SUMMARY REPORT DIGEST

DEPARTMENT OF VETERANS' AFFAIRS

COMPLIANCE ATTESTATION EXAMINATION

For the Two Years Ended: June 30, 2010

Release Date: September 22, 2011

Summary of Findings:

Total this audit: 25
Total last Central Office audit: 16
Repeated from prior audits: 16

SYNOPSIS

- The Department did not properly manage or maintain historical records of its waiting lists for its Illinois Veterans' Homes.
- The Department failed to fully implement a Post-Traumatic Stress Disorder Outpatient Counseling Program as required.
- The Department's Illinois Discharged Servicemember Task Force did not report on all elements as required.
- The Department did not exercise adequate control over its commodities inventory at the Illinois Veterans' Home at Manteno.
- The Department received and processed an excessive quantity of refunds.

{Expenditures and Activity Measures are summarized on the reverse page.}

DEPARTMENT OF VETERANS' AFFAIRS COMPLIANCE EXAMINATION

For the Two Years Ended June 30, 2010

EXPENDITURE STATISTICS	2010	2009	2008
Total Expenditures	\$ 94,154,801	\$ 96,800,800	\$ 90,302,016
OPERATIONS TOTAL	\$ 90,943,356 96.6%	\$ 92,807,814 95.9%	\$ 86,127,876 95.4%
Personal Services Other Payroll Costs (FICA, Retirement) All Other Operating Expenditures	59,615,574 8,606,505 22,721,277	55,969,098 15,972,122 20,866,594	52,542,641 12,657,276 20,927,959
AWARDS AND GRANTS	\$ 3,022,340 3.2%	\$ 3,759,387 3.8%	\$ 3,916,411 4.3%
REFUNDS % of Total Expenditures	\$ 64,589 0.1%	\$ 73,498 0.1%	\$ 79,636 0.1%
PERMANENT IMPROVEMENTS	\$ 124,516 0.1%	\$ 160,101 0.2%	\$ 178,093 0.2%
Total Receipts	\$ 38,320,660	\$ 33,804,719	\$ 32,449,857
Average Number of Employees	1,142	1,078	1,103

SELECTED ACTIVITY MEASURES (NOT			
EXAMINED)	2010	2009	2008
Field Services			
Number of permanent full-time offices	49	49	50
Number of part-time itinerant offices	64	59	41
<u>Grants</u>			
Number of claims processed	8,494	7,750	4,973

AGENCY DIRECTOR		
During Examination Period:	Ms. Tammy Duckworth (12/15/06 to 2/6/09)	
	Mr. Dan Grant (2/9/09 to 8/5/11)	
Currently:	Ms. Erica Borggren (8/8/11 to current)	

INTRODUCTION

This report presents our Department-wide compliance attestation examination for the two years ended June 30, 2010. At June 30, 2010 the Department operated four separate homes in Illinois (Anna, LaSalle, Manteno, and Quincy).

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

IMPROPER MANAGEMENT OF WAITING LISTS, ADMISSIONS, AND APPLICATIONS

Persons were not admitted in the proper order

The Department did not properly manage or maintain historical records of its waiting lists for its Illinois Veterans' Homes (Homes). In addition, the Department did not comply with all application and admission requirements of the Department of Veterans' Affairs Act (Act) with regard to its operations of the Homes. The Department operates 4 Homes throughout Illinois, located in Anna, LaSalle, Manteno, and Quincy. Some of the conditions we noted follow:

Persons were removed from the waiting list without explanation

Persons appearing on the Anna waiting list were not admitted in the proper order. In the most egregious instance noted during our testing, an applicant who was #9 on the Anna short-term skilled nursing care waiting list as of July 8, 2008 was bypassed by 19 persons who were listed below him on that same waiting list – or who did not appear on that waiting list at all – before finally being admitted on October 6, 2009.

Peace time veteran was admitted ahead of combat veterans

- Persons were removed from the Anna waiting list without notes or other contemporaneous documentation as to why. We noted 37 persons appearing on the Anna short-term skilled care nursing waiting list as of July 8, 2008 were not subsequently admitted to the Home, nor did their names appear on waiting lists subsequent to July 8, 2008.
- One of 9 (11%) tested veterans admitted to Anna during the examination period did not meet admission requirements. The individual served in the military during a time of peace, and therefore should not have been admitted to Anna ahead of

combat veterans. At the time this individual was admitted, there were several combat veterans on Anna's short-term skilled nursing care waiting list. The Act states an individual who served during a time of conflict as set forth in the Act has preference over all other qualifying candidates for purposes of eligibility for nursing home care at any Illinois Veterans Home.

Department agreed with auditors

We recommended the Department and Homes ensure each waiting list is promptly and properly maintained and that contemporaneous documentation is prepared each time a change occurs within each waiting list. We also recommended the Homes ensure historical waiting lists are maintained to document and justify the order of admissions that occurred at each Home. Lastly, we recommended the Homes implement procedures to ensure all admission and eligibility requirements are met and documented in the application file before granting admission into the Home. (Finding 1, pages 15-17)

Peer-support network for families of deployed service members not established

Department officials agreed with our recommendation and stated they will review admissions practices and identify solutions to ensure waiting lists are properly managed, appropriate supporting documentation is maintained, and all admissions and eligibility requirements are adhered to.

FAILURE TO IMPLEMENT POST-TRAUMATIC STRESS DISORDER OUTPATIENT COUNSELING PROGRAM

Department agreed with auditors

The Department failed to fully implement a Post-Traumatic Stress Disorder Outpatient Counseling Program as required by the Department of Veterans' Affairs Act (Act).

The Act requires the Department to provide informational and counseling services for the purpose of establishing and fostering peer-support networks throughout the State for families of deployed members of the reserves and the Illinois National Guard. However, the Department has not yet begun providing these services as required.

We recommended the Department establish a peersupport network for families of deployed service members as required by the Act, or seek a legislative remedy to the statutory requirement. (Finding 6, page 24)

Report neglected effects of posttraumatic stress disorder and disabilities Department officials agreed with our recommendation and stated they will continue to work with an approved vendor to pursue a peer-support network for families of deployed service members. Department officials noted they underestimated the cost of the program and did not request adequate appropriations to fully implement the program. Department officials also indicated they may consider pursuing a legislative remedy.

INADEQUATE REPORTING BY ILLINOIS DISCHARGED SERVICEMEMBER TASK FORCE

Department agreed with auditors

The Department's Illinois Discharged Servicemember Task Force (Task Force) did not report on all elements as required by the Department of Veterans' Affairs Act (Act).

The Act required the Department to establish the Task Force to investigate the effects of post-traumatic stress disorder, homelessness, disabilities, and other issues found by the Task Force to be relevant to service members who are returning to civilian life from active theater.

Excessive inventory balances noted

We noted the Task Force's report issued July 1, 2009, did not include information regarding the effects of post-traumatic stress disorder and disabilities on discharged service members, as required by the Act.

Inadequate segregation of duties

We recommended the Task Force ensure its reports are complete and include all required elements before submission to the required parties. (Finding 8, page 27)

Department officials agreed with our recommendation and stated they will ensure future reports include all required elements.

Items located on premises, yet not accounted for in inventory records

INADEQUATE CONTROL OVER COMMODITIES INVENTORY

The Department did not exercise adequate control over its commodities inventory at the Illinois Veterans' Home at Manteno. Some of the conditions we noted follow:

• Inventory balances for 7 of 25 (28%) inventory items tested exceeded a 12-month supply as of

June 30, 2010. The total cost of these overstocks noted in our testing was \$6,064.

- During the examination period, the Home did not maintain an adequate segregation of duties. We noted one employee had the authority to dispose of expired inventory and adjust inventory records without obtaining additional approval.
- During testing, we noted numerous items present in the inventory storage area that were not included in the Home's inventory records and remained unaccounted for in storage crates. The items were residual inventory of continuous orders placed by personnel other than the storekeeper and were never used or entered into inventory.

We recommended the Department and Home devote adequate resources to ensure that commodity records are accurate. In addition, we recommended the Home review their internal controls over inventory and implement additional safeguards as necessary to properly secure commodity items and the inventory storage area in general. Lastly, we recommended the Home perform an evaluation of all inventory items held to ensure inventory records are complete and to eliminate any items that are overstocked. (Finding 10, pages 33-34)

Processed refunds for overpayments on vendor invoices and overpayments of wages to employees

Department agreed with auditors

Department official agreed with our recommendation and stated they will evaluate measures to ensure the accuracy of commodities records, promote proper storage and security, properly segregate duties, and reduce overstock.

EXCESSIVE QUANTITY OF REFUNDS PROCESSED

The Department received and processed an excessive quantity of refunds.

Department agreed with auditors

During Fiscal Years 2009 and 2010, the Department received and processed 124 refunds, totaling \$317,273. We tested 25 of the 124 refunds, totaling \$191,050. While 2 of the refunds tested, totaling \$124,500, were due to the return of unused grant funds to the Department, which was out of the Department's control, we noted exceptions in other refunds tested as follows:

- 13 of 25 (52%) refunds tested, totaling \$27,209, were due to overpayments made on vendor invoices.
- 10 of 25 (40%) refunds tested, totaling \$39,342, were due to overpayment of wages to employees.

We recommended the Department strengthen its controls over expenditures by carefully reviewing each invoice before it is paid. Additionally, we recommended the Department carefully review payroll transactions prior to processing for payment. (Finding 13, pages 39-40)

Department officials accepted our recommendation and reported they will increase efforts to keep the quantity of refunds at an acceptable level.

OTHER FINDINGS

The remaining findings are reportedly being given attention by the Department. We will follow up on our findings during our next examination of the Department.

ACCOUNTANT'S REPORT

The auditors qualified their report on State Compliance for findings 10-1 and 10-19. Except for the noncompliance described in these findings, the auditors stated the Department complied, in all material respects, with the requirements described in the report.

WILLIAM G. HÖLLAND Auditor General

WGH:cmd:pkp

AUDITORS ASSIGNED

This engagement was performed by staff of the Office of the Auditor General.