and support over IES.

The Departments’ Disaster Recovery Plan for its IES application did not include the following:

- Detailed recovery scripts over the application and its data,
- Detailed environment diagrams,
- IES support staff and vendor contact information,
- Documentation on the backup and responsibilities for recovery of IES, and
- Documentation of the current environment.

Additionally, the auditors noted the Departments did not conduct recovery testing of critical systems and components in fiscal year 2023.

This finding was first noted during the Departments’ financial audits of the year ended June 30, 2019. In subsequent years, the Departments have been unable to fully implement its corrective action plan.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621(f)(2)(ii)(F), *ADP System Security Requirements and Review Process*, requires the Departments’ automated data processing (ADP) security plan, policies and procedures to include contingency plans to meet critical processing needs in the event of short or long-term interruption of service.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology, Contingency Planning section requires entities to develop contingency plans

for systems to achieve continuity of operations for organizational missions and business functions along with addressing system restoration and implementation of alternative missions or business processes when systems are compromised or breached.

The *Control Objectives for Information and Related Technologies* published by Information Systems Audit and Control Association (ISACA), Managed I&T-Related Risk Area, promotes controls for analyzing risks and maintaining a risk profile of risks and their potential impact and responses.

The Departments' management indicated the delayed completion of the Information System Contingency Plan (ISCP) for the IES application was due to the time required for IES technical teams to formulate and vet a complete, detailed failover playbook that would meet the Department's expectations for recovery time objectives.

The lack of an adequate Disaster Recovery Plan and testing could result in the Departments' inability to recover IES data in the event of disaster, which would be detrimental to recipients of benefits, and the Departments' and State's operations.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department has worked with IES application stakeholders, including DoIT, to complete the Information System Contingency Plan in FY24. The plan documents the recovery control requirements of the finding. A comprehensive tabletop test exercise of the IES contingency plan and playbook was completed on December 1, 2023. The Department will work toward testing and updating the IES contingency plan annually.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**

The Department of Healthcare and Family Services accepts the recommendation. The IES application and data reside on the Department of Innovation and Technology (DoIT) infrastructure and as our service provider they are responsible for ensuring disaster recovery controls are in place and tested. The Department of Human Services has worked with IES application stakeholders to complete the Information System Contingency Plan in FY24. The plan documents the recovery control requirements noted. A comprehensive tabletop test exercise of the IES contingency plan and playbook was completed on December 1, 2023. The Departments will work with DoIT to test and update the IES contingency plan annually.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

- DoIT, working with NTT Data and Kyndryl, has documented a full failover playbook for Disaster Recovery, as well as an Information System Contingency Plan (ISCP) for Legacy IES.
- DoIT, working with NTT Data and Kyndryl, has completed a tabletop exercise (TTE) for Legacy IES.

- DoIT, working with NTT Data and Kyndryl, has documented a full failover playbook for Disaster Recovery, as well as an Information System Contingency Plan (ISCP) for Technical Refresh IES. Technical Refresh IES was implemented to replace Legacy IES on 12/1/24.
- DoIT, working with NTT Data and Kyndryl, has completed a tabletop exercise (TTE) for Technical Refresh IES. The playbook and ISCP documents were updated based on findings from the TTE.

**Date of Completion: 08/16/2024**

- 6. The auditors recommend management of both Departments work together to strengthen controls over the IES environment by addressing all significant threats identified in the Plan of Actions and Milestones (2023) report to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.**

**Auditors also recommend management of both Departments ensure backout plans are developed and documented for infrastructure changes.**

**FINDING:** *Inadequate General Information Technology Controls over IES – This finding has been repeated since 2017.*

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the “Departments”) had weaknesses in the general information technology (IT) and security controls over the Integrated Eligibility System (IES).

Management of the Departments has a shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments’ IES is the automated system used by the Departments to intake, process (with the assistance of caseworkers), and approve assistance applications, maintenance items, Mid-Point Reports, and redeterminations of eligibility as well as to make payments for the State’s human service programs.

In addition to the conditions noted below, related IES issues over disaster recovery controls are noted in Finding Code No. 2023-005.

#### *Environment*

The IES application and data reside on the Department of Innovation and Technology (DoIT) environment. In this regard, DoIT is a service provider to the Departments.

During the Departments’ internal security review, completed as part of its Plan of Actions and Milestones (2023) report to the U.S. Department of Health and Human Services,

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Centers for Medicare and Medicaid Services (Federal CMS), significant threats over DoIT's general IT environment, which hosts IES, were identified.

Further, during the auditor's fieldwork it was noted the Departments experienced three security breaches related to the IES system; the first breach occurred in August 2022, the second breach was discovered in March 2023, and the third breach occurred in August 2023.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621(f)(1)), *ADP System Security Requirement*, requires the Departments to be responsible for the security of all automated data processing (ADP) system projects under development and operational systems involved in the administration of the U.S. Department of Health and Human Services programs. The Departments are required to determine the appropriate security requirements based on recognized industry standards or standards governing the security of federal ADP systems and information processing.

Federal CMS' *MARS-E Document Suite* (minimum acceptable risk standards for exchanges), states that protecting and ensuring the confidentiality, integrity, and availability of state Marketplace information, common enrollment information, and associated information is the responsibility of the states.

The internal control requirements of the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance) within the Code (2 C.F.R. § 200.303) requires the Departments to establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions and comply with federal statutes, regulations and terms and conditions of the Medicaid Program.

These internal controls should be in compliance with guidance in Standards for Internal Control in the Federal Government (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

The Departments' management indicated multi-year IES technology refresh projects are still in progress. The Departments continue working through project delays and challenges to resolve security weaknesses and close out aged Plan of Action and Milestone findings.

The Departments' failure to maintain adequate internal controls over the security of the IES application led to three security breaches and increases the risk IES may be exposed to further malicious attacks, security breaches, and unauthorized access to recipients' personal information.

### *Change Control*

IES Application Changes - Policies and Procedures

Based on their review of sampled infrastructure changes, the auditors noted backout plans to return the system to a previous functional version in the event a change moved into production caused undesired results had not been prepared for individual infrastructure changes for 5 out of 5 (100%) changes reviewed.

The National Institute of Standards and Technology (NIST), Special Publication 800-53, Fifth Revision, *Security and Privacy Controls for Information Systems and Organizations*, Configuration Management section, backout plans should be retained to support rollback of changes made to systems.

Additionally, DoIT's Change Management Policy requires that each change have a backout plan documented.

The Departments' management indicated the Departments have made improvements to the current change management process and are working with DoIT to provide additional infrastructure change required documentation.

Findings over the IES Environment and Change Control were first noted during the Departments' financial audits of the year ended June 30, 2017. In subsequent years, the Departments have been unsuccessful in fully implementing corrective action plans.

Failure to establish and document backout plans for changes to IES infrastructure diminishes the Departments' ability to recover the application if an error were to occur during the change process.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Departments will work to implement the IES Technical Refresh (TR) and Okta MFA projects, as planned in FY25, to resolve security weaknesses and close out aged Plan of Action and Milestone findings. The Department will also work with the Department of Innovation and Technology on documented backout plans with all IES infrastructure changes.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**

The Department of Healthcare and Family Services accepts the recommendation. The IES application and data reside on the Department of Innovation and Technology (DoIT) infrastructure and as our service provider they are responsible for ensuring a secure environment, significant threats are identified and backout plans for changes are developed. The Departments will work with DoIT to implement the IES Technical Refresh (TR) and Okta MFA projects as planned in FY25 to resolve security weaknesses and close out aged Plan of Action and Milestone findings. The Departments will also require DoIT provide documented backout plans with all IES infrastructure changes.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

- IDHS will work with DoIT to implement Okta MFA (09/27/2024) and the IES Technical Refresh Phase 3 modernization (12/02/2024) projects, to close out aged Legacy POAMs. All operational Legacy application servers will be decommissioned by 01/30/2025.
- For infrastructure changes deployed that cause undesired results, all reasonable attempts to resolve the issue(s) will be attempted. If DoIT IES administrators determine they cannot remediate the issue(s), they will return the system to its previous functional version and/or configuration. This will be documented in the ticket “notes” section.

**Date of Completion: 01/30/2025**

- 7. The auditors recommend management of both Departments work together to implement additional controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES, and to complete certifications of applications and redeterminations timely.**

**FINDING:** *Inadequate Controls over Eligibility Determinations and Redeterminations – New*

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the “Departments”) lacked controls over eligibility determinations and redeterminations for Federal programs where such determination is documented using the Integrated Eligibility System (IES).

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments’ IES is the automated system used by the Departments to intake, process (with the assistance of caseworkers), and approve assistance applications, maintenance items, Mid-Point Reports and redeterminations of eligibility as well as to make payments for the State’s human service programs.

In order to conclude if the determination of eligibility was proper, the auditors selected a sample of 60 cases (30 new applications and 30 redeterminations) and tested whether the cases were properly certified (approved or denied) based on non-financial, financial and timeliness criteria. Their testing considered all the documentation contained within the case file, including the scanned documentation supporting caseworker overrides required prior to certification. In 12 of the 60 cases tested (20%), they noted exceptions. Specifically, auditors noted:

- Two new applications (7%) tested did not have the certification completed timely. Certifications were 12 and 162 days late.

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- One new application (3%) tested did not have residency and citizenship verified.
- One redetermination (3%) did not have the required documentation maintained.
- Five redeterminations (17%) tested did not have the certification completed timely. Certifications were 35 to 101 days late.
- Two redeterminations (7%) used the net pay instead of the gross pay for the benefit calculation with no impact to the benefit provided.
- One redetermination (3%) had unearned income incorrectly calculated.

The Code of Federal Regulations (Code) (42 C.F.R. § 435.403), *Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa*, requires recipients of Medicaid to provide documentary evidence of their citizenship, residency, SSNs, and income. Further, the Code (42 C.F.R. § 431.17), *Maintenance of Records* requires the Departments to maintain records of each applicant and beneficiary, including records which support the determination of eligibility.

The Code (7 C.F.R. § 273.10), *Determining Household Eligibility and Benefit Levels*, requires the household's eligibility be determined for the month of application by considering the household's circumstances for the entire calendar month in which the household filed its application. Eligibility for recertification shall be determined based on circumstances anticipated for the certification period starting the month following the expiration of the current certification period.

The Code (7 C.F.R. § 274.1 and §274.2), *Issuance System Approval Standards and Providing Benefits to Participants*, indicates DHS is responsible for the timely and accurate issuance of SNAP benefits to certified eligible households, and that all newly certified households (except those given expedited service) shall be given the opportunity to participate no later than 30 calendar days following the date the application was filed.

The Departments' management indicated contributing factors for the exceptions noted include worker errors in manual processes, the high volume of work and the complexity of the programs involved.

Inadequate controls over eligibility determinations resulted in determinations of eligibility that were not demonstrated or documented prior to recipient certification, and the State expending Federal and State funds for recipients that may not have been eligible to receive benefits. Noncompliance with federal laws and regulations could lead to sanctions and/or loss of future Federal funding, disallowance of costs, and the requirement to return Federal funds previously received.

### **DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS, in conjunction with HFS and our IES Vendor, is in the process of implementing additional controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES, and that certifications are made timely.

### **DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**

The Department of Healthcare and Family Services accepts the recommendation. The two cases related to medical were due to caseworker error. The Department has an ongoing monitoring program of caseworkers. The Bureau of Eligibility Integrity is working on a refresher training that is focused on errors caseworkers make.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

- Workload Management dashboard was implemented to track by queue, task title, and age. (100% Complete)
- A revised Case Progression Report Dashboard in Tableau was implemented. (100% Complete)
- Case Error Reduction page was implemented in IES. (100% Complete)

Phase 1 flags potential errors:

- Prompt to document Financial Management
- Prompt to use current, accurate income during application or Rede
- Prompt to update student status for students of Higher Education
- Failure to meet Expedited processing timelines
- Additional SNAP potential error prone flags will be added to Case Error Reduction page. (20% Complete)
- Potential error prone flags for Cash and Medical will be added to Case Error Reduction page. (20% Complete)

**Estimated Date of Completion: 12/31/2025**

- 8. The auditors recommend the Departments strengthen internal controls to ensure providers continue to meet criteria in accordance with the Code.**

**FINDING:** *Insufficient Review and Documentation of Provider Enrollment – This finding has been repeated since 2018.*

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the “Departments”) failed to sufficiently review and document provider enrollment requirements during the required monthly screenings for enrolled providers.

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a multi-agency effort to implement a web-based system to give providers a more convenient and consistent user experience and to ensure

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beneficiaries receive timely and high-quality Medicaid Services. IMPACT is an automated system used by the Departments to accommodate provider enrollment approvals and all Medicaid claim payments to such providers.

During fiscal year 2023, the IMPACT system had 304,070 active providers. Monthly batch screenings are utilized by the Departments to support providers continued to meet the enrollment criteria. In order to determine the Departments monitored the monthly batch screenings, the auditors selected a sample of 60 providers for testing. Their testing results noted HFS was unable to provide support for one or more monthly batch screenings performed for 22 (37%) providers tested.

Finally, this finding was first noted during the Departments' fiscal year 2018 financial audit, five years ago. While the Departments did successfully execute an interagency agreement as recommended in prior engagements, the Departments' management has been unsuccessful in implementing a corrective action plan to remedy the provider enrollment deficiency.

The Code of Federal Regulations (Code) (42 C.F.R. § 455.436 (c)(1)) requires the Departments to consult appropriate databases to confirm identity upon enrollment and reenrollment. In addition, the Code (42 C.F.R. § 455.450 (a)(3)) requires the Departments to conduct database checks on a pre-and post-enrollment basis to ensure providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

The Code (2 C.F.R. § 200.303), Internal Controls, requires the Departments to: (1) establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions; and (2) comply with federal statutes, regulations and terms and conditions of the Medicaid Program. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the "Internal Control Integrated Framework" issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

Additionally, the Code (42 C.F.R. § 431.17) requires the Departments to maintain records necessary for the proper and efficient operations of the State's Medicaid Plan.

Finally, the Departments' management teams are responsible for implementing timely corrective action on all of the findings identified during a financial audit.

The Departments' management indicated issues with provider monthly batch screenings was due to a system error which was corrected in June 2023.

Inadequate controls over the operation of IMPACT, such as insufficient review and monitoring of monthly batch screenings, could result in expenditures to providers who are no longer eligible and represent noncompliance with the Code.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with HFS and the service provider to ensure controls over IMPACT are adequate.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**

The Department of Healthcare and Family Services (HFS) accepts the recommendation. A system error caused issues with the provider month batch screenings and was corrected as part of the IL -1.6 System Release in June 2023. Screenings have been occurring on a regular basis since then.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

Recurring email to be sent monthly to HFS to confirm batch screenings completion.

**Date of Completion: 01/07/2025**

- 9. The auditors recommend the Departments strengthen their internal controls over the timely removal of access to the IMPACT system for terminated employees or employees no longer requiring access.**

**FINDING:** *Inadequate General Information Technology Controls over IMPACT – This finding has been repeated since 2018.*

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the “Departments”) had inadequate general information technology controls over the State of Illinois’ Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system.

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments’ IMPACT system is a multi-agency effort to implement a web-based system to give providers a more convenient and consistent user experience and to ensure beneficiaries receive timely and high-quality Medicaid Services. IMPACT is an automated system used by the Departments to accommodate provider enrollment approvals and all Medicaid claim payments to such providers.

The Departments did not have adequate user access controls for the IMPACT system. During testing auditors noted:

- Four of 17 (24%) terminated users from HFS had not been deleted from the system. As of June 30, 2023, the deletion of users was 15 to 336 days late.

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- One of 17 (6%) terminated users from HFS did not have access timely deleted. The user was deleted from the system 148 days after the user's termination date.
- One of one (100%) terminated users from DHS had not been deleted from the system. As of June 30, 2023, the deletion of the user was 346 days late.
- One of seven (14%) active users from DHS no longer required the use of IMPACT and did not have access timely deleted. As of June 30, 2023, the deletion of the user was 45 days late.

Although an automated process prevents access after 60 days from the user's last login to the program, the users noted in the exceptions were not deleted. The automated process is for non-use only, after 60 days. However, if the individuals were to continue to utilize their accounts, they would remain active until deleted.

This finding was first noted during the Departments' fiscal year 2018 financial audit, five years ago. As such, the Departments' management has been unsuccessful in implementing a corrective action plan to remedy this deficiency.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, (Fifth Revision)) published by the National Institute of Standards and Technology (NIST), Access Control section, requires entities to develop and comply with control over the timely termination of access rights and the periodic review of access rights.

Furthermore, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls, to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability of the State's resources.

Finally, the Departments' management teams are responsible for implementing timely corrective action on all of the findings identified during a financial audit.

HFS management stated user access was not timely terminated due to limitations in communication between the departments. DHS management stated user access was not timely terminated due to changes in staffing levels that led to difficulties in executing the offboarding process.

Inadequate internal controls over user access could result in unauthorized use and/or inappropriate access to the IMPACT system, which could go undetected by the Departments for an extended period of time and could lead to confidential information being compromised.

### **DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review the onboarding and offboarding procedures. Administration will create a process to review User access. Monthly reminders will be sent to all managers reminding

them of the requirements for terminating user access upon separation or transfer of employees.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**

The Department of Healthcare and Family Services (HFS) accepts the recommendation. The Division of Personnel has implemented an exit process for employees leaving the Department. Part of this process is to ensure system access is communicated and removed promptly.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

- IDHS will review the onboarding and offboarding procedures.
- Administration will create a process to review user access.
- Monthly reminders will be sent to all managers of the requirements for terminating user access upon separation or transfer of employees.

**Date of Completion: 07/19/2024**

10. **The auditors recommend Department management and staff strengthen controls over records maintenance for each area in which a compliance requirement is present. To every extent possible, population records should be sequentially numbered. Further, they recommend the Department strengthen its internal controls to ensure it maintains complete and accurate populations.**

**FINDING:** *Complete Populations Not Provided – This finding has been repeated since 2017.*

The Department of Human Services (Department) was unable to provide adequate records substantiating the completeness of populations for one or more laws, regulations, or other requirements selected for testing, as of the end of fieldwork. Due to these conditions, the auditors concluded the Department's population records were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36) to test the Department's compliance with the following:

- Reporting functions within the Department's accounting information system did not generate accurate populations used for leases and asset additions and deletions reported on the Department's Agency Report of State Property (C-15 Form).
- While testing compliance with various Mental Health and Developmental Disabilities Administrative Acts and other State laws governing the State-Operated Mental Health and Developmental Disabilities facilities, the auditors noted the following:
  - For Mental Health and Developmental Disabilities Code (MH Code) (405

ILCS 5/2-108(a- e)), the Fox Developmental Center was not able to provide adequate records substantiating the population of restraints issued during the examination period. Additional information can be found in Finding 2023-011.

- For MH Code (405 ILCS 5/2-108(g-h)), the Ludeman Developmental Center was not able to provide adequate records substantiating the population of employees qualified to order the use of restraints at the Facility during the examination period. Additional information can be found in Finding 2023-011.
- For the Mental Health and Developmental Disabilities Administrative Act (MH Administrative Act) (20 ILCS 1705/47), the Jack Mabley Developmental Center was unable to provide adequate records substantiating the populations of visitor entry logs (for visitors who visited the facilities' residents) during the examination period. Additional information can be found in Finding 2023-012.
- For MH Code (405 ILCS 5/2-113) Fox Developmental Center, Chester Mental Health, Ludeman Developmental Center, and Shapiro Developmental Center were unable to provide adequate records substantiating the populations provided for testing. Additional information on these populations by location can be found in finding 2023-013.
- For the MH Administrative Act (20 ILCS 1705/10.1), Shapiro Developmental Center was unable to provide adequate records substantiating the population of women of child-bearing age residing at the facility during the examination period. Additional information can be found in Finding 2023-015.

Even given the population limitations noted above which hindered their ability to conclude whether the selected sample was representative of the population as a whole, the auditors obtained the population provided by the Department for each of the areas above, selected a sample, and tested for compliance. For the samples tested, noncompliance was reported in the Findings referenced above, where applicable.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

According to the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36), when using information produced by the entity, the practitioner should evaluate whether the information is sufficiently reliable for the practitioner's purposes, including, as necessary, obtaining evidence about the accuracy and completeness of the information, and evaluating whether the information is sufficiently precise and detailed for the practitioner's purposes.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the essential transactions of the Department to protect both the legal and financial rights of the State and of persons directly affected by the Department's activities.

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The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law.

Department personnel indicated that with the transition to the Enterprise Resource Planning accounting system, the Department discovered some of the reporting functions were generating incomplete and inaccurate lease, asset addition, and asset deletion populations which required consultation with the Department of Innovation and Technology and the vendor to address. Substantiation of the population of the other areas noted above was difficult based on the nature of the population.

Without the Department providing complete and adequate documentation to enable testing, the auditors were impeded in completing their procedures and providing useful and relevant feedback to the General Assembly regarding the Department's compliance for the above areas. Further, the Department is unable to demonstrate it has met each compliance requirement it is subject to when sufficient records are not maintained.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. Each Division will work to strengthen controls to ensure adequate records are maintained and can be provided when requested.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will review all systems/trackers that are utilized to generate population reports to standardize practices and will ensure correct procedures are in place at each SODC via retraining and oversight. SODC Operations is also trying to get additional headcount at each SODC to add a Quality Assurance Manager.

**Estimated Date of Completion: 12/31/2025**

**DBHR-DMH**

DBHR Operations will review all systems/trackers that are utilized to generate population reports to standardize practices and will ensure correct procedures are in place at each Facility via retraining and oversight.

**Estimated Date of Completion: 12/31/2025**

**OBS**

This issue occurred during the Agency conversion and implementation of SAP. The system restraints and differences from WCS and EIS were not fully understood so there were gaps in the way the transactions for the quarterly C-15 reports were derived. We

accepted the finding, and a corrective action plan was developed. The process was tested and will be fully initiated 100% effective 7/1/25. The process allows for transaction reports to be produced later in the month after the close of period. This additional time allows any transactions that were still pending at the end of the period to be identified. In addition, a comparison for previous quarter periods is done at the end of each fiscal year to identify if any transactions were missed being reported and if so, appropriate revisions to quarterly reports can be completed. **(100% Complete)**

**Date of Completion: 07/01/2025**

**11. The auditors recommend Department management re-train staff on compliance with statutory requirements regarding the use of restraints. This training should include documentation requirements when restraints are ordered. They also recommend Department management establish a process to monitor compliance with annual training requirements.**

***FINDING: Noncompliance with Statutory Requirements Regarding the Use of Restraints and Seclusion – This finding has been repeated since 2011.***

The Department of Human Services (Department) did not comply with statutory requirements regarding the use of restraints.

During fieldwork, the auditors performed on-site testing regarding the use of restraints at five of the Department's State-Operated facilities. As noted in Finding 2023-010, Fox Developmental Center was unable to provide adequate records substantiating the population of restraints issued and Ludeman Developmental was unable to provide adequate records substantiating the population of employees qualified to order the use of restraints on residents during the examination period.

Although they were unable to obtain the above complete populations across all five facilities, the auditors performed testing on information provided which resulted in the following exceptions at three Department facilities:

**Chester Mental Health Center**

- For 1 of 12 (8%) residents tested, the Center was unable to provide support that prior written authorization was given by the Facility Director prior to the application of the restraint.
- For 1 of 12 (8%) residents tested, they were unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours.
- For 2 of 12 (17%) residents tested, prior authorization was not obtained before applying the same restraint within a 48 – hour period.
- For 5 of 12 (42%) residents tested, they were unable to determine if the Facility Director reviewed the ordered restraints.
- For 13 of 59 (22%) restraints tested, employee restraint certifications were not valid upon application of restraint date.
- For 5 of 59 (8%) restraints tested, the Facility was unable to provide documentation

to support the certifications for the employees who applied the restraints were up to date on the date of restraint application.

Elgin Mental Health Facility

- For 2 of 12 (17%) restraints tested, the Facility was unable to provide documentation to support the certifications for the employees who applied the restraints were up to date on the date of restraint application.

Ludeman Developmental Center

- For 1 of 12 (8%) residents tested, the resident was not examined by a physician or supervisory nurse within two hours after the initial employment of the emergency restraint.
- For 4 of 12 (33%) residents tested, auditors were unable to determine the person applying the restraint had completed the proper training.
- For 1 of 12 (8%) residents tested, auditors were unable to determine if prior authorization was obtained before the restraints were applied.
- For 1 of 12 (8%) residents tested, auditors were unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours.
- For 11 of 12 (92%) resident restraints tested, the Facility was unable to provide documentation to support the certifications for the employees who applied the restraints were up to date on the date of restraint application.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2011. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-108) requires the following:

- a written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities to employ the use of restraint;
- in the event of a temporary emergency restraint order, a physician or supervisory nurse shall examine the recipient within two hours after the initial employment of the emergency restraint;
- the person who ordered the restraint to inform the Facility Director or his designee in writing of the use of the restraint within 24 hours;
- the Facility Director to review all restraint orders daily and inquire into reasons for the orders for restraint by any person who routinely orders them;
- once a restraint has been employed during one 24-hour period, it shall not be used again on the same resident during the next 48 hours without the prior written authorization of the Facility director; and,
- all employees authorized to employ restraints on patients receive training in the safe and human application of restraints and maintenance of records detailing which employees have been trained and are authorized to apply restraint, the date of training and the type of restraint that the employee was trained to use.

According to the Facility Procedural Guide # MD460 Use of Restraints & Seclusion (Containment) in Mental Health Facilities, all staff involved in the use of mechanical restraint and seclusion are to receive training and to demonstrate (ongoing and annual) competence. Only staff who demonstrated competency may implement, monitor, or supervise the use of restraint and seclusion in a mental health facility.

Further, the Department's Mental Health Program Directive (02.03.03.010) requires authorized staff to write an order for restraint on the IL462-0044 RD after personally observing and examining the resident.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated the issues were a result of inadequate oversight of processes and errors resulting from manual processes.

Failure to have adequate internal controls over the use and application of restraints and the training of persons administering restraints is noncompliance with the MH Code and could adversely affect the care and treatment of residents and could subject the State to unnecessary legal risks. Furthermore, failure to re-train personnel within 12-month periods represents noncompliance with the Department's Mental Health Program Directive. Failure to retain complete and accurate records represents noncompliance with the State Records Act.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will re-train staff on compliance with statutory requirements regarding the use of restraints. This training will include documentation requirements when restraints are ordered. Furthermore, procedures to monitor compliance will be developed.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

- SODC Operations will ensure a corrective action plan at Fox Center is implemented, including retraining of all staff and Facility Management oversight, to ensure compliance with adequate record management related to restraints.

**Estimated Date of Completion: 09/30/2025**

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- SODC Operations will ensure a corrective action plan at Ludeman is implemented that includes retraining and Facility Management oversight on a quarterly basis to ensure restraint paperwork is completed properly and restraint training is in compliance.

**Estimated Date of Completion: 09/30/2025**

**DBHR-DMH**

- Re-train all staff on the statutory requirements regarding the use of restraints.
- Audit employee certifications and training records to ensure compliance with certification and training requirements.
- Review each facility restraint policy to ensure compliance with statutory requirements is clearly defined in the policy.

**Estimated Date of Completion: 09/30/2025**

- 12. The auditors recommend Department management enforce policies and procedures to ensure compliance with the MH Act regarding visitors to facilities and employees. The policies and procedures should include training personnel on compliance requirements and implementing management oversight over compliance requirements. They also recommend each Facility retain visitor entry logs as required. Further, the auditors recommend the Department improve controls over building access and monitoring.**

**FINDING: *Noncompliance with Statutory Requirements Regarding the Monitoring of Facility Visitors – This finding has been repeated since 2017.***

The Department of Human Services (Department) did not comply with statutory requirements regarding the monitoring of Facility visitors.

As part of their testing at eight of the Department's State-operated facilities, the auditors reviewed facility visitor logs and tested facility procedures regarding the monitoring of visitors. They were unable to obtain a complete population of visitor entry logs for Jack Mabley Development Center as noted in Finding 2023-010. Their testing resulted in the following exceptions:

**Elgin Mental Health Center**

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility failed to adequately document if visitors provided Security staff with State-issued identification in lieu of providing them a temporary badge.

**Shapiro Developmental Center**

- The Facility's visitor log appeared to be incomplete. Missing information included

time-in, time-out, organization or address of the individual, purpose, and area of visit.

Chester Mental Health Center

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility's policy for visitors did not include procedures for resident visitors.
- The Facility's policy for visitors is not being adequately followed.

Murray Developmental Center

- The Facility does not follow a consistent procedure for all business/non-employee visitors to the Facility.
- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Center did not maintain adequate physical safeguards regarding building access and monitoring.

Fox Developmental Center

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

Jack Mabley Developmental Center

- The Facility's visitor log appeared to be incomplete. Missing information included visitor's name, address, phone, email, purpose of visit, time in, time out, badge out and badge in.
- The Business Office at Jack Mabley Developmental Center concurrently utilized two types of visitor logs, resulting in some non-residential visitors signing on both logs.
- Inconsistencies were noted between different copies of the same visitor logs provided.

Jack Mabley Developmental Center (Continued)

- Copies of the visitor logs for the Maintenance Garage could not be provided for the period of July 1, 2021 through December 20, 2021.
- Business visitors were not always required to show identification on arrival.
- Visitors are not consistently provided visitor badges.

Illinois Center for Rehabilitation and Education – Wood

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- Visiting hours posted were not in agreement with the Facility's policies.

Ludeman Development Center

- The population of visitor logs maintained by the facility was incomplete.
- For 6 of 8 (75%) months selected, the Facility was unable to provide copies of the completed visitor logs.
- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- For 3 of 15 (20%) of employees selected, the auditors noted the employees were not displaying proper employee identification while at the Facility, as required.

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- For 2 of 15 (13%) of employees selected, the auditors noted the employees were unable to produce proper photo identification while at the Facility.
- The Center did not maintain adequate physical safeguards regarding building access and monitoring.

### Treatment and Detention Facility

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities. Additionally, the State Records Act (5 ILCS 160/17a) states that regardless of other authorization to the contrary, no record shall be disposed of by the Department, unless approval of the State Records Commission is first obtained.

The Illinois Administrative Code (59 Ill. Admin Code 102.10(e)) states only persons on official business, such as employees, authorized visitors, and persons providing required foods and services shall have access to center/program campus property.

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/47) states the Facility Director shall develop and implement written policies and procedures to insure those employees and visitor are properly identified at all times they are on the grounds of the Facility

Department Directive 01.01.02.210 states "Building security or a designated Employee must maintain a log of temporary badges issued. At certain locations, building security or a designated Employee will hold the Visitor's State-Issued identification (ID) card. The ID card will be returned upon receipt of the temporary badge".

Department personnel stated that staff turnover, error due to manual processes, and lack of oversight resulted in the issues noted.

Failure to enforce policies and procedures to ensure compliance with the MH Act governing the identification of all visitors to a facility could result in unauthorized individuals' access to facility grounds, posing an increased risk to the safety of the residents and facility staff. Additionally, failure to provide adequate physical safeguards regarding building access and monitoring could also result in unauthorized access to the facility campus and residents.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to ensure compliance with statutory requirements regarding monitoring of facility

visitors and employees. Staff will be trained regarding the requirements when processing visitors signing in at the facilities and procedures will be developed to monitor compliance.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will ensure all SODCs provide training on the visitor policy related to accurate completion of the log and retention requirements of the visitor logs.

**Estimated Date of Completion: 08/31/2025**

**DBHR-DMH**

DMH will review and update each facility policy on visitor's log to ensure compliance with the statutory requirements regarding the monitoring of Facility visitors.

**Estimated Date of Completion: 09/30/2025**

Staff will be retrained on the statutory requirements and updated policies regarding the monitoring of Facility visitors.

Visitor log audits will be implemented to ensure continued compliance.

**Estimated Date of Completion: 12/31/2025**

**DRS**

- Revise/Update visitor log. (100% Complete)
- Update visitor policy and procedures. (100% Complete)
- Train security personnel on policy and procedures. (100% Complete)
- Train new and current front desk staff on policy and procedures. (100% Complete)
- Update visitor hours posted onsite to align with Facility policy. (100% Complete)

**Date of Completion: 03/22/2023**

**13. The auditors recommend Department management review its systems of internal control over compliance to ensure:**

- 1. The Department's policies and procedures at each facility are up-to-date with current law and communicated to all staff;**
- 2. Facility-level and Department-wide training on the Department's policies and procedures for areas with recurrent noncompliance or complexity are performed; and,**

**3. A monitoring process is functioning to timely identify areas of noncompliance with State laws and Department policies at the facilities and implement corrective action.**

**FINDING:** *Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information -This finding has been repeated since 2017.*

The Department of Human Services (Department) did not comply with statutory requirements regarding residents' admissions, discharges, annual evaluations, and requests for information.

During fieldwork, the auditors performed on-site testing at seven of the Department's State-Operated facilities regarding resident admissions, discharges, and requests for information. Although they were unable to obtain complete populations in relation to testing for four facilities during the examination period (Fox Developmental Center, Chester Mental Health, Ludeman Developmental Center, and Shapiro Developmental Center), they sampled and tested 60 residents/students which resulted in the following exceptions:

Chester Mental Health Center

*During the performance of testing admissions:*

- For 2 of 10 (20%) residents tested, the Facility was unable to provide support that attempts were made to immediately make contact with at least two designated persons or agencies, or that notification concerning the admission was mailed within 24 hours.

*During the performance of testing requests for information:*

- The Facility was unable to provide a complete and accurate population of individuals requesting information relating to admission.
- For 4 of 10 (40%) residents tested, an authorization to disclose/obtain information form (Form IL462- 0146) could not be located in the resident's file.
- For 1 of 10 (10%) residents tested, the resident's progress notes note an authorization to disclose/obtain information form (IL462-0146) was signed on the date of admission. However, the date of the signature on form IL462-0146 differs.
- For 2 of 10 (20%) residents tested, the authorization to disclose/obtain information form (Form IL462- 0146) located in the patient's file was blank.
- For 3 of 3 (100%) external requests, required information of the requesting party was missing. Specifically, the missing information was the requesting party's address, phone number, and relationship to the resident.
- The Facility did not follow its policy to ensure compliance with the Mental Health and Developmental Disabilities Code. The auditors noted the facility staff did not consistently complete DHS Form 179 - External Correspondence Log, and external calls of this nature were not routed through a centralized location (Forensic Coordinator's Office).

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- The Facility does not have a detailed policy that reflects current practice regarding admissions and the use of the Authorization to Disclose/Obtain Information Form, Form 146. The policy does not indicate how or where to document when a patient does not wish anyone to be notified, when a patient refuses to sign the form, or when contact was made/attempted to be made in order to substantiate compliance with the Mental Health and Developmental Disabilities Code.

### *During the performance of testing discharges:*

- For 10 of 30 (33%) discharged patients tested, the written notice of discharge was given to the recipient between 4 and 7 days late. Further, none of the Notice of Discharge/Transfer Forms indicated the reason for transfer/discharge and why the statutorily required number of days' notice was not/could not be met.
- For 1 of 30 (3%) discharged patients tested, the Notice of Transfer could not be located in the patient's files.

### Elgin Mental Health Facility

#### *During the performance of testing discharges:*

- For 9 out of 30 (30%) discharged patients, the Facility failed to give more than 7 days of advanced written notice for residents' discharges. Notice was provided on the day of discharge.

### Fox Developmental Center

#### *During the performance of testing admissions:*

- The Center was unable to provide a complete and accurate population of newly admitted individuals.
- The Center was unable to provide a complete and accurate population of Dually Diagnosed persons for the period under examination. Additionally, the reports provided by the Center did not contain the residents' legal admission status, the date and Facility and unit of transfer or discharge, whether or not there is a public or private guardian, whether or not the Facility Director has certified that appropriate treatment and habilitation are available for and being provided to such person, and whether or not the patient or a guardian has requested review, and, if so, the outcome of the review.
- For 1 out of 8 (13%) residents tested, the Notice of Admission was not sent to the resident's guardian within the required 24 hours. Additionally, the wrong date of admissions was written on the form.
- For 1 out of 8 (13%) residents tested, the Notice of Admission could not be provided by the Center.

### Jack Mabley Developmental Center

#### *During the performance of testing admissions:*

- For 12 of 12 (100%) admissions tested, the facility did not maintain documentation that, upon admission, recipients were inquired if a spouse, family member, friend or agency is to be notified of their admission to the facility. As such, the auditors were unable to test compliance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-113(a)).

Ludeman Development Center

*During the performance of testing admissions:*

- The Center was unable to provide a complete and accurate population of Dually Diagnosed persons for the period under examination. Additionally, the reports provided by the Center did not contain the residents' diagnosis, whether the Facility Director has certified that appropriate treatment and habilitation are available for and being provided to such person, and whether or not the patient or a guardian has requested review, and, if so, the outcome of the review.

*During the performance of testing admissions:*

- For 3 of 20 (15%) residents tested, the facility was unable to provide adequate supporting documentation to complete testing.
- For 8 out of 8 (100%) residents tested, the Notice of Admission was not sent to the resident's guardian within the required 24 hours.

*During the performance of testing requests for information:*

The Facility disclosed that it has no internal controls or formal policy in place to document that request for information were responded to within two working days.

- For 8 of 8 (100%) residents tested, the authorization to disclose/obtain information form (Form IL462- 0146) was completed improperly.

*During the performance of testing discharges:*

- For 6 of 20 (30%) discharged patients tested, the Facility Director did not give a written notice of the discharge to the resident at least 14 days prior to the discharge of the patient.
- For 4 of 20 (20%) discharged patients tested, the Facility Director did not give a written notice of the discharge to the resident's guardians at least 14 days prior to the discharge of the patient.
- For 3 of 20 (15%) discharged patients tested, the notice of discharge to the resident did not have the date the resident received the notice. Therefore, the auditors could not determine if notice of discharge was provided 14 days prior to discharge.
- For 4 of 20 (20%) discharged patients tested, the notice of discharge to the guardian did not have the date that the guardian received the notice. Therefore, they could not determine if the guardian received a notice of discharge 14 days prior to discharging.

Shapiro Developmental Center

*During the performance of testing admissions:*

- The Center was unable to provide a complete and accurate population of Dually Diagnosed persons for the period under examination. Additionally, the reports provided by the Center did not contain the residents' legal admission status, the date and Facility and unit of transfer or discharge, whether or not there is a public or private guardian, whether or not the Facility Director has certified that appropriate treatment and habilitation are available for and being provided to such person, and whether or not the patient or a guardian has requested review, and, if so, the outcome of the review.

*During the performance of testing discharges:*

- For 5 of 20 (25%) discharged patients tested, the written notice of discharge was not given to the recipient prior to date of discharge. Further, the Center documented the guardian waived the 14-day notice requirement, however, did not document on what date the guardian waived the 14-day requirement. As such, the auditors were unable to determine whether the guardian was informed of the discharge prior to the discharge occurring.
- The Facility was unable to provide a complete and accurate population of discharges for the period under examination. Discrepancies were identified between the population provided by the Facility in comparison to the listing provided by the Central Office.

Treatment and Detention Facility

*During the performance of testing annual evaluations:*

- For 1 out of 4 (25%) residents selected for testing, the Facility did not complete the noted recipient's annual evaluation within 12 months of their commitment.
- For 1 out of 4 (25%) residents selected for testing, the Facility did not prepare the written report for the noted recipient within 30 days of their evaluation.

*During the performance of testing discharges:*

- For 3 out of 7 (43%) residents selected for testing, the facility did not file with the committing court of their intention to file, or not file, a petition for conditional release on behalf of the residents.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-113(a)) requires that upon admission, the Facility inquire of the resident if a spouse, family member, friend or an agency is to be notified of their admission. Good internal controls require employees to complete an admission form and maintain a copy of the admission form in the resident's file. The form should be signed by the employee making the inquiry of the resident.

Additionally, the MH Code (405 ILCS 5/2-113(b)-(f)) indicates that any person may request information from a developmental disability or mental health facility relating to whether an adult resident or minor resident admitted pursuant to Section 3-502 has been admitted to the facility. Any parties requesting information must submit proof of identification and list their name, address, phone number, relationship to the resident and reason for the request. The facility shall respond to the inquirer within 2 working days. If the resident is located at the facility, the facility director shall inform the resident of the request and shall advise the resident that disclosure of their presence at the facility will not obligate the resident to have contact with the inquirer. No information shall be disclosed unless the resident consents in writing to the disclosure. If the resident has consented to the release of information the facility shall inform the requesting party that the resident is located at the facility. The facility shall, with the resident's consent, tell the requesting party how to contact the resident. When the

resident is not located at the facility or when the resident does not consent in writing to release such information, the facility shall inform the consenting party that no information is available regarding that person. Transactions pursuant to this section shall be noted in the resident's record.

Further, Section (405 ILCS 5/4-201) of the MH Code indicates that a person with an intellectual disability shall not reside in a Department mental health facility unless the person is evaluated and is determined to be a person with mental illness and the facility director determines that appropriate treatment and habilitation are available and will be provided to such person on the unit. In all such cases, the Department of Mental Health facility director shall certify in writing within 30 days of the completion of the evaluation and every 30 days thereafter, that the person has been appropriately evaluated, that services specified in the treatment and habilitation plan are being provided, that the setting in which services are being provided is appropriate to the person's needs, and that provision of such services full complies with all applicable federal statutes and regulations concerning the provision of services to persons with a developmental disability.

Additionally, any person admitted to a Department mental health facility who is reasonably suspected of having a mild or moderate intellectual disability, including those who also have a mental illness, shall be evaluated by a multidisciplinary team which includes a qualified intellectual disability professional designated by the Department facility director. Section (405 ILCS 5/4-203(b)) of the MH Code requires the Department to ensure that a monthly report is maintained for each Department mental health facility, and each unit of a Department development disability facility for a dually diagnosed persons, which lists (1) initial of persons admitted to, residing at, or discharged from a Department mental health facility or unit for dually diagnosed persons of Department developmental disability facility during that month with a primary or secondary diagnosis of intellectual disability, (2) the date and facility and unit of admission or continuing care, (3) the legal admission status, (4) the recipient's diagnosis, (5) the date and facility and unit of transfer or discharge, (6) whether or not there is a public or private guardian, (7) whether the facility director has certified that appropriate treatment and habilitations are available for and being provided to such person, and (8) whether the person or guardian has requested review, and if so, the outcome of the review.

The MH Code (405 ILCS 5/4-704(a)) states that at least 14 days prior to the discharge of a client from a department developmental disabilities facility under Section 4-701 or 4-702, the facility director shall give written notice of the discharge to the client, if he is 12 years of age or older, to his attorney and guardian, if any, to the person who executed the application for admission and to the resident school district when appropriate.

The MH Code (405 ILCS 5/3-903) requires the Facility Director to give written notice of discharge from a Department mental health facility to the recipient, his attorney, and guardian, if any, at least 7 days prior to the date of intended discharge.

The Sexually Violent Persons Commitment Act (725 ILCS 207/55(a)) requires the Department to submit a written report to the court on their mental condition at least once every 12 months after an initial commitment.

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The Sexually Violent Persons Commitment Act (725 ILCS 207/55(c)) requires any examiner conducting an examination under this Section to be prepare a written report of the examination no later than 30 days after the date of the examination.

The Sexually Violent Persons Commitment Act (725 ILCS 207/60(a)) states that if the evaluator on behalf of the Department recommends conditional release, then the director or their designee shall, within 30 days of the receipt of the evaluator's report, file with the committing court notice of their intention whether or not to petition for conditional release on the committed person's behalf.

Chester Mental Health Center policy (RI.03.05.03.02, Request for Patient Information, IV "Income Calls requesting Patient information on admission status") requires that when a call is an inquiry about a patient's admission status, the Clinical Staff employee that responds to the request will then send an email to the Forensic Coordinator's office with the date/time that the response was given to the requestor. The Forensic Coordinator's office will then log the date/time the request was completed on the CMHC-179.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by Department's activities.

Department personnel stated that lack of oversight, error due to manual processes, and need for training and policy revisions resulted in the issues noted.

Failure to ensure conformity with statutory requirements regarding each resident's admission to and discharge from Department facilities could adversely impact the care and treatment of each resident, could hinder a resident's interaction with parties external to the facility, may result in intellectually disabled persons not residing in a facility appropriate to their needs, and represents non-compliance with State Law.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review and retrain staff on internal policies to ensure compliance with laws and regulations. Additionally, IDHS will pursue an automated solution to meet reporting requirements.

### **UPDATED RESPONSE:**

**Partially Implemented.**

### **Corrective Action Plan:**

#### **DBHR-DMH**

DMH will review and update all facility policies and procedures to ensure they are up to date with current laws and statutory requirements.

**Estimated Date of Completion: 09/30/2025**

DMH will retrain all staff on appropriate policies and procedures regarding patient admissions, discharges, annual evaluations, and requests for information.

**Estimated Date of Completion: 12/31/2025**

A regular audit schedule will be devised and implemented to ensure that timely identify areas of noncompliance with State laws and Department policies.

**Estimated Date of Completion: 12/31/2025**

**DDD**

SODC Operations will ensure all facilities cited will implement corrective action plans that include retraining of staff related to Notices of Admissions and Discharges as well as requirements of 405 ILCS 5/2-113(a).

SODC Operations will continue to require all SODCs to report monthly their admissions and discharges, and these will be reviewed for accuracy to ensure accurate populations are achieved.

**Estimated Date of Completion: 09/30/2025**

SODC Operations will continue to work with DoIT (ITR 33864) to create a Clinical E-Report to utilize for statute compliance related to serving dually diagnosed persons.

**Estimated Date of Completion: 09/30/2025**

- 14. The auditors recommend the Department provide dental services, and physical and mental health examinations to residents as required. They recommend the Department improve internal control over the completion and retention of information pertaining to facility residents such as examination records and medication records.**

**FINDING:** *Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, and Physical Examinations – This finding has been repeated since 2017.*

The Department of Human Services (Department) did not comply with statutory requirements regarding residents' dental, mental, and physical examinations.

During fieldwork, the auditors performed on-site testing at five of the Department's State-Operated facilities regarding resident dental, mental, and physical examinations. They sampled and tested 60 residents prescribed medications, which resulted in the following exceptions:

Chester Mental Health Center

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- For 5 out of 48 (10%) medication administrations tested, the nurse administering the medication did not sign the Medication Administration Record (MAR).

### Fox Developmental Center

- For 1 out of 12 (8%) residents tested, the Center administered medication to the resident before the completion of a physical or mental exam. Further, the physical or mental exam was not completed timely after admission. The Center did not report this to the Director or retain such a report in the resident's file.
- For 4 out of 48 (8%) medication administrations tested, the nurse administering the medication did not sign the MAR.
- For 1 out of 48 (2%) medication administrations tested, the Center could not identify the nurse administering the medication. Therefore, the auditors were unable to determine if medications were properly administered by persons legally qualified under the law.
- For 2 out of 48 (4%) medication administrations tested, the name of the nurse administering the medication on the MAR did not match the name on the license number provided, so the auditors were unable to determine if the nurse who signed the MAR was licensed by the State.
- For 2 out of 48 (4%) medication administrations tested, the physician's order's effective date was before the date the doctor signed the order.
- For 1 out of 12 (8%) residents tested, the physical exam was completed before the resident was admitted to the Center.
- For 1 out of 12 (8%) residents tested, the Center did not provide the requested information. Therefore, they were unable to determine if medication was administered prior to a mental or physical exam. Furthermore, it appears the psychological exam was not completed upon admission as required.

### Ludeman Developmental Center

- For 2 out of 12 (17%) residents tested, the Center could not provide the completed physical exam.
- For 7 out of 12 (58%) residents tested, the Center did not provide the requested information. Therefore, the auditors were unable to determine if medication was administered prior to a mental or physical exam.
- For 2 out of 12 (17%) medication administrations tested, the nurse administering the medication could not be identified on the MAR. As a result, they were unable to determine if medication was administered only by a person legally qualified under the State.
- For 1 out of 12 (8%) medication administrations tested, the nurse administering the medication did not sign the MAR.
- For 1 of 12 (8%) residents tested, the Center failed to provide dental examinations at least once every 18 months. The dental examinations were provided 616 days late.

### Ludeman Developmental Center (Continued)

- During testing, the auditors identified an instance of a patient who was improperly included in the population. The patient was discharged in fiscal year 2021 and

should not have been included in the population provided.

Mabley Developmental Center

- Two support workers selected for testing were providing 1:1 care without meeting the minimum qualifications. The auditors were unable to determine if the individuals met the qualifications for a Mental Health Technician 1.

Shapiro Developmental Center

- For 3 out of 48 (6%) medication administrations tested, the nurses did not properly complete the MAR.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7) states medication shall not be prescribed until a physical and mental examination of the recipient has been completed. The Act requires all medications administered to recipients shall be administered only by those persons who are legally qualified to do so by the laws of the State of Illinois. Additionally, it requires the Department to adopt a model protocol and forms for recording all patient diagnosis, care, and treatment at each State-operated facility for the mentally ill and for persons with developmental disabilities under the jurisdiction of the Department. The model protocol and forms shall be used by each facility unless the Department determines that equivalent alternatives justify an exemption. Good internal controls should ensure that the forms are properly completed.

The Mental Health and Development Disabilities Administrative Act (MH Act) (20 ILCS 1705/7) states that all recipients in a Department facility shall be given a dental examination by a licensed dentist or registered dental hygienist at least once every 18 months and shall be assigned to a dentist for such dental care and treatment as is necessary.

The Facility's Dental Procedures (Policy Number 12-02) state all individuals will be referred for a dental examination within 30 days of admission.

The Department of Central Management Services' position description for a Mental Health Technician I at Mabley Developmental Center requires a Mental Health Technician I to have successfully completed a comprehensive training program at the Mental Health Technical Trainee level.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

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Department personnel stated that inadequate oversight, error due to manual processes and temporary staff to cover vacancies resulted in the issues noted.

Failure to properly administer and prescribe drugs could result in harm to the residents. Failure to retain supporting documentation supporting resident care impedes the ability to monitor the provision of necessary care to residents. Failure to provide residents timely dental examinations could adversely affect the care and treatment of the resident as well as impact the operations of the facilities. Furthermore, it represents noncompliance with State law.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. Staff will be retrained, and policy and procedures will be reviewed to ensure medication is administered, examinations are completed, and medication records are maintained in accordance with statutory requirements.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will ensure corrective action plans are implemented and completed at all cited facilities that include internal policy review and retraining related to physical examinations, dental examinations and medication administration.

**Estimated Date of Completion: 08/31/2025**

Each SODC will also implement oversight and monitoring on a regular basis to ensure compliance.

**Estimated Date of Completion: 09/30/2025**

**DBHR-DMH**

DMH will review and update all facility policies and procedures to ensure they are current with all statutory requirements.

**Estimated Date of Completion: 09/30/2025**

DMH will retrain all staff on appropriate policies and procedures regarding patient's dental, mental, and physical examinations.

**Estimated Date of Completion: 12/31/2025**

A regular audit schedule will be devised and implemented to ensure that timely identify areas of noncompliance with State laws and Department policies.

**Estimated Date of Completion: 12/31/2025**

- 15. The auditors recommend the Department establish comprehensive Department-wide internal controls over compliance with the MH Act**

**regarding pregnancy testing and residents' menstrual cycles, which should include training personnel on compliance requirements and outline management oversight over compliance requirements.**

**FINDING:** *Noncompliance with Statutory Requirements Regarding Pregnancy Policies, Administering Pregnancy Tests and Recording Residents' Menstrual Cycles – This finding has been repeated since 2017.*

The Department of Human Services (Department) did not comply with statutory requirements regarding prenatal care for residents, administering pregnancy tests and recording resident's menstrual cycles.

During fieldwork, the auditors performed on-site testing at twelve of the Department's State-Operated facilities. They sampled and tested 60 residents across four facilities, which resulted in the following exceptions:

Elgin Mental Health Center

- For 1 of 20 (5%) residents selected for testing, the Center did not have consent forms or emergency room (ER) documentation to support testing of pregnancy prior to admission.

Fox Developmental Center

- For 3 of 6 (50%) residents selected for testing, the auditors were unable to determine if a pregnancy plan was required as the Center was unable to provide documentation of pregnancy tests performed subsequent to a resident being noted as not menstruating.
- For 3 of 6 (50%) residents selected for testing, the Center did not properly complete the monthly menstrual tracking sheet.
- The Center does not have a policy that indicates when a subsequent pregnancy test to the initial admission test should be performed. During testing, several residents were noted to have no menstruation for multiple months. However, subsequent pregnancy tests subsequent to those missed menstruations were not performed and/or documented.
- The auditors were unable to place reliance on the population of pregnancies provided by the Center.

Ludeman Developmental Center

- For 16 of 19 (84%) residents selected, the Center did not properly complete or retain the monthly menstrual tracking sheet.
- For 13 of 19 (68%) residents selected, the consent for pregnancy testing signed by the recipient or guardian was not present in the recipients' medical records.

Shapiro Developmental Center

- The Center was unable to provide adequate records substantiating the population of women of child-bearing age residing at the facility during the period. Further, a resident who was pregnant during the examination period was improperly excluded from the listing.

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- For 4 of 15 (27%) residents selected, the Center failed to document the tracking of the resident's menstruation in the Menstrual Tracking Records.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Administrative Act (MH Act) (20 ILCS 1705/10.1) requires every woman of child-bearing age who is admitted to the facility under the jurisdiction of the Department, with her consent or the consent of her guardian, be tested for pregnancy upon admission and thereafter as indicated. Additionally, it requires records of menstrual cycles to be maintained for a resident who is admitted to and remains in a facility for more than 60 days.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Facility designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated that error due to manual processes and employee oversight resulted in the issues noted.

Failure to obtain or retain a record of a signed consent form prior to administering a pregnancy test to a resident could result in a resident receiving unauthorized medical care and/or subject the State to unnecessary legal risks. Failure to perform or retain a record of a resident's pregnancy testing and menstrual cycle could adversely affect the care and treatment of the resident as well as impact the operations of the facilities. Further, it represents noncompliance with State law.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review and revise related policies and establish comprehensive Department-wide internal controls regarding pregnancy testing and residents' menstrual cycles, including training personnel, compliance monitoring, and improved management oversight to ensure compliance with the Mental Health Act.

### **UPDATED RESPONSE:**

**Partially Implemented.**

### **Corrective Action Plan:**

#### **DDD**

SODC Operations will ensure all cited facilities review internal pregnancy policies to ensure all requirements of the Code are addressed in the policy. All cited Facilities will provide training on these policies.

**Estimated Date of Completion: 08/31/2025**

**DBHR-DMH**

DMH will review and update all facility policies and procedures to ensure they are in compliance with all statutory requirements.

**Estimated Date of Completion: 09/30/2025**

DMH will retrain all staff on appropriate policies and procedures regarding prenatal care for patients, administering pregnancy tests and recording resident's menstrual cycles.

**Estimated Date of Completion: 12/31/2025**

**16. The auditors recommend Department management execute all interagency agreements as required by law. In addition, they recommend all parties to the interagency agreements sign the agreement prior to the effective date of the agreement.**

**FINDING:** *Inadequate Execution and Monitoring of Interagency Agreements – This finding has been repeated since 2015.*

The Department of Human Services (Department) failed to adequately execute and monitor interagency agreements.

During testing, auditors noted the following:

During the examination period, the Illinois Public Aid Code (Code) (305 ILCS 5/12-4.7b) required the Department to enter into intergovernmental agreements to conduct monthly exchanges of information with the Illinois Department of Corrections, the Cook County Department of Corrections, and the office of the sheriff of every other county to determine whether any individual included in an assistance unit receiving public aid under any Article of this Code is an inmate in a facility operated by the Illinois Department of Corrections, the Cook County Department of Corrections, or a county sheriff. During the testing of these agreements, they noted:

- For 27 of 102 (26%) counties of the State, the Department had not established a data sharing agreement with the respective sheriff offices.
- For 3 of 60 (5%) of individuals with terminated benefits tested, the Department was not able to provide the underlying support.

The data used for testing of benefit termination for incarcerated individuals is based on current integrated eligibility system data. As a result, the population provided as of the date of the request may not properly represent the population for the period under examination. Due to this limitation, they auditors were unable

to determine if there were additional individuals which should have been included in the population provided by the Department and subjected to their testing.

Additionally, the auditors selected a sample of other intergovernmental agreements and noted the following:

- 3 of 46 (7%) intergovernmental agreements tested were signed between 173 and 602 after the effective date of the agreement.

Good internal controls require the approval of agreements prior to the effective date. The Statewide Accounting Management System (SAMS) Manual (Procedure 15.20.30) indicates a contract is reduced to writing when the contract is signed by the vendor and then by more than one authorized agency representative at the earliest date of signature.

- For 1 of 46 (2%) intergovernmental agreements tested, documentation was not provided by the Department to substantiate compliance with the duties outlined.

The Fiscal Control and Internal Audit Act (FCIAA) (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable laws.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate proper documentation of the essential transactions of the Department to protect both the legal and financial rights of the State and of person directly affected by the Department's activities.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2015. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department personnel indicated they reached out to all Sheriff's Offices in the State of Illinois in an attempt to establish a data sharing agreement. The Sheriffs who agreed have had data sharing agreements executed. Additionally, interagency agreements were signed late for various reasons including competing priorities and necessary revisions and updates to the documents. Furthermore, for the one intergovernmental agreement for which documentation was not provided, Department personnel indicated that the program transitioned to another Agency which resulted in the oversight in maintaining proper documentation.

The Department enters into multiple agreements with other State agencies and other units of government. The purpose of the agreements is to assist the Department in fulfilling its mandated mission. In order to assess whether the agreement is reasonable, appropriate, and sufficiently documents the responsibilities of the appropriate parties, the agreement needs to be approved prior to the effective date. Additionally, failure to execute

agreements that are mandated by law is noncompliance with the applicable law and noncompliance could negatively impact those affected by the law.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to ensure all future interagency agreements are signed prior to the effective date and any required statutory deadlines. Additionally, IDHS has sent data sharing agreements to all county sheriff offices of which seventy-seven have signed agreements and clarifications were received noting five do not house inmates. Additionally, a change to the statute effective January 1, 2025 allows IDHS to obtain the needed information by other means and as a result, IDHS has worked with the Department of Innovation and Technology in the development of a reporting process for each sheriff's office.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DBHR-DMH**

DMH Initial Response - Historically when IDHS/DMH wanted to enter an IGA with an outside governmental agency we would draft the IGA using the effective date that we preferred. There are several issues that have caused DMH to occasionally miss these deadlines and have an agreement signed after the effective date. Going forward IDHS DMH has been informed that all IGA's need to use the language "Effective the date of the last signature". We will notify all IDHS/DMH leadership as well as staff responsible for contracting about this change.

**Date of Completion: 07/1/2025**

**DBHR-SUPR**

SUPR extended the length of the contract to prevent issues with late signatures. In addition, no services will be performed until after the intergovernmental agreement has been completed

**Estimated Date of Completion: 01/01/2026**

- 17. The auditors recommend Department management and staff comply with current laws, regulations, and policies and procedures regarding locally held funds and petty cash. They also recommend management develop and maintain a system to support the segregation of duties.**

**FINDING: *Inadequate Administration of Locally Held Funds and Petty Cash – This finding has been repeated since 2009.***

The Department of Human Services (Department) inadequately administered locally held funds (bank accounts) and petty cash during the examination period. Exceptions were

noted regarding the administration, accounting, reconciliation, reporting, receipt, and disbursement of these funds.

During fieldwork, the auditors tested quarterly reporting of receipts and disbursements of locally held funds at five of the Department's State-Operated facilities. They also performed on-site testing of the Department's petty cash funds at five of the Department's State-Operated facilities. The auditors noted the following exceptions:

Illinois Center for Rehabilitation and Education - Roosevelt

*Locally Held Funds*

- The Center had insufficient segregation of duties over the cash receipts process for the locally held funds (Fund 1150 (Permanent Trust) and 1149 (Special Revenue)). One employee had the authority to perform significant portions of the transaction cycle.
- 1 of 6 (17%) of receipts tested, totaling \$930, was deposited 10 days late.
- 6 of 16 (38%) quarterly *Report of Receipts and Disbursements for Locally Held Funds* (C-17 Reports) did not reconcile to the Center's general ledger.

*Petty Cash*

- For 1 of 2 (50%) of replenishments tested, the Facility did not follow the Department's policy when replenishing the Petty Cash Fund. At the time of replenishment, the Petty Cash Fund was not below 50%, they did not have a large number of invoices on hand, the fund was not dissolving, they were not changing custodians, nor was the replenishment representing the final reimbursement for the current fiscal year end.
- 1 of 2 (50%) *Petty Cash Fund Usage Reports* (Form C-18) was submitted 9 days late.

Illinois Center for Rehabilitation and Education – Wood

*Locally Held Funds*

- The Facility did not maintain a complete general ledger for funds 1149 and 1150.
- The Facility did not perform bank reconciliations during the examination period for funds 1149 and 1150.

Ludeman Developmental Center

*Locally Held Funds*

- During the testing of the Other Special Trust Fund (Fund 1139), the auditors noted the following:
  - For 2 of 2 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger. The net difference identified was \$2,737.
  - 2 of 8 (25%) C-17 Reports did not reconcile to the receipts recorded in the facility's general ledger. Variances ranged from (\$145) to (\$979).
  - 1 of 8 (13%) C-17 Reports did not reconcile to the disbursements recorded in the facility's general ledger. Variances ranged from (\$100) to \$2.
  - For 1 of 5 (20%) receipts selected for testing, totaling \$300, the Facility was unable to provide supporting documentation.

- During testing of the Resident's Trust Fund (Fund 1143), the auditors noted the following:
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger or the C-17 Report. The difference identified between the general ledger and bank account was \$148,252. The difference identified between the C-17 Report and the bank account was \$148,256.
  - 10 checks totaling \$25,259 were outstanding between 168 and 826 days, as of June 30, 2023.
  - 4 deposits totaling \$10,143, were not recorded to the general ledger in a timely manner. The deposits were recorded to the ledger between 91 and 704 days after the original deposit.
  - 4 services fees totaling \$14,148, were not timely submitted to the Department within 30 days of being received by the Facility.
  - An unreconciled variance of \$576,705 as of June 30, 2023 was identified during review of the bank reconciliation for the fund.

#### *Petty Cash*

- The Facility's General Revenue petty cash fund turnover rates on its Form C-18 submitted in Calendar Years 2022 and 2023, were 0 and not provided, respectively. The Facility did not provide explanations on the Form C-18 stating why the current level of the fund is needed.
- 1 of 2 (50%) of petty cash disbursements tested, totaling \$60, was for costs to renew a commercial driver's license. This license did not appear to have any connection to the employee's job description. The Facility was unable to provide documentation that the disbursement was approved by the Office of Comptroller.
- Per review of the check register, the auditors identified four checks from the Facility's General Revenue petty cash fund were issued out of sequence.
- For 2 of 2 (100%) of reimbursements tested, totaling \$175, the Facility did not document the source or the reason the receipt was received by the Facility.

#### Shapiro Developmental Center

##### *Locally Held Funds*

- During the testing of the Other Special Trust Fund (Fund 1139), the auditors noted the following:
  - 1 of 2 (50%) C-17 Reports tested could not be reconciled to the related bank statement. The unreconciled variance identified was \$169.
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger or C-17 Report. The difference identified was (\$169).
- During the testing of the Resident's Trust Fund (Fund 1143), the auditors noted the following:
  - 2 of 2 (100%) C-17 Reports tested could not be reconciled to the related bank statement. The unreconciled variances identified were \$145 and (\$2,002), respectively.
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger. The difference identified was (\$2,002).

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- During the testing of the Rehabilitation Fund (Fund 1144), the auditors noted the following:
  - For 2 of 30 (7%) disbursements selected for testing, the amount per the disbursement journal was not in agreement with the amount per the bank statement.
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger. The difference identified was \$270.
  - 2 of 2 (100%) C-17 Reports tested could not be reconciled to the related bank statements. The unreconciled variances identified were \$133 and \$270, respectively.

### Treatment and Detention Facility

#### *Locally Held Funds*

- For 1 of 7 (14%) disbursements tested, the Facility did not maintain a copy of the release receipt. As a result, the auditors were unable to determine if the disbursement was properly approved.

### Central Office

#### *Petty Cash*

- 1 of 59 (2%) petty cash funds tested did not have any money for two years and was not in use.
- For 2 of 15 (13%) petty cash funds tested, funds were below the approved amount for at least two years. Additionally, no log information could be provided to support the funds' activity.
- For 1 of 15 (7%) petty cash funds tested, the fund was below the approved funded amount since 2014.
- For 1 of 24 (4%) petty cash receipts and disbursements tested, notation of payment from petty cash was not documented on either the internal petty cash vouchers, vendor invoice, or statement.
- For 18 of 18 (100%) petty cash funds tested, Form C-18s were not timely filed with the Illinois Office of Comptroller. 6 (33%) were not filed and 12 (67%) were filed between 8 and 56 days late.
- For 7 of 18 (39%) petty cash funds tested, the Department was not able to provide copies of Form C-18.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2009. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Public Funds Deposit Act (30 ILCS 225/1) states when such deposits become collected funds and are not needed for immediate disbursement, they shall be invested within two working days at prevailing rates or better. Receipts between \$500 and \$10,000 should be deposited within 48 hours.

## **REVIEW: #4587 DEPARTMENT OF HUMAN SERVICES FY22-23 COMPLIANCE**

The Department of Human Services' Program Directive (Directive) (02.08.01.010) states that the Business Administrator is responsible for ensuring that adequate accounting controls exist over locally held funds. This includes responsibility for: a) establishing and maintaining adequate and effective controls over cash; and c) posting transactions onto the Locally Held Fund System timely and accurately to the proper accounts; d) reconciling bank accounts for locally held funds; f) ensuring that disbursement is properly authorized; h) providing Central Office with all information necessary to meet the Department's reporting requirements for locally held funds.

Directive (01.09.01.020) states that replenishment of Petty Cash Funds should only be made when one of the following occurred: 1) When 50% of the fund has been exhausted; 2) When a large number of invoices are on hand; 3) Before dissolving the fund; 4) When changing custodians; or 5) When the amount represents the final reimbursement for the current fiscal year.

The Statewide Accounting Management System (SAMS) Manual (Procedure 33.13.20) requires the Facility to submit accurate C-17 Reports reflecting the receipts and disbursements occurring in each locally held fund each quarter.

The SAMS (Procedure 09.10.40) requires:

- Form C-18 to be completed for all petty cash funds exceeding \$100 and to be filed with the Comptroller's Office no later than January 31 for the preceding calendar year.
- The petty cash fund to turn over approximately six times annually to ensure the proper dollar level of the fund and reduce the dollar level of the fund if the Form C-18 shows insufficient activity.
- Notation of payment to be made on the face of the internal petty cash vouchers (or attached there- to) or vendor's invoices or statements after payment by the custodian to the individual.

Good business practices prescribe checks be voided and reissued if they have been outstanding for 60 days.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Facility's activities.

**REVIEW: #4587 DEPARTMENT OF HUMAN SERVICES FY22-23 COMPLIANCE**

Department personnel stated that oversight and insufficient staff to ensure adequate separation of duties resulted in the issues noted.

It is important to properly administer locally held funds as they are not subject to appropriations, are often in a fiduciary capacity, and are held outside the State Treasury. In addition, failure to adequately administer locally held funds could lead to fraud, theft, or overdraft charges. Inadequate administration of locally held funds and petty represents noncompliance with State statutes. Inadequate controls over the locally held funds and petty cash funds results in noncompliance with the Department's Administrative Directive, SAMS procedures, and other requirements and could result in errors or irregularities not being detected in the normal course of business.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to strengthen controls over the administration of locally held funds, petty cash, and postage. The Department will re-train staff on proper procedures, ensure segregation of duties where feasible, and implement a process to monitor compliance.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will provide training on the reconciliation process monthly and quarterly for Locally Held Funds as well as requirements for C-17 and C-18 reporting.

DDD -Ludeman Fiscal Management will provide ongoing oversight to ensure all GRF Petty Cash procedures are done correctly.

**Estimated Date of Completion: 09/30/2025**

**DBHR-DMH**

DBHR-DMH will retrain Business Office staff on adequately administering locally held funds to ensure compliance with current laws, regulations, and policies & procedures.

Audit spot checks will be implemented to review disbursements of funds to ensure oversight.

Business Office organizational charts will be reviewed to ensure sufficient staffing and separation of duties.

**DRS**

ICRE-R - Comply with current laws, regulations, and policies and procedures regarding locally held funds and petty cash: (50% Complete)

- Segregation of duties – hire additional staff.
- Review and monitor bank reconciliation process of general ledger balance monthly.

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- Ensure timely deposits, replenishment, and usage reporting.
- Review and adhere to DHS Petty Cash replenishment policies.
- Review and update written procedures for LHF – Petty Cash.

**Estimated Date of Completion: 09/30/2025**

ICRE-W – 1) Establish and maintain local held funds by working with DoIT, SAP Team, General Accounting, Fiscal Services and ICRE-Roosevelt to create a ledger and back reconciliation using SAP.

2) Modify the back reconciliation - update the check register to keep a running balance. (100% Complete 8/1/24)

**Estimated Date of Completion: 12/30/2025**

**18. The auditors recommend the Department comply with current processes and procedures regarding maintenance of personnel files, completion of Form I-9s, and completion of employee performance evaluations. Additionally, they recommend the Department ensure overtime and leaves of absence are properly approved, employees file required Statements of Economic Interest, and employees timely complete required trainings. Finally, the auditors recommend Department management provide additional training to supervisors pertaining to its Directive and the Act and hold staff accountable for maintaining appropriate time records.**

**FINDING: *Inadequate Controls over Personal Services – This finding has been repeated since 2017.***

The Department of Human Services (Department) did not maintain adequate controls over its personal services function.

During the performance of testing at the Central office, the auditors noted the following:

### *Employee File Testing*

The auditors selected 60 employee files for examination testing procedures. Of the 60 selections, 9 selections were new hires during the period under examination. During the performance of testing, they noted the following:

- For 12 of 60 (20%) personnel files tested, a completed employment application form was missing from the employee's personnel folder and could not be located by the Department.
- For 1 of 9 (11%) personnel files tested for new hires, a completed U.S. Citizenship and Immigration Services (USCIS) I-9 Employment Eligibility Verification Form (Form I-9) was missing from the employee's personnel folder and could not be located by the Department.
- For 3 of 9 (33%) personnel files tested for new hires, the auditors were unable to

determine the employer's authorized representative completed and signed Section 2 of the Form I-9 no later than three business days after the employee's first day of employment.

- For 9 of 58 (16%) employees subject to a performance evaluation, the Department was unable to provide documentation to support the completion of the employees' performance evaluation.
- For 45 of 58 (78%) employees subject to a performance evaluation, the performance evaluation was not completed in a timely manner.
- For 1 of 12 (8%) terminated employees tested, the employee was overpaid by \$64.15 in their final gross pay.
- For 3 of 60 (5%) personnel files tested, variances were identified between the salary amount paid out and salary amount identified in the personnel file.

USCIS instructions for Form I-9s require Section 1 to be completed no later than the first day of employment. After completing Section 1, the employee is to sign their name and document the date signed. Additionally, Section 1 of the Form I-9 requires the employee to indicate whether a preparer, translator, or other individual provided assistance in completing the Form I-9. The employer is to complete and sign Section 2 of the Form I-9 within 3 days of the employees' first day of employment.

Further, the Illinois Administrative Code (80 Ill. Admin. Code 302.270) requires the Department to prepare an evaluation of employee performance not less often than annually to support administrative personnel decisions by documenting regular performance measures.

#### *Timesheet Testing*

During testing of timesheets, the auditors noted the following exceptions:

- For 14 of 60 (23%) employees tested, the Daily Summary Attendance Reports (IL444-4141) were not signed by the employees' supervisor.
- For 5 of 60 (8%) employees tested, the IL444-4141 could not be provided for the pay period requested for examination.
- For 3 of 60 (5%) employees tested, the IL444-4141 was not properly completed by the timekeeper.
- For 2 of 60 (3%) employees tested, documentation was not provided to support the approval of time off.

The State Officials and Employees Ethics Act (Act) (5 ILCS 430/5-5(c)) requires State employees to periodically submit time sheets documenting the time spent each day on official State business to the nearest quarter hour either on paper, electronically, or both. Time sheets are to be maintained in either paper or electronic format by the applicable fiscal office for a period of at least two years.

The Department's Administrative Directive (01.02.02.170) requires timekeepers to be responsible for keeping the time and attendance of all staff in the assigned area. Each timekeeper is to complete the IL444- 4141 for every calendar day (including weekends

and holidays), or is to ensure that another timekeeper completes it. Supervisors, or the supervisor's designee, are responsible for approving the IL444-4141.

*Overtime Testing*

During testing of timesheets, there were 10 employees who worked overtime during the pay periods selected for examination. For 1 of 10 (10%) of employees, documentation could not be provided by the Department to support the approval of the 31.50 hours of overtime worked by the employee.

The Department's Administrative Directive (01.02.02.230) states supervisors are responsible for determining the need for overtime and approving the time worked.

*Statement of Economic Interest Testing*

Of the 60 employees selected for testing, 10 were required to file statement of economic interest (statement). During the testing of statements filed, the auditors noted the following exceptions:

- 1 of 10 (10%) of employees did not file a statement with the Office of the Secretary of State.

The Illinois Governmental Ethics Act (5 ILCS 420/4A-105) except as provided in section 4A-106.1, by May 1 of each year a statement must be filed by each person whose position at that time subjects him to the filing requirements of Section 4A-101 or 4A-101.5 unless he has already filed a statement in relation to the same unit of government in that calendar year.

*Leave of Absence Testing*

During testing of employees who took leave of absence (LOA), the auditors noted the following exceptions:

- For 1 of 60 (2%) employees tested, authorized CMS2 forms identifying and approving the beginning leave of absence date could not be located by the Department.

The Department's Administrative Directive (01.02.02.140) states that written requests are required to be submitted for LOA approval.

*Employee Trainings*

During testing of employee trainings, the auditors noted the following exception:

- For 2 of 60 (3%) employees, 7 required trainings were completed between 9 and 136 days late.

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During fieldwork, they performed on-site testing at four of the Department's State-operated facilities over employee timesheet records. Their testing resulted in the following exceptions:

### Elgin Mental Health Center

- While testing Monthly Attendance Records (MARs), the auditors noted the following:
  - For 5 out of 60 (8%) MARs selected for testing, the MARs were not signed and dated by the timekeeper within 10 working days of the employee's receipt of the MAR.
  - For 5 out of 60 (8%) MARs selected for testing, the MARs did not contain the required signatures and/or dates from the employee, supervisor, and/or timekeeper.
  - For 7 of 60 (12%) MARs selected for testing, the MAR could not be located within the employees' personnel file and therefore no testing could be performed.
- While testing Staff Request for Time Off (IL444-4140), the auditors noted the following:
  - For 9 out of 218 (4%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the IL444- 4141 did not trace to the employees' monthly MAR.
  - For 61 out of 218 (28%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the Center was unable to provide the completed form.

### Kiley Developmental Center

- While testing MARs, the auditors noted the following:
  - For 1 of 60 (2%) MARs tested were not signed by the employee.
  - For 6 of 60 (10%) MARs tested, the employees did not timely sign the MAR. The MARs were signed between 24 and 130 days late.
  - For 10 of 60 (17%) MARs tested, the MARs did not contain signatures of the supervisor and/or the timekeeper.
- While testing Daily Staff Attendance Reports (IL444-4141), the auditors noted the following:
  - For 19 of 214 (9%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the reports were not completed by the employee.
  - For 4 of 214 (2%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the Center was unable to provide the completed form.
  - For 19 of 214 (9%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the reports did not contain proper evidence of the supervisor's signature.
  - For 1 of 214 (0.5%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the report was not completed within two working days of returning to work.
  - For 2 of 214 (1%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the employee did not fill out the attendance sheet while present at the Center.
- While testing Staff Request for Time Off forms (IL444-4140) the auditors noted the

following:

- For 2 of 214 (1%) Staff Request for Time Off forms (IL444-4140) selected for testing, the employee was on their regularly scheduled day off but marked as unexcused.
- While testing Payroll Timekeeping System (PTS) User Access the auditors noted the following:
  - For 1 of 18 (6%) of PTS users tested, the user did not have their access removed in a timely manner.

#### Shapiro Developmental Center

- A poster was not conspicuously displayed providing notice of state employee protection under the Whistle Blower Protection Article of the State Officials Employees Ethics Act (Act).
- While testing MARs, the auditors noted the following:
  - For 1 of 53 (2%) MARs selected for testing, the MARs did not contain all required signatures from the employee, supervisor, and/or timekeeper.
  - For 3 of 53 (6%) MARs selected for testing, the MARs did not reflect the accurate time codes for employee attendance following the completion of the Employee Time Correction Report (IL444- 4090).
  - For 4 of 273 (1.5%) dates tested, the IL444-4090 for one of the employee's selected was not properly signed and dated.
- While testing documentation related to staff time off and timekeeping, the auditors noted the following:
  - For 2 of 273 (1%) dates tested, the IL444-4140 was not properly completed as the signature and date from the employee were missing.
  - For 1 of 273 (.4%) Work Away Record (IL444-4604) was not properly approved as the signature and date from the timekeeping Department were missing.
  - For 5 of 297 (2%) dates tested, the IL444-4141 did not trace to the MAR.
  - For 2 of 273 (1%) dates tested, the Facility could not provide a copy of the completed IL444- 4140 for testing.
  - For 2 of 297 (1%) dates tested, the IL444-4141 did not contain all the proper initials.
  - For 9 of 273 (3%) dates tested, the IL444-4140 did not trace to the Daily Staff Attendance Record (IL444-4141).

#### Ludeman Developmental Center

While testing MARs, the auditors noted the following:

- For 44 of 60 (73%) months tested where the MAR could be provided, the MARs did not contain all required signatures from the employee, supervisor, and/or timekeeper.
- For 44 of 60 (73%) months tested where the MAR could be provided, the MARs were not signed and completed within 10 working days of employee receipt.
- For 7 of 60 (12%) MARs tested, the MAR could not be located within the employee's personnel file.

While testing documentation related to staff time off and timekeeping, the auditors noted the following:

- For 15 of 96 (16%) dates tested, the Daily Staff Attendance Record (IL444-4141) did not trace to the employees' MAR.
- For 64 of 70 (91%) dates tested, the Facility was unable to provide the Staff Request for Time Off (IL444-4140).
- For 24 of 96 (25%) dates tested, the Facility was unable to provide the Daily Staff Attendance Report (IL444-4141).
- For 1 of 15 (7%) employees tested, the Facility was unable to provide the Staff Request for Time Off (IL444-4140) and the Daily Staff Attendance Report (IL444-4141).

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Department's Administrative Directive (Directive) (01.02.02.170) requires a report, which documents that the employee time was spent on official State business, and which should be reviewed and signed by the employee, timekeeper, and supervisor within 10 working days.

The Department's Directive (01.02.02.170(G)) states employees are to promptly review the MAR and determine whether it accurately reflects time spent on official State business and authorized leave. If the MAR is accurate, the employee shall sign and date it then submits it to his/her supervisor or supervisor's designee for signature and date. Once the supervisor has signed and dated it, it shall be submitted to the timekeeper for signature and date. The entire signature process, from employee to timekeeper, must be completed within ten (10) working days of the employee's receipt of the MAR.

The Department's Directive (01.02.02.170 (Procedure I.A)) states supervisors are responsible for appointing a timekeeper to keep accurate and timely attendance records for each employee within the assigned area. Both the employee and the appointed timekeeper are responsible for maintaining accurate records of the employee's use of time. Supervisors, or the supervisor's designee, are also responsible for approving time off for all employees under their direct supervision. Employees are responsible for submitting the Staff Request for Time Off form (IL444-4140) to request time off. Also, the Directive 01.02.02.170(Procedure I.I) states that supervisors are responsible for ensuring that time and attendance records are retained for a 3-year period on-site and 2 years archived off-site for a total of 5 years.

The Department's Directive (01.02.03.015(B)) states employees and supervisors are responsible for ensuring that all time off requests are completed properly and that the increments of time requested are accurate. Documentation for approved time off must be documented by the submission of the Staff Request for Time Off form (IL444-4140) to the employee's supervisor or designated timekeeper. Also, the Directive (01.02.02.170(I.A)) states the supervisor has responsibility for verifying that an employee has available

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benefit time. If an employee takes time off and has no benefit time available, loss of pay or administrative action might occur.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated that lack of oversight and inefficiencies in manual processes resulted in the issues noted.

Failure to maintain complete Form I-9s is a violation of USCIS requirements and could expose the Department to penalties. Annual performance evaluations are important to ensure all employees understand the duties and responsibilities assigned to them and that they are adequately performing the duties for which they are being compensated. Without performance evaluations there is no documented basis for promotion, demotion, discharge, layoff, recall, or reinstatement and current employment status. Finally, by not maintaining appropriate time records, the Department is not in compliance with the Act and its Directives which could result in improper payments to employees and inaccurate accrual of benefit time.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will develop tools and training to address the retention requirements and timeliness to ensure adherence to various rules, regulations, and compliance requirements. IDHS will develop a plan that will incorporate a quality assurance review process.

### **UPDATED RESPONSE:**

**Partially Implemented.**

### **Corrective Action Plan:**

#### **DDD**

SODC Operations will ensure retraining of all these areas is completed by all SODCs that includes retraining for timekeepers and supervisors on the proper completion of the IL444-4141 and the required paperwork support needed.

**Estimated Date of Completion: 09/30/2025**

### **Legal**

The frequency of reminders to involved agency liaisons for the filing of Statements of Economic Interest, that specifically mentions leave of absences, have been doubled from 3 to 6. This will continue yearly.

**Date of Completion: 05/30/2025**

**OHR**

Training on maintenance of personnel files, completion of Form I-9 and employee performance evaluations will be held for all facility Human Resource staff and facility leadership.

**Estimated Date of Completion: 09/30/2025**

Central office Human Resource staff will randomly select a personnel file for each facility quarterly for an internal audit by OHR to ensure all records are within controls of the personal services functions.

**Estimated Date of Completion: 09/30/2025**

Facility Human Resource departments will maintain an ongoing performance evaluation list to ensure managers are completing performance evaluations on a timely basis.

**Estimated Date of Completion: 06/30/2025**

The 24/7 Facilities and Schools are now storing personnel files electronically via DocuWare. With an Agency of our size, OHR relies heavily on our liaisons at every facility/office to ensure timely completion of evaluations, mandatory trainings, and timekeeping. We will continue to send reminders to all program areas and strive for a 100% completion/accuracy rate.

**Date of Completion: 04/01/2025**

- 19. The auditors recommend Department management and staff comply with current policies and procedures regarding property and equipment and follow the control system in place. Additionally, they recommend the Department adequately maintain buildings and facilities to prevent further deterioration.**

**FINDING: *Inadequate Controls over State Property and Equipment – This audit has been repeated since 2005.***

The Department of Human Services (Department) did not have adequate internal control over State property inventories and record keeping.

During fieldwork, the auditors performed on-site property and equipment testing at five of the Department's State- operated facilities. Their testing resulted in the following exceptions:

Ann Kiley Developmental Center

- 10 of 12 (83%) equipment items selected for backwards testing were not properly recorded in the Department's *Physical Asset Balance Report* as of June 30, 2023.
- 1 out of 12 (8%) equipment items tested was not located in the area indicated on the inventory listing.

Elgin Mental Health Center

- 4 out of 12 (33%) equipment items selected for backwards testing were not properly recorded in the Department's *Physical Asset Balance Report* as of June 30, 2023.
- The Facility's grounds were not properly maintained. During a tour of the Facility, the auditors identified several areas/rooms/buildings that required repair work.
- The Facility does not maintain a tracking mechanism for its obsolete or unused property. Due to this condition, they could not conclude that the Facility's population records for obsolete or unused property were complete and accurate.
- The Facility improperly removed obsolete property still in its custody from property records.

Illinois Center for Rehabilitation and Education – Wood

- 1 of 12 (8%) items selected for forwards testing did not contain a property tag.
- 12 of 12 (100%) items selected for backwards testing did not trace to the facility's property records.
- 1 out of 12 (8%) equipment items, totaling \$743, was not in the location noted on the Facility's records.

Ludeman Developmental Center

- The Facility's grounds were not properly maintained. Several instances of property deterioration, including damaged sidewalks and roads, were noted while touring the facility's grounds.
- 6 of 12 (50%) equipment items tested were not in the location noted on the Facility's records.
- 8 of 12 (67%) property items selected for testing could not be located on the facility's property records.

Shapiro Development Center

- The Facility's grounds were not properly maintained. During a tour of the Facility, several instances of property deterioration were observed, including ceilings that were falling in and several areas/rooms/buildings that required repair work.
- A large amount of equipment items were observed which appeared to be transferable and were not identified by the Facility as such. Furthermore, the Facility does not appear to have controls in place to safeguard against the accumulation of obsolete or unused equipment. Further, 4 of 7 (57%) obsolete items could not be located.
- 3 of 12 (25%) equipment items were not located in the area indicated on the inventory listing.
- 3 of 12 (25%) equipment items could not be located on premises on the date of their site visit. The Department was subsequently able to locate the property.

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- 1 of 12 (8%) equipment items tested could not be traced to the *Physical Asset Balance Report*.
- 3 of 6 (50%) transferable equipment items were not identified as transferable.
- 19 of 19 (100%) equipment items could not be located on the facility's *Physical Asset Balance Report*.
- 1 of 12 (8%) of equipment items selected during backwards testing was coded with the incorrect plant code.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2005. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Property Control Act (30 ILCS 605/4) requires the Department to be accountable for the supervision, control, and inventory of all items under its jurisdiction.

The Statewide Accounting Management System (SAMS) (Procedure 29.10.10) requires the Department to maintain detailed records of all property which includes the correct descriptions of asset and correct information of its location. Additionally, the Department is required to identify assets that are obsolete, damaged, or no longer used in operations and, if necessary, remove them from asset records. The asset records should be reconciled with the results of inventory and updated accordingly.

The Illinois Administrative Code Section (44 Ill. Admin. Code 5010.400) requires agencies to adjust property records within 90 days after acquisition, change, or deletion of equipment items.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation; and revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Finally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Facility's activities.

Department personnel stated that lack of employee and management oversight. Additionally, multiple ongoing capital development projects have caused significant declines in ground and property maintenance. These projects have taken the focus from regular operational needs.

Failure to properly control and record State property represent noncompliance with State law and increases the potential for possible loss or theft of State property. Failure to

transfer or find a use for excess property does not allow the State to manage State assets in the most economical manner and could lead to unnecessary purchases by other State agencies. Failure to properly record State property can lead to inaccurate financial information being reported. In addition, failure to properly maintain property could lead to further damage and/or usage conditions.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS Office of Business Services is working to review property policies and procedures and communicate the importance of strict adherence to documented policy. In addition, requests for maintenance and repair projects for buildings and facilities have been submitted, as required, to the Capital Development Board for review and funding.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will ensure all facilities cited implement and complete a corrective action plan addressing the issues found and will complete retraining with applicable staff.

**Estimated Date of Completion: 08/31/2025**

All SODCs will implement routine quality assurance monitoring for property control (forwards and/or backwards testing as well as ensuring property tag is visible) on a routine basis.

**Estimated Date of Completion: 09/30/2025**

**DBHR-DMH**

Regional Chief Engineers for DMH will survey DMH facilities quarterly and report on grounds that have not be properly maintained. This will allow for DMH to address property needs timely.

**Estimated Date of Completion: 09/30/2025**

DMH staff will be retrained on current policies and procedures regarding property and equipment.

**Estimated Date of Completion: 09/30/2025**

**DRS**

Ensure compliance of all policies and procedures by:

- 1) Retraining the PCC with Director of Business Services. (100% Complete – 2/20/24)
- 2) Sending a memo throughout the facility regarding proper property/equipment movement procedures. (100% Complete – 7/29/24)

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- 3) Work closely with Central Office to secure property tags. 100% Complete – 5/30/25.
- 4) Review procedures to ensure compliance. (100% Complete – 5/30/25)

**Date of Completion: 05/30/2025**

- 20. The auditors recommend Department management monitor controls over the monthly reconciliations in accordance with the SAMS to identify and correct errors in a timely manner.**

**FINDING:** *Inadequate Controls over Monthly Revenue Status (SB04) Reconciliations - New*

The Department of Human Services (Department) had inadequate controls over the reconciliation of its internal receipt records to the Office of Comptroller's (Comptroller) *Monthly Revenue Status Reports (SB04)*.

The auditors noted the following:

- 1 of 55 (2%) reconciliations contained a discrepancy of \$30,000,000 that was not identified and resolved.
- 3 of 12 (25%) reconciliations of internal receipts records to the SB04 tested were prepared between 1-2 days late.

The Statewide Accounting Management System (SAMS) Manual (Procedure 07.30.20) states agency reconciliations are the primary control that ensures certain requirements are being satisfied. Agencies must reconcile to the SAMS on a monthly basis and notify the Comptroller of any irreconcilable differences so that necessary corrective action can be taken to locate the differences and correct the accounting records. These reconciliations must be completed within 60 days of the month end. SAMS Procedure 25.40.20 required the Department to reconcile on a monthly basis and notify Comptroller of any unreconcilable differences so necessary corrective action can be taken to locate the differences and correct the accounting records.

Department personnel stated that the discrepancy noted on the reconciliation was a keying error due to this being a manual process. Oversight resulted in the late submissions.

Failure to timely and properly reconcile the Monthly Revenue Status (SB04) can result in errors not being identified and resolved in a timely manner.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to improve oversight and revise internal operating procedures to ensure reconciliations are accurate and submitted timely.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

**OFS**

The Department has added fields to the reconciliation tracking worksheet to clearly identify the due date of each monthly reconciliation. Procedures have been updated to stress data review to prevent oversight of errors.

**Date of Completion: 06/20/2025**

21. **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 facility staff. They also recommend the Department update policies and procedures to reflect the conversion to the ERP system and ensure staff are adequately trained on inventory policies and procedures.**

**FINDING:** *Inadequate Controls over Commodities – This finding has been repeated since 2013.*

The Department of Human Services (Department) did not maintain adequate internal control and oversight over annual inventory procedures.

**Central Office Location Testing**

During fiscal year 2022, the Department converted from the Department's Warehouse Control System (WCS) to the inventory module within the Enterprise Resource Planning (ERP) system. During observation of inventory counts for fiscal year 2023, the auditors noted the following:

- The Department's Administrative Directive (01.05.07.010) provided to the Department's staff performing inventory counts was not updated to reflect the conversion from WCS to ERP.
- The Department was not able to generate reports from the ERP which reflect the average cost of inventory.
- For 1 of 12 (8%) of inventory items tested, there was a discrepancy between auditor counts and the Department's final inventory adjustment.
- The Department did not track and calculate the annual percentage of local farm or food products purchased during fiscal years 2022 and 2023.

**State-Operated Facility Testing**

During fieldwork, the auditors performed on-site pharmacy and non-pharmacy commodities inventory tests at three of the Department's State-Operated facilities:

**Elgin Mental Health Center**

- For 8 of 20 (40%) pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from -1 to 3.

- For 5 of 20 (25%) non-pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from 3 to 144.
- For 4 of 20 (20%) additions to inventory selected for cutoff procedures, data input into the Facility's system did not agree with purchase orders, facility requisition reports, receiving reports, invoices, or inventory stock card reports.
- There is a lack of segregation of duties over the inventory cycle. Employees responsible for ordering, receiving, recording, and maintaining custody are also performing inventory counts. Additionally, these employees are responsible for reconciling, reviewing reconciliations, approving, and posting adjustments.

**Ludeman Developmental Center**

- For 4 of 20 (20%) non-pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from -12 to 100.
- For 4 of 40 (10%) inventory items selected for addition cutoff procedures, data input into the Facility's system did not agree with the related purchase orders.

**Shapiro Developmental Center**

- During testing, one individual on the user listing did not appear to be an employee of the Department.
- There is a lack of segregation of duties over the inventory cycle. Employees responsible for ordering, receiving, recording, and maintaining custody, are also performing inventory counts. Additionally, these employees are responsible for reconciling, reviewing reconciliations, approving, and posting adjustments.
- During inventory procedures, teams performing counts were instructed to not count specific inventory items that should have been included in the final inventory count.
- For 3 of 34 (9%) inventory items selected for testing, the Facility was unable to provide the related vouchers.
- For 4 of 80 (5%) non-pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from -4 to 15.
- For 1 of 40 (3%) non-pharmacy inventory items counted during the annual inventory, the description of the item within ERP was not in agreement with the item's physical marker.
- For 1 of 40 (3%) non-pharmacy inventory items counted during the annual inventory, the items were counted under the improper unit type.
- 1 of 20 (5%) non-pharmacy additions tested was excluded from inventory adjustments. While reviewing commodities inventory procedures, the directions provided require employees to set aside items received the inventory process and to exclude these items from their counts. Such instructions contradict the Administrative Directive.
- 7 of 466 (1%) total non-pharmacy inventory items appeared on the facility's final valuation report but were not counted by the facility during inventory procedures.
- 94 inventory adjustments made by the facility for the 466 non-pharmacy items were recorded inaccurately.

- 83 of 658 (13%) medications tested that were used on June 29th and June 30th, were not properly removed from the system.
- Several instances were identified of inventory not being maintained in sanitary conditions.
- For 1 of 11 (9%) inventory items tested for turnover, the item had a turnover rate of less than one. The Facility was not able to provide a reasonable explanation to support the quantity maintained.
- For 2 of 11 (18%) inventory items tested for turnover, the auditors were unable to determine the turnover ratio. As a result, they were unable to assess compliance with State statute.
- For 2 of 10 (20%) non-pharmacy inventory additions tested, receipts of inventory did not appear to be entered into the ERP system.
- For 1 of 15 (7%) items tested, the Facility stated the inventory entered in the system was incorrect.
- 3 of 20 (15%) inventory requisitions tested were not properly authorized.
- 9 of 20 (45%) inventory requisitions tested received prior to fiscal year end were not entered into the system until the following fiscal year.
- The Facility was unable to provide documentation to support the ending balances of the fiscal year 2021 and fiscal year 2022 inventory. As a result, the auditors were unable to perform testing for inventory balance fluctuations through fiscal year 2023.
- During the performance of inventory procedures, 68 items were identified as having inventory on hand but having no assigned value.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Statewide Accounting Management System (SAMS) Manual (Procedure 03.60.20) requires the Department to perform an annual physical count of inventory on hand and to reconcile the results to inventory records to ensure the completeness and accuracy of those records. In addition, inventory held by governmental funds should be valued at cost.

In addition, generally accepted accounting principles require the proper valuation of inventory for financial reporting purposes. This would require verifying detailed transactions agree to the recorded inventory balances.

The Local Food, Farms and Jobs Act (Act) (30 ILCS 595/10(a)) states in order to create, strengthen, and expand local farm and food economies through Illinois, it shall be the goal of this State that 20% of all and food products purchased by State agencies and State-owned facilities, including, without limitation, facilities for persons with mental health and development disabilities, be local farm or food products. Furthermore, the Act (30 ILCS 595/10(d)) states all State agencies and State-owned facilities that purchase food and food products shall develop a system for (i) identifying the percentage of local farm or food products purchased for fiscal year 2021 as the baseline; and (ii) tracking and reporting local farm or food products purchases on an annual basis.

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The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law; that funds property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and that revenues, expenditures, and transfers of assets, resources, or fund applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over State's resources.

The Illinois Procurement Code (30 ILCS 500/50-55) requires every State agency to stock no more than a 12-month supply of inventory. An inventory turnover ratio of less than one indicates a greater than 12-month supply of inventory.

Department personnel stated the exceptions noted were due to oversight and revisions to Administrative Directives to reflect the new process in ERP not yet being finalized. Further, Department personnel stated, although the Department is able to calculate the annual percentage of local farm or food products after purchases are made, the Department was not tracking the percentage on an ongoing basis due to oversight.

Failure to develop and maintain strong controls over commodities could lead to fraud, waste, and abuse of commodity items.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review policies and procedures and continue to train staff on job functions and the importance of proper segregation of duties to ensure compliance.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

All cited facilities will ensure all staff are retrained on policies and procedures related to inventory and inventory processes. Additionally, this training will encompass the Annual Inventory procedures related to staff segregation of duties.

**Estimated Date of Completion: 09/30/2025**

**DBHR-DMH**

DMH will review and update all policies and procedures to ensure compliance with the ERP system.

**Estimated Date of Completion: 09/30/2025**

Staff will be retrained on inventory policies and procedures related to internal controls and oversight of the annual inventory processes.

**Estimated Date of Completion: 12/31/2025**

Tracking the local food has been challenging due to a lack of accuracy as it relates to the definition of “local food”. The Statute definition does not align with how local food has been handled by different agencies. CMS guidance was sought in preparation of the annual report – which is based on the data gathering that caused the audit finding. The guidance was a different interpretation of DHS’ understanding of what data was to be collected and reported upon. A Task Force was developed to study the issue. DHS, CMS, the Chief Procurement Officer and others were appointed to the Task Force. The report issued at the end did not capture the recommendations of all which caused the resulting bill to be withdrawn. A new Task Force has been assembled and is preparing for its first meeting. A Business Administrator in DD will represent DHS on it. Though DHS accepts this audit finding, it should be noted that should DHS follow the example and/or guidance of other State agencies, the after the fact approach of gathering the information (this is the approach which lead to the audit finding) will result in the most accurate information. Until such time as the guidance has been modified, the method employed in the first year will remain unchanged.

**Estimated Date of Completion: 01/01/2027**

- 22. The auditors recommend Department management comply with State law by completing and adopting rules related to community-based residential settings and enforcing the requirement for developmental agencies to certify regarding wage increases to benefits.**

***FINDING: Failure to Implement Policies and Rules over Community Integrated Living Arrangements and Community-Based Residential Settings and Adequately Monitor CILAs – This finding has been repeated since 2017.***

The Department of Human Services (Department) failed to finalize and implement policies and rules for certain community-integrated living arrangements (CILA), and community-based residential settings.

***Failure to Finalize and Implement Rules***

During the examination period, the auditors noted the Department had not finalized and implemented rules regarding community-based residential settings. As of June 30, 2023, the adoption of the rules was 11.5 years past the due date required by statute.

The Mental Health & Developmental Disabilities Act (Act) (20 ILCS 1705/73(b)) requires the Department to draft and promulgate rules governing community-based residential settings. The rules for community-based residential settings shall include settings that

offer to persons with serious mental illness (i) community- based residential recovery-oriented mental health care, treatment, and services; and (ii) community-based residential mental health and co-occurring substance use disorder care, treatment, and services. The rule was required to be drafted by January 1, 2012.

Department personnel stated although they are not finalized, the Division of Mental Health has developed draft rules. This work began in fiscal year 2011, but when it appeared close to completion, pushback from community providers and legislators caused the administration at the time to pause the work on this task.

During the prior examination, the auditors noted the Department had not finalized and implemented rules related to the assignment and operations of monitors and receiverships for CILAs as required by the Act. During the current examination period, they noted that the rules had been finalized and implemented.

### ***Failure to Adequately Monitor the CILA Program***

During the performance of testing, the auditors determined 63 of 230 (27%) developmental services agencies did not certify with the Department that mandated wage increases to benefits are passed through in accordance with the legislative or administrative mandate.

Under the Act (210 ILCS 135/4(c-5)), each developmental services agency licensed under this Act shall submit an annual report to the Department, as a contractual requirement between the Department and the developmental services agency, certifying that all legislatively or administratively mandated wage increases to benefit workers are passed through in accordance with the legislative or administrative mandate. The Department shall determine the manner and form of the annual report.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department management stated that although they reached out multiple times through their networks to explain the requirement and remind providers, some providers did not complete the requirement.

Failure to adopt and implement rules governing community-based residential settings could adversely impact the care and treatment of individuals and represents noncompliance with the Act. Failure to receive the annual report from service agencies represents noncompliance with Act and limits the Department's oversight of wage increases.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. Rule 115, which oversees the Community Integrated Living Arrangements (CILA), was officially

updated in 2023 and Rule 120, which governs all three developmental disabilities waivers, was updated in 2024. IDHS has recorded a training regarding the updates to the Rules and provided updated resources regarding the changes. Furthermore, IDHS publishes Information Bulletins about updated rules. Regarding the monitoring of the implementation of direct support professional wage increase, IDHS has strengthened the process to ensure attestations are completed by CILA and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) providers, which has included email and phone call follow up to improve the response rate of providers.

**UPDATED RESPONSE:**  
**Partially Implemented.**

**Corrective Action Plan:**  
**DDD**

Update the process for attestations regarding wage implementation to increase responses and hold community-based providers accountable. DDD updated the attestation forms and survey process to include tracking of completion and follow up activities for those non-respondents. This includes individualized outreach and phone and email communication. DDD also updated HCBS waiver language with increases.

**Date of Completion: 12/31/2024**

**DBHR-DMH**

DHS Division of Behavioral Health and Recovery (DBHR) will complete drafting and internal review of 59 Illinois Adm. Code 113.

**Estimated Date of Completion: 09/30/2025**

DBHR will work with IDHS Bureau of Rules within the General Counsel's Office to publish the proposed rule for First Notice.

**Estimated Date of Completion: 12/31/2025**

- 23. The auditors recommend Department management maintain and develop internal controls that adequately provide transportation trainings to staff and enhance management oversight to ensure trip information packets are filled completely.**

**FINDING:** *Inadequate Controls over Forensic Patient Transport – First reported 2021, Last 2023*

The Department of Human Services (Department) did not implement adequate corrective actions related to its Elgin Mental Health Center (Elgin MHC) Forensic Patient Transport Procedures.

In August 2016, the Office of the Auditor General (OAG) released a Performance Audit of the Department's Forensic Patient Transport Procedures pursuant to Illinois House of

Representatives Resolution Number 199 and amended by Legislative Audit Commission Resolution Number 147. The OAG's Forensic Patient Transport Performance Audit contained 5 recommendations in which the Department was to take corrective actions necessary to ensure responsible parties at the Elgin MHC had adequate policies and procedures to ensure material compliance with all relevant governing laws, rules, and regulations. During the previous examination, the auditors reported the Department had implemented 2 of the 5 recommendations, and partially implemented 3 of the 5 recommendations.

As required by *Governmental Auditing Standards*, the auditors were required to follow-up on the Department's implementation of the corrective actions for the three partially implemented recommendations during the examination period.

Based on their follow-up testing procedures, the auditors noted the Department still had not fully implemented two of the five recommendations. Specifically, they identified the following:

- Ensuring Trip Information packets are filled out completely and appropriately for all trips:  
During fieldwork, auditors selected 60 trips during the examination period and identified 4 of 60 (7%) trip packets did not include vehicle safety and security checklists and 4 of 60 (7%) trip packets did not have required signatures.
- Ensuring Elgin MHC staff receive annual training on current transportation policy and application of security devices:  
During fieldwork, the auditors selected 70 security personnel at the Elgin MHC by trips completed during the examination period. They noted the following:
  - 8 of 70 (11%) security personnel tested did not have documentation on file to support completed trainings.
  - 35 of 70 (50%) employees tested did not properly complete training prior to the patient transport.

Elgin MHC Forensic Treatment Program Policy 730 (FTP 730), Transportation Outside the Secure Setting for Court/ Medical/ Other - issued 4/29/15 and revised 8/29/17, requires pre-trip documentation to have a vehicle safety & security checklist and a trip information packet, among other documentation. The trip information packet includes details such as date, route, and staffing level. After the trip, the trip information packet is required to be reviewed by the Sallyport Officer to insure it is complete and noted on the Sallyport Officer checklist. If approved, the trip information packet is then to be signed by the senior security office assigned to the trip. The reviewing supervisor is then required to note any additional instructions for the transportation team.

FTP 730 requires all transportation staff to complete training in current transportation procedure at least annually.

Department personnel stated the exceptions noted were the result of staff error.

Failure to complete and maintain accurate documentation over forensic transport

procedures represents noncompliance with State regulations. Further, failure to follow internal controls governing the transportation of patients increases the risk of potential harm to the patient, Elgin MHC staff, or unassuming third parties.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has implemented additional oversight to the trip packet process to improve reviews and ensure completion. Additionally, the completed trips are reviewed by the security department and results are reported to the Quality Department. Also, Staff Development has implemented a training tracker accessible to all managers to monitor for timely completion of trainings and to address failure to timely complete trainings within employee evaluations.

**UPDATED RESPONSE:**

**Implemented.**

**Corrective Action Plan:**

**DBHR - DMH**

Auditing monthly since April 2024 to present. The Auditing process changed once this finding occurred where now the CEO/designee reviews over the trip packet and if correct signs and then the Medical Director/designee reviews and signs. After the trip occurs then the entire trip packet is returned to the Chief of Security where it is audited. If there are any mistakes the staff involved are reeducated. Since this new process has occurred all mistakes have been caught by the CEO/designee and or the Medical Director/designee. Monthly these audits are reported to the Quality Council meeting. Staff Development developed a tracker for staff CBL's also CBL's are reported to Quality Council on monthly basis. Staff transcripts are also pulled at the time of their annual evaluation.

**Date of Completion: 05/30/2025**

- 24. The auditors recommend Department management enhance its policies and procedures to ensure facilities and community agencies timely submit written responses to the OIG. They further recommend that if responses are not received within the 30 calendar days outlined by statute, the Secretary determines the appropriate corrective action to be taken as required by law.**

**FINDING:** *Untimely Receipt of Facility and Community Agency Responses to the Department OIG – First reported 2021, Last reported 2023*

The Department of Human Services (Department) did not ensure mental health facilities, developmental disabilities facilities, and community agencies under its operational authority timely filed written responses with the Department's Office of the Inspector General (OIG).

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During the examination period, the auditors tested 26 OIG investigative reports to determine if the respective facilities or community agency timely filed their written response. The results of their testing indicated 6 of 26 (23%) investigative report responses from facilities and community agencies were not timely filed within 30 calendar days of receiving the report from the Department's OIG. Responses to the report were submitted between 1 and 585 days late by the facilities and community agencies. The Secretary was not notified reports were not submitted within the required 30-day period and therefore did not determine corrective action to be taken.

The Department's OIG Services was created by the Department of Human Services Act (Act) (20 ILCS 1305/1-17) to investigate and report upon allegations of abuse, neglect, or financial exploitation of individuals receiving services within mental health facilities, developmental disabilities facilities, and community agencies operated, licensed, funded, or certified by the Department, but not licensed or certified by any other State agency.

Further, the Act (20 ILCS 1305/1-17(n)(1)) requires within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, absent a reconsideration request, the facility or community agency shall file a written response with the OIG that addresses, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent recurrences; and (iii) eliminate the problems identified. The written response is required to include the implementation and completion dates of such actions. If the written response is not filed within the allotted 30 calendar day period, the Act then requires the Department's Secretary to determine the appropriate corrective action to be taken.

Department personnel stated, for various reasons, the applicable facilities were unable to complete the responses within the 30 calendar days. For 2 out of the 6, the responses were a day late due to failing to count a holiday in the 30 calendar days. Department management further stated the unfiled responses were not brought to the Secretary's attention because Department management knew the responses were being worked on and would ultimately be completed and submitted by the facilities.

Failure to properly file and respond to investigative reports could result in matters not being addressed or remedied in a timely manner, affecting those individuals utilizing the response facilities and community agencies.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has developed and implemented a process to ensure facilities timely submit written responses to the OIG. This process is being formalized in a standard operating procedure and will be circulated upon completion. Additionally, the Secretary has appointed designees within the Divisions of Mental Health and Developmental Disabilities to determine appropriate corrective action if a response to the OIG's report is not filed within the allotted 30 calendar day period.

### **UPDATED RESPONSE:**

Implemented.

**Corrective Action Plan:**

**DHS Programs**

IDHS developed and implemented a process to ensure compliance. Secretary has appointed designees within DMH and DDD to determine corrective action if a response to the OIG's report is not filed within the allotted 30 calendar day period.

**Date of Completion: 01/16/2025**

**DDD & DBHR-DMH**

A process has been developed with the OIG for addressing non-responding community agencies.

**Date of Completion: 04/29/2025**

**25. The auditors recommend the Department comply with the respective statutory requirements or seek legislative remedy as appropriate.**

**FINDING: *Inadequate Controls over the Monitoring and Implementation of State Statutes – New***

The Department of Human Services (Department) did not comply with various statutory mandates. During testing, the auditors noted the following:

- The Department developed and made publicly available a strategic plan regarding improving access to inpatient psychiatric beds 110 days late.

The Mental Health Inpatient Facility Access Act (405 ILCS 140/15) requires the strategic plan to be finalized and made publicly available one year after the effective date of the Act.

Department personnel stated the report was delayed due to extensive research, stakeholder input, and a lengthy legal review process involved in producing an effective strategic plan.

Failure to timely provide a strategic plan could adversely impact the care and treatment of individuals and represents noncompliance with the Mental Health Inpatient Facility Access Act.

- The Department failed to collaborate with the Department of Healthcare and Family Services (HFS) to develop a standard format for information collection.

Per the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/63.5), no later than January 1, 2023, the Department shall collaborate to develop a standardized format for:

1) collecting de-identified aggregate data from all member assessment tools; 2) collecting other de-identified aggregate data that behavioral health providers are required to submit to the State pertaining to the administration of mental health and behavioral health services, including, but not limited to, substance use disorder at the Department of Human Services or the Department of Healthcare and Family Services; and 3) registration for Value Options through Beacon Health Options Provider Connect portal. The Department must comply with the new standardized format within 6 months after its date of completion.

Department personnel stated the Department had been in contact with HFS regarding developing the standardized format as specified in the Act. However, the project could not be completed by January 1, 2023.

Failure to create a standardized format for data collection could lead to information not being properly captured and make it more difficult to perform data analysis.

- Surplus funds in the Mental Health Reporting Fund (Fund) were not used to award grants that promote the National School Mental Health Curriculum model for school-based mental health support, integration, and services. Additionally, the Department had not created a National School Mental Health curriculum model for school-based mental health support, integration, and services.

The State Finance Act (Act) (30 ILCS 105/6z-99(b)) requires the Illinois State Police and Department to coordinate to use moneys in the Fund to finance their respective duties of collecting and reporting data on mental health records and ensuring that mental health firearm possession prohibitors are enforced as set forth under the Firearms Concealed Carry Act and the Firearm Owners Identification Card Act. Any surplus in the Fund beyond what is necessary to ensure compliance with mental health reporting under these Acts shall be used by the Department for mental health treatment programs, as follows: (1) 50% shall be used to fund community-based mental health programs aimed at reducing gun violence, community integration and education, or mental health awareness and prevention, including administrative costs; and (2) 50% shall be used to award grants that use and promote the National School Mental Health Curriculum model for school-based mental health support, integration, and services.

Department personnel stated that while the Department was aware of the requirement, the Division of Mental Health was not aware these funds were available to spend on this program.

Failing to use excess funds to provide mental health treatment programs represents noncompliance with the Act and impedes the Department's ability to provide mental health programs aimed at reducing gun violence.

- The Department had not publicly posted information regarding patient rights about pregnancy and childbirth to its website.

The Medical Patient Rights Act (410 ILCS 50/3.4(b)) requires the Department to post, either by physical or electronic means, information about rights regarding pregnancy and childbirth on its publicly available website.

Department management stated the required information was not publicly posted to the Department's website due to oversight. It has since been posted as of February 20, 2024.

Failure to post information related to medical patient rights could impact patients and their treatments.

- The Child Care Assistance Program Eligibility Calculator on the Department's website was updated 619 days after the effective date of Section 9A-11 of the Public Aid Code (Code).
- Policies identifying eligibility for the Child Care Assistance Program did not identify the following categories of families as being eligible:
  - Families transitioning from TANF to work;
  - Families at risk of becoming recipients of TANF; and,
  - Families with special needs as defined by rule.

The Code (305 ILCS 5/9A-11) requires the Department to update the Child Care Assistance Program Eligibility Calculator posted on its website to include a question on whether a family is applying for childcare assistance for the first time or is applying for a redetermination of eligibility.

Further, the Code (305 ILCS 5/9A-11) enumerates the categories of families to be covered, including families transitioning from TANF to work, families at risk of becoming recipients of TANF, and families with special needs as defined by rule.

Department personnel stated changes in staffing and assigned duties within the Division of Early Childhood caused delays in updating the eligibility calculator. Furthermore, some of the mandate language relates to defunct programs that were in place prior to the current Child Care Assistance Program (CCAP).

Failure to timely post updates to the Child Care Assistance Program Eligibility Calculator and develop policies to identify all categories of eligible families represents noncompliance with the Code and could result in eligible families not receiving available child care assistance.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review the requirements of the statutes identified and the need for any related policy

and procedure changes to remedy the issues. Additionally, IDHS will assess the need for additional staff or the need to fill staff vacancies to improve compliance.

**UPDATED RESPONSE:**  
**Partially Implemented.**

**Corrective Action Plan:**

**DBHR-DMH**

IDHS/DMH has hired two staff responsible to monitoring and managing legislative activities. These staff were recently moved under the DMH Chief of Staff team to have a broader reach throughout DMH.

**Date of Completion: 02/01/2025**

**FCS**

FCS -Reviewed the legislative requirement and required language;

1. Reached out to other agencies named in this statute to align messaging for consistency;
2. Worked with other DHS Divisions to coordinate messaging.
  - a. It was determined the information should be placed on the website with other Pregnancy and Parenting information.
  - b. This was implemented in February of 2024-IDHS: Maternal Patient Rights

A control has been established to review the website annually each January, ensuring its content remains current and accurate.

**Date of Completion: 02/20/2024**

This legislation was reviewed for 2024. No changes were made to this legislation in 2024. (Source: P.A. 101-445, eff. 1-1-20; 102-4, eff. 4-27-21.-- 410 ILCS 50/3.4.b)

**Date of Completion: 01/16/2025**

- 26. The auditors recommend Department management submit all reports on or before the due date as specified in the applicable State law or seek legislative relief from the reporting requirement.**

**FINDING:** *Late Submission of Required Reports – This finding has been repeated since 2013*

The Department of Human Services (Department) did not submit required reports to the Governor, the General Assembly, or other officials in a timely manner.

During the examination period, the Department was required to submit various reports to the Governor, the General Assembly, and other officials. The following reports were not submitted timely:

- The Department did not submit an annual report by January 1, 2022 and 2023, to the General Assembly as required by the Children and Family Services Act.
- Furthermore, the related interagency agreement with the Department of Children and Family Services (DCFS) expired on January 21, 2023, and was not subsequently renewed.

The Children and Family Services Act (Act) (20 ILCS 505/43(c)) requires the Department on each January 1, to submit a report to the General Assembly on: 1) the number of youth in care and young adults who were intercepted during the reporting period and the supportive services and treatment programs they were connected with to prevent homelessness, incarceration, or other negative outcomes; and 2) the duration of the services the youth in care and young adults received in order to stabilize them during their transition out of State care. Additionally, the Act (20 ILCS 505/43(a)) requires the Department, DCFS, and other agencies to enter into an interagency agreement for the purpose of providing preventive services to youth in care and young adults who are aging out of or have recently aged out of the custody or guardianship of DCFS.

Department management indicated that due to confidentiality laws, the Department does not have access to the information needed to write the report. Furthermore, due to competing priorities and employee oversight, communication was not made regarding renewal of this interagency agreement.

- The Department submitted 1 of 2 (50%) annual reports required under the Reimagine Public Safety Act during the examination period 123 days late.

The Reimagine Public Safety Act (430 ILCS 69/35-20(e)), requires the Office of Firearm Prevention within the Department to issue a report to the General Assembly no later than January 1 of each year that identifies communities within Illinois municipalities of 1,000,000 or more residents and municipalities with less than 1,000,000 residents and more than 35,000 residents that are experiencing concentrated firearm violence, explaining the investments that are being made to reduce concentrated firearm violence, and making further recommendations on how to end Illinois' firearm violence epidemic.

Department personnel stated the report was submitted past the deadline due to the need to ensure the accuracy and completeness of the data included in the report.

- The Department did not timely submit annual reports required to the General Assembly regarding homeless minors older than 16 years of age but less than 18 referred to a youth transitional housing program for whom parental consent to enter the program is not obtained. The reports for calendar years 2021 and 2022 were submitted 479 and 114 days late, respectively.

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The Emancipation of Minors Act (750 ILCS 30/2) requires the Department to annually report to the General Assembly, beginning January 1, 2019, and annually thereafter through January 1, 2024, regarding homeless minors older than 16 years of age but less than 18 years of age referred to a youth transitional housing program for whom parental consent to enter the program is not obtained.

Department personnel stated delays in submitting the reports were due to the need to obtain required information from a partner agency and delays resulting from compiling, reviewing, and approving the information contained in the report.

- 5 of 10 (50%) quarterly report filings required under the Illinois Public Aid Code (Code) were filed between 13 and 109 days after the end of the next fiscal quarter.

The Code (305 ILCS 5/12-5), requires the Department to report to the General Assembly at the end of each fiscal quarter the amount of all funds received and paid into the Social Services Block Grant Fund and the Local Initiative Fund and the expenditures and transfers of such funds for services, programs and other purposes authorized by law. The Code does not identify a due date for the quarterly reports.

Department personnel stated the Code does not include a due date and believed they were in compliance with filing of the reports.

- 6 of 8 (75%) monthly reports required to be filed under the Accountability for the Investment of Public Funds Act (Act) were filed between 1 and 44 days late.

The Act (30 ILCS 237/10) requires the Department to make “sufficient information concerning the investment of any public funds” available on the Internet and updated by the 15th of each month. Furthermore, the reports are to identify the amount of funds held by the Department on the last day of the month or the average daily balance of the preceding month, total monthly investment income, the asset allocation of the investments made by the agency and a complete listing of institutions approved to do business with the Department.

Department personnel stated that during the period, there was a vacancy in the position that performs these duties, resulting in the reports not posting timely.

This finding was first reported in the Department’s *State Compliance Examination* for the two years ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Failure to prepare, submit, or publish required reports to the Governor, General Assembly, and other officials in a timely manner is noncompliance with State law and could impact decisions made by the Governor, General Assembly, and other officials.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS is developing a centralized process to ensure mandated reports are filed timely. Additionally, IDHS will work with partner agencies to obtain information needed to ensure compliance with reporting requirements.

**UPDATED RESPONSE:**  
**Partially Implemented.**

**Corrective Action Plan:**

**OFVP**

The Office of Firearm Violence Prevention has worked closely with the Illinois General Assembly to amend the Reimagine Public Safety Act, ensuring that adequate time is provided for the accuracy and completeness of the data included in its annual report. Senate Bill 2280 revises the submission timeline, requiring the Office to issue a report to the General Assembly annually rather than by January 1 of each year. This report will identify communities within Illinois municipalities with more than one million residents, as well as those with populations between 35,000 and one million, that are experiencing concentrated firearm violence. It will also outline the investments being made to reduce violence in these areas and provide further recommendations to address the firearm violence epidemic in Illinois.

SB2280 successfully passed both chambers of the Illinois General Assembly on May 23, 2025, and was sent to the Governor on 6/20/2025. The Governor has 60 days to either sign or veto the bill. If no action is taken within this period, the bill will automatically become law.

**Estimated Date of Completion: 08/31/2025**

**FCS**

IDHS and DCFS are in process of drafting an updated IGA for the purpose of providing preventative services to youth in care and young adults who are aging out of or have recently aged out of the custody or guardianship of DCFS. IGA is in Legal review for both Departments. Once finalized, the IGA will circulate for signature.

**Estimated Date of Completion: 08/31/2025**

The updated IGA states DCFS will submit the required report to the General Assembly on January 1<sup>st</sup> of each year. IDHS will provide any necessary information to DCFS, if needed, for the completion of this report. This will be considered complete upon execution of the IGA.

**Estimated Date of Completion: 08/31/2025**

**OFS**

The Department currently sends hard copies of the required report to Business Services to distribute. The Department will reach out to the State Library to inquire about uploading them to the "Illinois Document List".

**Estimated Date of Completion: 10/01/2025**

Data to be provided under the Accountability for the Investment of Public Funds Act will be updated on the DHS website as soon as it has been received by all facilities. General Accounting will continue to follow up with facilities who have not provided the needed data by the 15<sup>th</sup> of each month.

**Date of Completion: 06/01/2025**

**27. The auditors recommend Department management enhance its processes and internal controls to ensure compliance with insurance and reporting requirements for individually assigned vehicles, accident reporting requirements, and vehicle maintenance and usage requirements.**

**FINDING:** *Lack of Compliance with Policies for Vehicles – This finding has been repeated since 2005.*

The Department of Human Services (Department) did not fully comply with the requirements applicable to its operation of automotive equipment.

***Reporting Requirements for Individually Assigned Vehicles***

During testing, the auditors noted the following:

- For 1 of 9 (11%) individuals tested who were personally assigned a vehicle, the Department was not able to provide documentation of proper insurance coverages.
- For 4 of 9 (44%) individuals tested who were personally assigned a vehicle, the Department was unable to provide documentation to support the assignment was communicated to the Department of Central Management Services (DCMS) within 30 days of assignment.
- 2 of 2 (100%) Individually Assigned Vehicle (IAV) Annual Reports tested were submitted 38 days late.

The Illinois Vehicle Code (625 ILCS 5/10-101(b)) requires every employee of the State, who operates for purposes of State business a vehicle, not owned, leased, or controlled by the State to procure insurance in the limits of the amounts liability not less than the amounts required in Section 7-23 of the Illinois Vehicle Code. The Department's procedure regarding certification is to have employees complete the Insurance Verification Card (Form IL444-4042).

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The Illinois Administrative Code (44 Ill. Admin. Code 5040.340) requires agencies to report to DCMS annually and when changes occur, including the name of each employee assigned a vehicle, the equipment number and license plate of the assigned vehicle, employee's headquarters and residence, and any additional information requested by DCMS.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001(3)) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. Management has the ultimate responsibility for the Department's internal control over reporting of information. This responsibility should include adequate systems of reviewing the completeness, accuracy, and maintenance of all Department records.

Department management stated the exceptions noted regarding Individually Assigned Vehicles were due to the need for additional time to make necessary changes and oversight of requirements.

Failure to obtain documentation of employee licensure and insurance is noncompliance with the Illinois Vehicle Code and potentially subjects the State to unnecessary liability costs. Failure to submit individually assigned vehicle assignments and annual reports in a timely manner represents noncompliance with the Administrative Code and limits DCMS' oversight of State vehicles.

### ***Reporting Requirements for Vehicle Accidents***

During testing, the auditors noted the following:

- For 2 of 9 (22%) accidents involving State owned vehicles used by Department employees, a Motorist's Report of Illinois Vehicle Accident Form (Form SR-1) was not submitted to DCMS.
- For 2 of 9 (22%) accidents involving State owned vehicles, the Department could not provide documentation to support the timely submission of the Form SR-1 to DCMS.

The Department's Administrative Directive 01.05.05.030, regarding reporting of motor vehicle accidents and insurance coverage, requires that as a condition of coverage, employees involved in a motor vehicle accident are required to have a legible written report of the accident in the DCMS Division of Risk Management no later than 7 calendar days following the accident.

The Illinois Administrative Code (44 Ill. Admin. Code 5040.520(i)) requires agencies to submit a Motorist's Report of Illinois Motor Vehicle Accident form (Form SR-1) to DCMS within 7 calendar days following an accident.

Department management stated delays occurred for various reasons including the need to obtain information from employees that were unavailable due to being on leave of absence or injuries resulting from the accident. Furthermore, for one “accident”, there was no known accident identified but rather damage identified upon inspection of the vehicle for regular maintenance.

Failure to report accidents to DCMS in a timely manner may impact the State’s ability to investigate and defend itself against resulting claims.

*Maintenance and Utilization of State Vehicles*

During testing of maintenance and utilization records for Department vehicles, the auditors noted the following:

- For 11 of 60 (18%) vehicles tested, the Department was unable to provide documentation to support the performance of required maintenance.
- For 38 of 60 (63%) vehicles tested, oil changes were not performed as required.
- For 18 of 60 (30%) vehicles tested, tire rotations were not performed as required.
- For 11 of 60 (18%) vehicles tested, there was no documentation to support an annual inspection was performed.
- For 6 of 60 (10%) vehicles tested, there was no documentation to support the performance of the 6-month safety inspection.
- For 21 of 60 (35%) vehicles tested, the auditors were unable to confirm the last service performed in fiscal year 2021. As a result, they were unable to conclude on compliance with vehicle maintenance during the period under examination.
- For 8 of 60 (13%) vehicles tested, breakeven mileage requirements were not met.
- For 3 of 60 (5%) vehicles tested, they identified variances between the odometer readings and support provided by the Department. As a result, they are unable to rely on the calculation for vehicle utilization.

This finding was first reported in the Department’s *State Compliance Examination* for the two years ended June 30, 2017. In the subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

DCMS issued a Memorandum to agency vehicle coordinators on September 24, 2018, which outlines maintenance, lube, oil and filter change interval policies for passenger vehicles. Per this Memorandum, the standard lube, oil and filter change interval requirement for passenger fleet vehicles 10 years and older is 3,000 miles or 12 months, whichever comes first. For passenger vehicles 9 years and newer, the policy is 5,000 miles or 12 months, whichever comes first. Tire rotation on all passenger vehicles is required every other oil change.

Further, the Illinois Administrative Code (44 Ill. Admin. Code 5040.410(a)) requires agencies to have vehicles inspected by DCMS or an authorized vendor at least once per year or as required by law and shall maintain vehicles in accordance with the schedules provided by DCMS or with other schedules acceptable to DCMS that provide for proper care and maintenance of special use vehicles.

DCMS Vehicle Usage Policy states vehicles that are used for transporting passengers are required to have both the annual and safety inspection. The 6-month safety test includes the testing and inspection of brakes, lights, horns, reflections, rear vision mirrors, mufflers, safety chains, windshield wipers, warning flags and flares, frame, axle, cab and body, or cab or body, wheels, steering apparatus, and other safety devices and appliances.

DCMS Vehicle Usage Policy states underutilized vehicles that are not able to be redeployed due to age, mileage, and/or condition will be turned-in to DCMS' Surplus Property to be disposed through a sale on Ibid, the State's online auction site, or offered to another agency at DCMS's discretion.

Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001(3)) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. Management has the ultimate responsibility for the Department's internal control over reporting of information. This responsibility should include adequate systems of reviewing the completeness, accuracy, and maintenance of all Department records.

Department management stated that the discrepancies noted occurred during and were a direct result of the COVID-19 pandemic. Travel was severely restricted, if not prohibited, and as a result vehicle were largely underutilized or not used at all. Employees were not at headquarters and were working remotely which resulted in maintenance requirements being missed as no one was available to schedule and/or take vehicles to maintenance facilities.

Failure to maintain and utilize vehicles in accordance with DCMS policy could result in the vehicle not being operable through its estimated useful life and could result in costly repairs.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The IDHS Office of Business Services will continue to work with Executive Leadership and Division Directors regarding the timely submission of vehicle maintenance reports and accident reports and implement process changes to ensure insurance verification certifications are provided timely and verified prior to approval of vehicle use.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**OBS**

AD 01.05.05.030 Reporting Motor Vehicle Accidents, breakdowns and Emergencies  
- revisions made and submitted to IDHS Legal for review.

**Estimated Date of Completion: 09/30/2025**

IDHS IAV Packet covers all requirements around vehicle maintenance reports, accident reports, and insurance verifications for staff who are assigned an IAV. OBS will draft a stand-alone AD for IAV use to further enhance the process.

**Estimated Date of Completion: 01/01/2026**

AD's 01.05.02.020 and 01.05.05.030/040/050/080 all cover the requirement for OHS employees to file Insurance Verification Forms annually if they are going to utilize any vehicle in the performance of their duties. AD 01.05.02.020 was revised and submitted for OHS Legal approval. In addition, AD's 01.05.05.030/and 050 were revised and submitted to OHS Legal for approval.

**Estimated Date of Completion: 09/30/2025**

**28. The auditors recommend the Department conduct a BIA to identify and prioritize critical IT systems and components.**

**FINDING:** *Weaknesses in Contingency Planning – This finding has been repeated since 2005.*

The Department of Human Services (Department) had not conducted a business impact analysis (BIA) during the examination period.

During the examination of the Department's security and control of confidential information, the auditors noted the Department had not conducted a BIA in conjunction with the Department of Innovation & Technology (DoIT) in 2023.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Control Objectives for Information and Related Technologies* published by *Information Systems Audit and Control Association* (ISACA), Managed I&T-Related Risk Area, promotes controls for analyzing risks and maintaining a risk profile of risks and their potential impact and responses.

The Department stated that due to DoIT temporarily overhauling their BIA template, a BIA was not performed during the examination period.

Failure to conduct BIA hinders the ability for the Department to identify and prioritize critical IT systems and components. Without performing BIA, the Department could have trouble

aligning business processes and systems, determining maximum tolerable downtime, and set objectives for recovery times.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will conduct a Business Impact Analysis (BIA) to identify and prioritize critical IT systems and components, with assistance from the Department of Innovation and Technology (DoIT).

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DHS Operations**

DoIT Bureau of Continuity Management has implemented BIAs for the Enterprise agencies including DHS. Instead of one overarching DHS BIA, the new ServiceNow system of record for contingency correlates a BIA with each DHS application/system contingency plan. Currently there are 51 BIA completed, with 25 left to be completed. DHS application/system business owners will work with DoIT to complete BIAs for the remaining 25 contingency plans.

**Estimated Date of Completion: 10/31/2025**

**29. The auditors recommend the Department:**

- **Enhance user access review procedures to ensure that application users' access rights align with their job responsibilities for RE2, EVV, and PTS applications;**
- **Implement a review process to ensure all EVV users are reviewed for appropriateness on an annual basis; and,**
- **Implement processes to ensure user access is removed timely for the EVV application.**

**FINDING:** *Access to Systems Not Controlled – This finding has been repeated since 2019*

The Department of Human Services (Department) did not adequately control access to certain systems.

During their testing of system access, the auditors noted the Department did not adequately monitor user access to the Recipient Reimbursements (RE2), Electronic Visit Visitation (EVV) and the Payroll and Timekeeping System (PTS). They noted:

- 5 of 25 (20%) users who were interviewed about their job duties appeared to have access across EVV and RE2 applications that did not align with their job duties.

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- The Department does not have an adequate review process in place to ensure all users with access to EVV are reviewed in a calendar year.
- The Department does not timely remove user access to EVV after the user's termination date. Auditors noted 35 of 495 (7%) EVV users were still assigned to districts after their termination date and at the time of testing, in which access had remained ranging up to approximately 4 years after their termination date.
- The Department did not properly follow procedures to deactivate terminated users' access within 5 business days for 2 of 25 (8%) samples the auditors tested for the PTS application as access was removed 2 weeks and 1 month later.
- For 5 of 60 (8%) active individuals tested, Form IL444-4056 was not completed in accordance with policy.
- For 5 of 60 (8%) active individuals tested, the Department was unable to provide Form IL444-4056.
- For 4 of 67 (6%) terminated individuals tested, access was not timely deactivated.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST), Account Management section promotes controls for ensuring access to system resources are appropriately authorized, monitored, and disabled.

Department policy requires that access must be removed at the end of the user's last day, or at a minimum, within 5 business days for transfers and other voluntary separations.

The Department's policy requires a completed and signed Form IL444-4056 for access to the system.

The Department stated the primary access termination occurs at the network level, and then at the RACF layer used to restrict access to mainframe-based application systems, preventing employees from accessing state resources. This led to incorrect reliance on network and RACF access removal rather than removing application specific access.

Failure to transparently review user access and timely deactivate terminated users' access could result in unauthorized access to the Department's systems and confidential data.

### **DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will enhance user access review procedures to ensure application users' access aligns with their job responsibilities for RE2, EVV, and PTS applications. IDHS will implement a

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formalized process for the annual review of EVV users to verify appropriateness and compliance with access control policies. The Department will also establish procedures to ensure user access is removed promptly following employee offboarding or role changes. IDHS will collaborate with Human Resources and stakeholders to strengthen access monitoring, ensuring that only authorized personnel retain system access. Furthermore, the Department will reinforce staff awareness and compliance efforts regarding secure system access management.

**UPDATED RESPONSE:**  
**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will implement a required monthly review of payroll and timekeeping access (PTS) at all SODCs that requires Facility Management review/approval. Instructions on the process have been drafted and will be provided to the facilities for implementation.

**Estimated Date of Completion: 08/30/2025**

All SODCs will provide training to applicable staff to ensure timely notification for employees who separate to ensure timely termination of their access.

**Estimated Date of Completion: 08/31/2025**

**Payroll**

- Implemented a system of checking against the active employee roster to ensure no PTS users have been left active after termination. (100% Complete)
- Modified to 4056 form to ensure that appropriate access for the specific duties is granted across the agency. (100% Complete)

**Date of Completion: 06/30/2025**

**DRS**

- 1) Monthly check of comings and goings on OneNet page and communicate with DHS personnel at same interval to ensure access to EVV system is limited to only those whose job duties require access.
- 2) Develop and implement process to ensure annual review of access for all users of EVV.

**Estimated Date of Completion: 12/31/2025**

**30. The auditors recommend the Department:**

- **Develop a risk management framework and perform a comprehensive risk assessment;**

- **Develop an Acceptable Use Policy;**
- **Review policies/procedures on a defined frequency;**
- **Require staff/contractors to acknowledge policies and procedures on an annual basis;**
- **Develop a formal cybersecurity plan; and,**
- **Develop a complete and accurate listing of service providers.**

**FINDING:** *Weaknesses in Cybersecurity Programs and Practices – This finding has been repeated since 2019.*

The Department of Human Services (Department) had not implemented adequate internal controls related to cybersecurity programs and practices.

The Department is responsible for the protection of sensitive information collected, including Social Security Numbers, personally identifiable information, protected health information, and financial information associated with fulfilling its overall mission. The Illinois State Auditing Act (30 ILCS 5/3-2.4) requires the Auditor General to review State agencies and their cybersecurity programs and practices. During the examination of the Department's cybersecurity program, practices, and control of confidential information, the auditors noted the Department had not:

- developed a risk management framework or performed a comprehensive risk assessment to identify confidential information susceptible to attacks or evaluate and implement risk-reducing controls.
- have an Acceptable Use Policy in place for the period.
- conducted regular reviews of policies including policies relied on from the Department of Innovation and Technology (DoIT) for the period.
- required staff to acknowledge policies and procedures on an annual basis.
- have a formal cybersecurity plan in place for the period.

Additionally, the Department did not provide a complete and accurate listing of service providers and thus, all relevant SOC reports may not have been reviewed as required. As such, the auditors were unable to conclude the Department's population records were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accounts (AT-C § 205.36).

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by National Institute of Standards and Technology (NIST), requires entities to consider risk management practices, threat environments, legal and regulatory requirements, mission objectives and constraints in order to ensure the security of their applications, data, and continued business mission.

The Department indicated management believed the reliance on DoIT's policies and procedures was appropriate and its risk assessment was comprehensive.

The lack of adequate cybersecurity programs and practices could result in unidentified risk and vulnerabilities, which could ultimately lead to the Department's volumes of personally identifiable information being susceptible to cyber-attacks and unauthorized disclosure.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with the Department of Innovation and Technology (DoIT) to develop a risk management framework and conduct a comprehensive risk assessment to identify and mitigate cybersecurity risks. IDHS will implement an Acceptable Use Policy and establish a process to review policies and procedures on a defined frequency. Additionally, IDHS will require staff and contractors to acknowledge policies and procedures annually to ensure compliance and awareness. IDHS will also develop a process to track and manage service providers.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DHS Operations**

Comprehensive Risk Assessment completed within ServiceNow for FY25. (100% Complete)

**Date of Completion: 06/30/2025**

Acceptable Use Policy 02.11.01.010 in process of being documented.

**Estimated Date of Completion: 11/30/2025**

Develop a program directive for Policy and Procedure review in accordance with regulations.

**Estimated Date of Completion: 12/31/2025**

Develop process for Staff and Contractors to acknowledge policies and procedures on annual basis.

**Estimated Date of Completion: 12/31/2025**

Update formal Cybersecurity Plan document.

**Estimated Date of Completion: 11/30/2025**

Gather data and create a listing of DHS Services Providers.

**Estimated Date of Completion: 11/30/2025**

**31. The auditors recommend the Department implement controls and follow policies regarding the protection of confidential/personal information.**

**FINDING: *Inadequate Controls over the Protection of Confidential Information – New***

The Department of Human Services (Department) had not followed all of their policies and procedures related to the protection of certain confidential information.

During the performance of facility visits, the auditors noted the following:

- One instance of improper protection of protected health information (PHI) (McFarland).
- One unlocked shred bin identified (Ludeman).
- One instance of improper disposal of sensitive employee information (Shapiro).

The Personal Information Protection Act (Act) (815 ILCS 530/30) requires the safe disposal of information. The Act requires any State agency that collects personal data that is no longer needed or stored at the agency shall dispose of the personal data or written material it has collected in such a manner as to ensure the security and confidentiality of the material.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

Department personnel stated that lack of employee and management oversight resulted in the issues noted.

The lack of adequate controls could result in unidentified risk and vulnerabilities and ultimately lead to the Department's volumes of personally identifiable information and protected health information being susceptible to unauthorized disclosure.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will retrain staff on the processes and policies regarding the protection of confidential information. Furthermore, additional oversight and monitoring procedures will be implemented to ensure compliance.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**DDD**

SODC Operations will ensure all SODCs retrain staff on processes and policies related to the protection of confidential information and the proper disposal of confidential information.

**Estimated Date of Completion: 09/30/2025**

All SODCs will implement routine monitoring of confidential information to ensure compliance.

**Estimated Date of Completion: 09/30/2025**

**DBHR - DMH**

- Staff will be retrained on the policies and procedures related to the protection of certain confidential information.
- Internal audits will be implemented at each facility to ensure that all documents that contain PHI are being properly disposed of.

**Estimated Date of Completion: 09/30/2025**

**32. The auditors recommend the Department establish and maintain controls over employee travel to ensure compliance with State statutes, the Illinois Administrative Code, and internal policies.**

**FINDING: *Inadequate Controls over Employee Travel – New***

The Illinois Department of Human Services (Department) did not have adequate controls over employee travel.

***Travel Voucher Testing***

During testing, the auditors noted the following:

- 5 of 60 (8%) travel vouchers tested, totaling \$7,501, contained travel outside the State of Illinois and were not approved by the Governor's Office of Management and Budget (GOMB) 30 days prior to travel.

The Illinois Administrative Code (Code) (80 Ill. Admin Code 2800.700) requires travel outside of Illinois to be submitted to GOMB for approval at least 30 days in advance of the departure date.

Department personnel stated the travel was not preapproved by GOMB due to error.

***Insurance Verification***

During testing, the auditors noted the following:

- 8 of 40 (20%) employees tested received reimbursement for mileage prior to having completed and certifying to proper insurance coverage. Forms were signed between 56 and 627 days after expense reimbursement.
- 3 of 40 (8%) employees tested received reimbursement for mileage without having certifications of proper insurance coverage on file with the Department.

The Illinois Vehicle Code (625 ILCS 5/10-101(b)) requires every employee of the State, who operates for purposes of State business a vehicle, not owned, leased, or controlled by the State to procure insurance in the limits of the amount's liability not less than the amounts required in Section 7-23 of the Illinois Vehicle Code. The Department's procedure regarding certification is to require employees to complete the Insurance Verification Card (Form IL444-4042).

Department personnel stated when the agency transitioned to the Enterprise Resource Planning (ERP) accounting system and the old system was decommissioned, functionality was not replicated within ERP to provide an "indicator" that flags when an employee had a current insurance verification on file. Since ERP does not have this indicator, there is no current automated process that prevents reimbursement when an employee does not have a current insurance verification on file.

***Travel Headquarters Report (Form TA-2)***

During the performance of testing, the auditors noted the following:

- 2 of 4 (50%) Form TA-2s filed excluded employees from several divisions. The Form TA-2 due July 15, 2022, excluded 6 divisions and the Form TA-2 due January 15, 2023, excluded 1 division.
- 3 of 4 (75%) Form TA-2s filed did not agree to supporting documentation. Variances were noted between 1 and 8 employees.

The State Finance Act (30 ILCS 105/12-3) requires the Department to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which their official duties require them to spend the largest part of their working time.

Department personnel stated the discrepancies identified were the result of manual processes subject to human error.

Failure to obtain proper approvals can result in travel which is disallowed. Failure to obtain documentation of employer licensure and insurance represents noncompliance with the Illinois Vehicle Code and potentially subjects the State to unnecessary liability costs.

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Failure to file accurate Form TA-2 reports with the LAC reduces governmental oversight and represents noncompliance with the State Finance Act.

**DEPARTMENT RESPONSE:**

The Illinois Department of Human Services (IDHS) accepts the recommendation. The IDHS Office of Business Services (OBS) will recommend process changes to ensure Insurance Verification Cards are submitted timely and verified prior to approval of vehicle use. OBS will continue work to improve oversight, notifications, and review of TA-2 filings to ensure timely and accurate submissions.

**UPDATED RESPONSE:**

**Partially Implemented.**

**Corrective Action Plan:**

**OFS**

The Expenditure Accounting division will conduct travel training sessions to ensure those areas in DHS that prepare their own travel vouchers are aware of the rules and requirements associated with travel vouchers.

**Estimated Date of Completion: 10/01/2025**

**OBS**

AD's 01.05.02.020 and 01.05.05.030/040/050/080 all cover the requirement for DHS employees to file Insurance Verification Forms annually if they are going to utilize any vehicle in the performance of their duties. AD 01.05.02.020 was revised and submitted for OHS Legal approval. In addition, AD's 01.05.05.030/and 050 were revised and submitted to OHS Legal for approval.

**Estimated Date of Completion: 9/30/2025 (85% Complete)**

In addition to the AD revisions submitted for approval, OBS is considering the following requirement: ALL OHS travelers who plan on driving a vehicle on behalf of the state during the completion of their duties MUST submit a copy of their current Insurance Verification Form with EVERY vehicle reservation request (motor pool, fleet, rental, or personal car). IAV users would only need to provide an updated form by August 15<sup>th</sup> of every year they are assigned an IAV.

**Estimated Date of Completion: 08/15/2025**

AD 01.05.02.010 fully outlines the requirements of all OHS Divisions to identify and submit TA-2 forms by June 30 and December 31 each year, for any staff who spend more than 51% of their working time at locations other than their official headquarters. OBS has implemented multiple notifications and checks starting 2 months prior to each due date, to ensure sufficient time and notifications are provided across the agency. In addition, Senior Leadership is notified of un-responsive

Divisions so top-down pressure can be brought to bear to compel timely responses. Since this finding was initially presented, these corrective actions have been implemented and to-date, we believe the problem has been successfully resolved.

**Date of Completion: 5/31/2024 (100%)**

### **Emergency Purchases**

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

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

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

- In the first quarter of FY22, there were 5:
  - Estimated Cost - \$350,000 in state funds for temporary staffing assistance for non-medical staff such as housekeeping, dietary, laundry, and data entry staff for the Department's 24/7 facilities in the Division of Developmental Disabilities and schools in the Division of Rehabilitative Services.
  - Estimated Cost - \$66,000 in state funds for services required for inter-office delivery services for mail, CTA transit cards, and Pace

- bus tickets in the Chicagoland area until a new competitive bid can be completed.
- Estimated Cost - \$750,000 in state funds for procuring services to clean various DHS office locations to prevent contagious infections meeting applicable standards and compliance requirement including but not limited to those by the CDC.
- Estimated Cost - \$1,500,000 in state funds for procuring services to clean various DHS office locations to prevent contagious infections meeting applicable standards and compliance requirement including but not limited to those by the CDC.
- Estimated Cost - \$148,500 in state funds for temporarily hire 3 stationary engineers to staff the powerhouse at Elgin Mental Health Center until replacements can be hired.
- In the second quarter of FY22, there were 7:
  - Estimated Cost - \$125,000 in state funds for replacement of all fire sprinkler piping, drains, drum drums, sprinkler heads, and any applicable firewalls located at Building 704 on Shapiro Center campus. Additionally, vendor will replace the existing air compressor and install a new unit that is in compliance with NFPA Life Safety Codes.
  - Estimated Cost - \$330,000 in state funds for emergency plumbing services at Chicago-Read MHC.
  - Estimated Cost - \$90,000 in state funds for repair of hot water line between two buildings at the Madden campus.
  - Estimated Cost \$80,000 in federal funds for a firm to work with blind vendors under the Business Enterprise Program for the Blind while a new RFP is issued.
  - Estimated Cost - \$20,000 in state funds for asbestos removal at the Chicago-Read MHC.
  - Estimated Cost - \$82,500 in state funds for hiring a firm to develop an implementation plan of the statewide 988 system, coordinate planning and program activities, and provide consultation to UIC project staff and Department leaders on work products in accordance with the agreement.
  - Estimated Cost - \$82,500 in state funds for hiring an individual to design and conduct research to inform the development and assessment of the 988 plan and provide the project leaders with reports based on that research.
- In the third quarter of FY22, there were 3:
  - Estimated Cost - \$400,140 in federal funds for providing 104 hotel rooms for refugees.
  - Estimated Cost - \$1,087,920 in federal funds for providing 104 hotel rooms for refugees.
  - Estimated Cost - \$170,000 in state funds for hiring a vendor to establish and build capacity for Local Advisory Councils in municipalities identified by the Reimagine Public Safety Act.

- In the fourth quarter of FY22, there were 2:
  - Actual Cost - \$134,930 in state funds for replacing boiler controls that are not working.
  - Estimated Cost - \$39,500 in state funds for repair and replacing 4 buffalo water boxes and associated lines.
- In the first quarter of FY23, there were 4:
  - Actual Cost - \$185,500 in state funds for hiring a vendor to implement system changes resulting from their analysis, policy change recommendations, and re-training at the Kiley Center to ensure certification.
  - Estimated Cost - \$94,100 in state and federal funds for providing nutritional cooked meals on site to ICRE-Roosevelt students with physical disabilities and ICRE-Wood adult customers who are blind, visually impaired, and deaf blind.
  - Estimated Cost - \$40,000 in state funds for sidewalk repairs on Springfield campus.
  - Estimated Cost - \$1,500,000 in state funds for fence installation resulting from a court order at McFarland.
- In the second quarter of FY23, there were 2:
  - Estimated Cost - \$1,020,000 in state funds for hiring a vendor to provide business services for the Early Intervention program.
  - Estimated Cost - \$135,000 in state funds for hiring a vendor to provide guard services for mental health facility residents at offsite locations.
- In the third quarter of FY23, there were 2:
  - Actual cost - \$160,483.44 in state funds for emergency remediation/renovation services at Kilbourne North End.
  - Estimated cost - \$257,254.83 in state and federal funds to continue leasing services with Xerox while a new master contract is approved and executed.
- In the fourth quarter, there were 3:
  - Estimated Cost - \$628,492.74 in state funds to provide management of multiple, concurrent activities relating to the IES Tech Refresh Project.
  - Estimated Cost - \$260,046.66 in state and federal funds to continue leasing services of Xerox multi-function machines statewide until the Joint Purchase Master Contract (JPMC) is executed.
  - Estimated Cost - \$111,360 in state funds for hiring a vendor to provide guard services for mental health facility residents at offsite locations.

### **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

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any location other than that at which official duties require them to spend the largest part of their working time.

As of June 15, 2023, the Department had 148 employees assigned to locations others than official headquarters.