State of Illinois
Office of the Auditor General

Summary Report on

Follow-up to Performance Audit Recommendations

July 16, 2025

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Auditor General

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our summary report of follow-up to performance audit recommendations.

This report is a compilation of the results of follow-up conducted by my Office on past performance audit recommendations. The follow-up for specific audits is also presented within the Illinois Office of the Auditor General compliance examinations for each applicable agency. Preparing this compilation report allows members of the General Assembly to track the progress made by agencies in implementing recommendations over time.

The audit report is transmitted in conformance with Section 3-15 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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July 2025

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OFFICE OF THE AUDITOR GENERAL

July 16, 2025
Performance Audit
Report Highlights

Frank J. Mautino *Auditor General*
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Summary Report

Follow-up to Performance Audit Recommendations

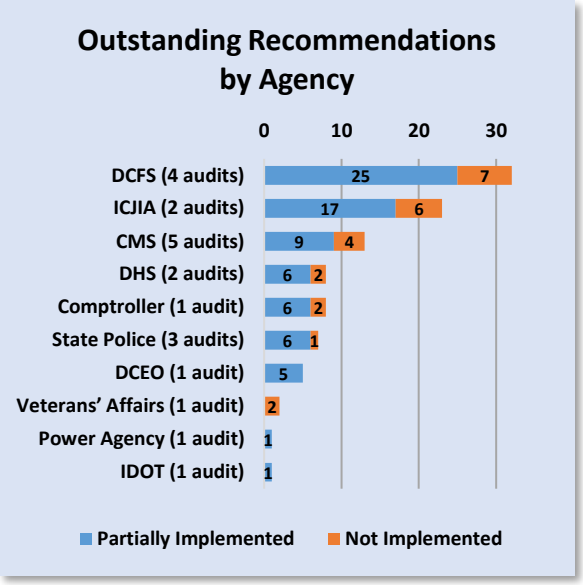
Background:

The State Auditing Act empowers the Auditor General to conduct performance audits when directed by a resolution of the Legislative Audit Commission, House of Representatives, or Senate. A Public Act may also be enacted directing an audit. The Performance Audit Division of the Office of the Auditor General conducts the performance audits, making recommendations to improve program performance and operations. After the performance audits are released, the Office conducts follow-up audit work to determine whether the recommendations have been implemented. This report presents a compilation of the results of the follow-up work.

Key Findings:

- Following our audit follow-up work through June 30, 2023, there are 20 previously released performance audits with outstanding audit recommendations that have not yet been fully implemented. In many instances, follow-up on these audit recommendations has been conducted multiple times. For these 20 audits, there are 100 recommendations that have not yet been fully implemented; 24 recommendations are classified as not implemented while 76 are classified as partially implemented.

- There are five agencies that have multiple audits with outstanding recommendations. The Department of Children and Family Services (DCFS) has the most outstanding recommendations: 32 recommendations not yet fully implemented from 4 different audits. The Illinois Criminal Justice Information Authority (ICJIA) has the second most outstanding recommendations: 23 recommendations not yet fully implemented from 2 different audits.



- The management and program audit of the Illinois State Police's Division of Forensic Services is the oldest audit with recommendations not yet fully implemented. The audit was released in March 2009 and contained 16 recommendations. Of the 16 recommendations, 2 were not yet fully implemented as of June 30, 2022, which was the 7th time that follow-up was conducted.

- There were seven audits where follow-up work was conducted for the first time, either as of June 30, 2022, or June 30, 2023:
  - The performance audit of the Department of Commerce and Economic Opportunity's (DCEO's) Economic Development for a Growing Economy (EDGE) tax credit program was released in June 2020 and contained six recommendations. Of the six recommendations, five were not yet fully implemented as of June 30, 2022.
  - The performance audit of the Department of Children and Family Services' compliance with its obligations to protect and affirm children and youth who are lesbian, gay, bisexual, transgender, questioning, or queer (LGBTQ) was released in February 2021 and contained 16 recommendations. Of the 16 recommendations, 12 were not yet fully implemented as of June 30, 2022.

- The performance audit of the Illinois renewable portfolio standard and the Illinois Power Agency's management of the Renewable Energy Credit procurement process and Adjustable Block Program was released in May 2021 and contained one recommendation. The recommendation was not yet fully implemented as of June 30, 2022.
- The performance audit of the Vendor Payment Program was released in June 2021 and contained 11 recommendations directed to both the Department of Central Management Services (CMS) and the Illinois Office of the Comptroller (IOC). Of the nine recommendations directed to CMS, seven were not yet fully implemented as of June 30, 2023. Of the eight recommendations directed to the IOC, none were fully implemented as of June 30, 2022.
- The performance audit of the Illinois Prescription Monitoring Program was released in September 2021 and contained 11 recommendations directed to both the Department of Human Services (DHS) and the Illinois Department of Public Health (IDPH). Of the 11 recommendations directed to DHS, 7 were not yet fully implemented as of June 30, 2023. The single recommendation directed to IDPH was not repeated because the requirement was removed from statute.
- The management audit of the Illinois State Police's administration of the Firearm Owners Identification Card Act (430 ILCS 65) and the Firearm Concealed Carry Act (430 ILCS 66) was released in September 2021 and contained six recommendations. Of the six recommendations, four were not yet fully implemented as of June 30, 2022.
- The performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home was released in May 2022 and contained three recommendations directed to both the Illinois Department of Public Health and the Illinois Department of Veterans' Affairs (IDVA). The single recommendation directed to IDPH was implemented. For the two recommendations directed to IDVA, the initial follow up has not been conducted; it will be conducted as part of the FY24 IDVA compliance examination.

Why we did this report:

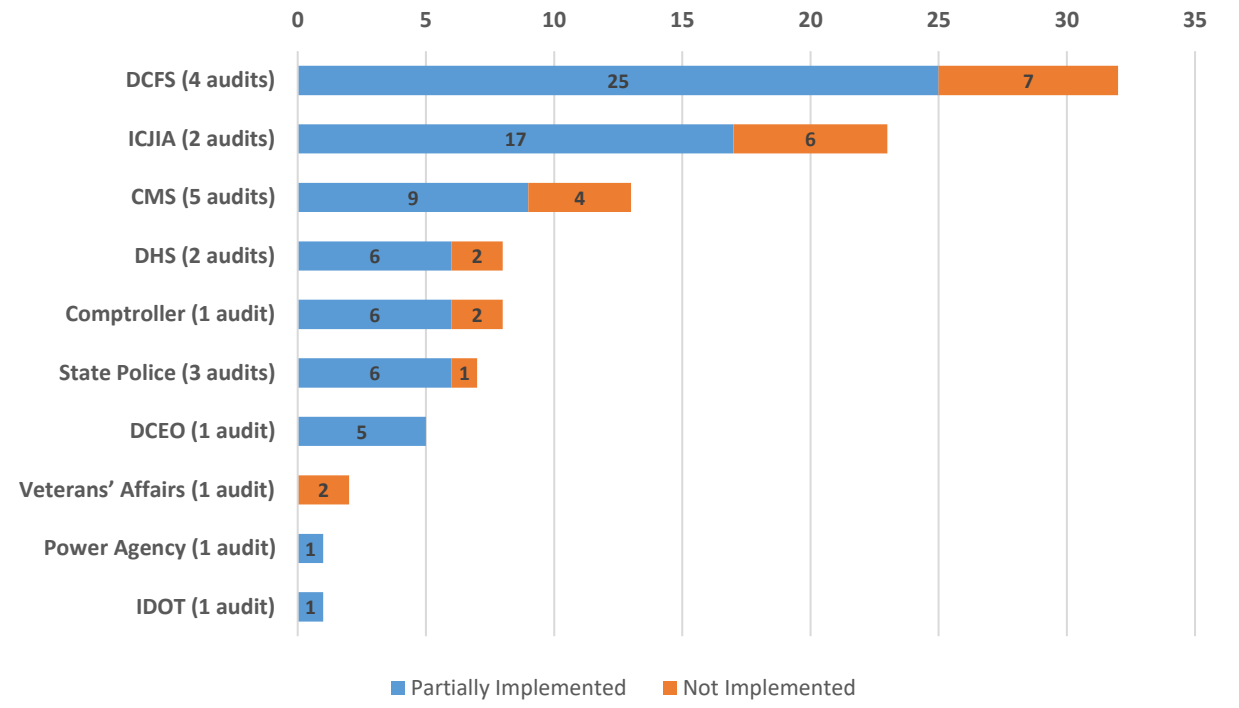
- Performance audits conducted by the Office of the Auditor General contain recommendations designed to improve operations of State government. For our Office's work to have the most benefit, agencies need to implement the recommendations. The more recommendations that are implemented, the more benefit will be derived from the audit work. Failure to implement recommendations can result in a number of negative consequences, including loss of funding, operational inefficiencies, potential legal actions, and, in the case of DCFS, putting children at risk.
- After performance audits are released, the Office conducts follow-up audit work to determine whether recommendations have been implemented. The results of the follow-up work are presented as part of the Illinois Office of the Auditor General compliance examinations for each applicable agency. Compliance examinations are conducted in even numbered years for some agencies and odd numbered years for other agencies. Therefore, the most recent follow-up work for this report was conducted as of June 30, 2022, or June 30, 2023. This report presents a compilation of the results of the follow-up work.
- This is the first compilation report issued by our Office of the follow-up audit work, which was previously conducted either by staff from our Office or our Special Assistant Auditors. The report shows the progress agencies have made in implementing performance audit recommendations and allows members of the General Assembly to track that progress over time.

Report Digest

The State Auditing Act empowers the Auditor General to conduct performance audits when directed by a resolution of the Legislative Audit Commission, House of Representatives, or Senate. A Public Act may also be enacted directing an audit. The Performance Audit Division of the Office of the Auditor General conducts the performance audits, making recommendations to improve program performance and operations. After the performance audits are released, the Office conducts follow-up audit work to determine whether the recommendations have been implemented. The results of the follow-up are presented as part of the Illinois Office of the Auditor General compliance examinations for each applicable agency. This report presents a compilation of the results of that follow-up work.

There are 20 previously released performance audits with outstanding audit recommendations where we have conducted follow-up work. In many instances, follow-up has been conducted multiple times. As shown in **Digest Exhibit 1** below, for those 20 audits, there are 100 recommendations that have not yet been fully implemented; 24 recommendations are classified as not implemented while 76 are classified as partially implemented. There are five agencies that have multiple audits with outstanding recommendations.

Digest Exhibit 1
OUTSTANDING RECOMMENDATIONS BY AGENCY



Note: Some audits direct recommendations to multiple agencies.

Source: Summary of OAG follow-up.

Digest Exhibit 2 shows the current status of past performance audit recommendations as of June 30, 2023. The management and program audit of the Illinois State Police's Division of Forensic Services is the oldest audit with recommendations not yet fully implemented. The audit was released in March 2009 and contained 16 recommendations. Of the 16 recommendations, 2 were not yet fully implemented as of June 30, 2022, which was the 7th time that follow-up was conducted.

Summary of Audit Follow-up

The following sections briefly summarize the follow-up for each of the 20 audits. The body of the report discusses the follow-up on the audit recommendations for each performance audit in more detail.

ISP's Division of Forensic Services (March 2009)

House Resolution Number 451 (from the 95th General Assembly) directed the Auditor General to conduct a management and program audit of the Illinois State Police's Division of Forensic Services. The audit was released in March 2009 and contained 16 recommendations. Of the 16 recommendations, **2 are not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the two partially implemented recommendations reported in the June 30, 2020 report. This was the 7th time that follow-up had been conducted. (pages 5-7)

State Police's Administration of the FOID Act (April 2012)

House Resolution Number 89 (from the 97th General Assembly) directed the Auditor General to conduct a management audit of the Department of State Police's administration of the Firearm Owner's Identification Card (FOID) Act. The audit was released in April 2012 and contained 12 recommendations. Of the 12 recommendations, **1 is not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the one partially implemented recommendation reported in the June 30, 2020 report. This was the 6th time that follow-up had been conducted. (page 8-9)

Workers' Compensation Program (April 2012)

House Resolution Number 131 (from the 97th General Assembly) directed the Auditor General to conduct a management audit of the workers' compensation program as it applies to State employees. The audit was released in April 2012 and contained 12 recommendations directed to the Department of Central Management Services. Of the 12 recommendations, **1 is not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the two partially implemented recommendations reported in the June 30, 2021 report. This was the 6th time that follow-up had been conducted. (pages 10-12)

Digest Exhibit 2
OUTSTANDING PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022 and June 30, 2023[1]

Year Released	Audit Name	Agency	Recommendations	
			Total	Outstanding
2009	ISP's Division of Forensic Services	State Police	16	2
2012	State Police's Administration of the FOID Act	State Police	12	1
	Workers' Compensation Program	CMS	12	1
	IDOT's Life-Cycle Cost Analysis	IDOT	6	1
2013	CMS' Space Utilization Program	CMS	9	2
2014	State Moneys Provided to the Illinois Violence Prevention Authority for the Neighborhood Recovery Initiative	Illinois Criminal Justice Information Authority	19	9
	DCFS Missing Children	DCFS	9	8
2016	State Moneys Provided to the Illinois Criminal Justice Information Authority for Violence Prevention	Illinois Criminal Justice Information Authority	28	14
	DCFS Placement of Children	DCFS	4	4
2019	Morneau Shepell Contract	CMS	9	2
	DCFS Investigations of Abuse and Neglect	DCFS	13	8
	CMS Multiple Choice Exams	CMS	4	1
2020	ISC Selection Process	DHS	13	1
	EDGE Tax Credit Program	DCEO	6	5
2021	DCFS LGBTQ Youth in Care	DCFS	16	12
	Illinois Power Agency – Future Energy Jobs Act	Power Agency	1	1
	Vendor Payment Program	CMS	9	7
		Comptroller	8	8
	Prescription Monitoring Program	DHS	11	7
		Public Health	1	0
	FOID Card and Concealed Carry License Programs	State Police	6	4
2022	LaSalle Veterans' Home	Veterans' Affairs	2	2[2]
		Public Health	1	0

[1] The results of the follow-up are presented as part of the Illinois Office of the Auditor General compliance examinations for each applicable agency. Compliance examinations are conducted in even numbered years for some agencies and odd numbered years for other agencies. Therefore, the most recent follow-up was conducted as of June 30, 2022, or June 30, 2023.

[2] The initial follow-up for Veterans' Affairs has not been conducted; it will be conducted as part of the June 30, 2024 compliance examination.

Source: Summary of OAG follow-up.

IDOT's Life-Cycle Cost Analysis (May 2012)

Legislative Audit Commission Resolution Number 140 directed the Auditor General to conduct a management audit of the Illinois Department of Transportation's (IDOT's) implementation of life-cycle cost analysis for road

construction contracts. The audit was released in May 2012 and contained six recommendations. Of the six recommendations, **one is not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the one partially implemented recommendation reported in the June 30, 2020 report. This was the 5th time that follow-up had been conducted. (pages 13-14)

CMS' Space Utilization Program (October 2013)

House Resolution Number 788 (from the 98th General Assembly) directed the Auditor General to conduct a management audit of the Department of Central Management Services' (CMS') administration of the State's space utilization program. The audit was released in October 2013 and contained nine recommendations. Of the nine recommendations, two **are not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the two partially implemented recommendations reported in the June 30, 2021 report. This was the 5th time that follow-up had been conducted. (pages 15-17)

State Moneys Provided to the Illinois Violence Prevention Authority for the Neighborhood Recovery Initiative (February 2014)

House Resolution Number 1110 (from the 97th General Assembly) directed the Auditor General to conduct a performance audit of the State moneys provided by or through the Illinois Violence Prevention Authority to the Neighborhood Recovery Initiative. The audit was released in February 2014 and contained 19 recommendations. Of the 19 recommendations, **9 are not yet fully implemented**.

As part of the compliance examination of the Illinois Criminal Justice Information Authority for the period ending June 30, 2023, auditors followed up on the status of the nine recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 4th time that follow-up had been conducted. (pages 18-22)

DCFS Missing Children (December 2014)

House Resolution Number 120 (from the 98th General Assembly) directed the Auditor General to conduct a management audit of the Department of Children and Family Services' (DCFS') search for missing children. The audit was released in December 2014 and contained nine recommendations. Of the nine recommendations, eight **are not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the eight recommendations not yet fully implemented as reported in the June 30, 2020 report. This was the 4th time that follow-up had been conducted. (pages 23-28)

State Moneys Provided to the Illinois Criminal Justice Information Authority for Violence Prevention (April 2016)

House Resolution Number 888 (from the 98th General Assembly) directed the Auditor General to conduct a performance audit of the State moneys provided by or through the Illinois Criminal Justice Information Authority (ICJIA) to all community based violence prevention programs, the After-School Program, and the Chicago Area Project. The audit was released in April 2016 and contained 28 recommendations of which **14 are not yet fully implemented**.

As part of the compliance examination of ICJIA for the period ending June 30, 2023, auditors followed up on the status of the 16 recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 4th time that follow-up had been conducted. (pages 29-36)

DCFS Placement of Children (September 2016)

Senate Resolution Number 140 (from the 99th General Assembly) directed the Auditor General to conduct a performance audit of the Department of Children and Family Services' compliance with its obligations to place children in its care in placements consistent with their best interests. The audit was released in September 2016 and contained four recommendations. **None of the four recommendations are fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the four recommendations not yet fully implemented as reported in the June 30, 2020 report. This was the 3rd time that follow-up had been conducted. (pages 37-39)

Morneau Shepell Contract (March 2019)

House Resolution Number 522 (from the 100th General Assembly) directed the Auditor General to conduct a performance audit of the procurement and administration of the contract with Morneau Shepell. The audit was released in March 2019 and contained 9 recommendations. Of the 9 recommendations, **2 are not yet fully implemented**.

As part of the compliance examination of the Department of Central Management Services for the period ending June 30, 2023, auditors followed up on the status of the two recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 2nd time that follow-up had been conducted. (pages 40-41)

DCFS Investigations of Abuse and Neglect (May 2019)

House Resolution Number 418 (from the 100th General Assembly) directed the Auditor General to conduct a performance audit of the Department of Children and Family Services to review and assess the Department's protocols for investigating reports of child abuse and neglect. The audit was released in May 2019 and contained 13 recommendations. Of the 13 recommendations, **8 are not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the 10 recommendations not yet fully implemented as reported in the June 30, 2020 report. This was the 2nd time that follow-up had been conducted. (pages 42-49)

CMS Multiple Choice Exams (December 2019)

House Resolution Number 816 (from the 100th General Assembly) directed the Auditor General to conduct a performance audit of the Department of Central Management Services to review and assess the Department's automated multiple choice exams for specific position titles listed in the audit resolution. The audit was released in December 2019 and contained four recommendations. Of the four recommendations, **one is not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the four recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 2nd time that follow-up had been conducted. (pages 50-53)

ISC Selection Process (April 2020)

House Resolution Number 214 (from the 101st General Assembly) directed the Auditor General to conduct a management audit of the Department of Human Services' (DHS') process for selecting Independent Service Coordination (ISC) agencies for the Fiscal Year commencing July 1, 2019. The audit was released in April 2020 and contained 13 recommendations. Of the 13 recommendations, **1 is not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the 10 recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 2nd time that follow-up had been conducted. (pages 54-58)

EDGE Tax Credit Program (June 2020)

House Resolution Number 381 (from the 101st General Assembly) directed the Auditor General to conduct a performance audit of the Department of Commerce and Economic Opportunity's (DCEO's) Economic Development for a Growing Economy (EDGE) tax credit program. The audit was released in June 2020 and contained six recommendations. Of the six recommendations, **five are not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the six recommendations. This was the 1st time that follow-up had been conducted. (pages 59-65)

DCFS LGBTQ Youth in Care (February 2021)

Senate Resolution Number 403 (from the 101st General Assembly) directed the Auditor General to conduct a performance audit of the Department of Children and Family Services' compliance with its obligations to protect and affirm children and youth who are lesbian, gay, bisexual, transgender, questioning, or queer (LGBTQ). The audit was released in February 2021 and contained 16

recommendations. Of the 16 recommendations, **12 are not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the 16 recommendations. This was the 1st time that follow-up had been conducted. (pages 66-82)

Illinois Power Agency – Future Energy Jobs Act (May 2021)

Legislative Audit Commission Resolution Number 153 directed the Auditor General to conduct a performance audit of the Illinois renewable portfolio standard and the Illinois Power Agency's management of the Renewable Energy Credit procurement process and Adjustable Block Program. The audit was released in May 2021 and contained one recommendation. **The recommendation is not yet fully implemented**.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the recommendation. This was the 1st time that follow-up had been conducted. (pages 83-85)

Vendor Payment Program (June 2021)

Public Act 100-1089 directed the Auditor General to conduct a performance audit of the Vendor Payment Program. The audit was released in June 2021 and contained 11 recommendations directed to both the Department of Central Management Services and the Illinois Office of the Comptroller (IOC). Of the nine recommendations directed to CMS, **seven are not yet fully implemented**. Of the eight recommendations directed to the IOC, **none are fully implemented**.

As part of the compliance examination of the IOC for the period ending June 30, 2022, auditors followed up on the status of the eight recommendations directed to the IOC. As part of the compliance examination of CMS for the period ending June 30, 2023, auditors followed up on the status of the nine recommendations directed to CMS. This was the 1st time that follow-up had been conducted. (pages 86-97)

Prescription Monitoring Program (September 2021)

Legislative Audit Commission Resolution Number 154 directed the Auditor General to conduct a performance audit of the Illinois Prescription Monitoring Program. The audit was released in September 2021 and contained 11 recommendations directed to both the Department of Human Services and the Illinois Department of Public Health (IDPH). Of the 11 recommendations directed to DHS, **7 are not yet fully implemented**. The single recommendation directed to IDPH was not repeated because the requirement was removed from statute.

As part of the compliance examination of DHS for the period ending June 30, 2023, auditors followed up on the status of the 11 recommendations directed to DHS. As part of the compliance examination of IDPH for the period ending June 30, 2023, auditors followed up on the status of the single recommendation

directed to IDPH. This was the 1st time that follow-up had been conducted. (pages 98-109)

FOID Card and Concealed Carry License Programs (September 2021)

Legislative Audit Commission Resolution Number 155 directed the Auditor General to conduct a management audit of the Illinois State Police's administration of the Firearm Owners Identification Card Act (430 ILCS 65) and the Firearm Concealed Carry Act (430 ILCS 66). The audit was released in September 2021 and contained six recommendations. Of the six recommendations, **four are not yet fully implemented**.

As part of the compliance examination of the Illinois State Police for the period ending June 30, 2022, auditors followed up on the status of the six recommendations. This was the 1st time that follow-up had been conducted. (pages 110-114)

LaSalle Veterans' Home (May 2022)

House Resolution Number 62 (from the 102nd General Assembly) directed the Auditor General to conduct a performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home. The audit was released in May 2022 and contained three recommendations directed to both the Illinois Department of Public Health and the Illinois Department of Veterans' Affairs (IDVA). The single recommendation directed to IDPH was implemented. For the two recommendations directed to IDVA, the initial follow-up has not been conducted; it will be conducted as part of the FY24 IDVA compliance examination.

As part of the compliance examination of IDPH for the period ending June 30, 2023, auditors followed up on the status of the single recommendation directed to IDPH. This was the 1st time that follow-up had been conducted. (pages 115-118)

Conclusion

This is the first compilation follow-up report issued by our Office. The report shows the progress agencies have made in implementing performance audit recommendations and allows members of the General Assembly to track that progress over time.

This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

This report was compiled by the staff of the Office of the Auditor General.

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

This report is transmitted in accordance with Section 3-15 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:DJB

Contents

Introduction

The State Auditing Act empowers the Auditor General to conduct performance audits when directed by a resolution of the Legislative Audit Commission, House of Representatives, or Senate. A Public Act may also be enacted directing an audit. The Performance Audit Division of the Office of the Auditor General conducts the performance audits, making recommendations to improve program performance and operations. After the performance audits are released, the Office conducts follow-up audit work to determine whether the recommendations have been implemented.

The results of the follow-up work are presented as part of the Illinois Office of the Auditor General compliance examinations for each applicable agency. Compliance examinations are conducted in even numbered years for some agencies and odd numbered years for other agencies. Therefore, the most recent follow-up work was conducted as of June 30, 2022, or June 30, 2023. This report presents a compilation of the results of that follow-up work.

This is the first **compilation report** issued by our Office of the follow-up audit work, which was previously conducted either by staff from our Office or our Special Assistant Auditors. This report does not constitute new follow-up work; it simply compiles work previously issued by our Office into one report. The report shows the progress agencies have made in implementing performance audit recommendations and allows members of the General Assembly to track that progress over time.

Exhibit 1 shows the current status of past performance audit recommendations as of June 30, 2023. There are 20 previously released performance audits listed

where we have conducted follow-up on audit recommendations and those recommendations are not yet fully implemented. In many instances, follow-up has been conducted multiple times. For those 20 audits, there are 100 recommendations that have not yet been fully implemented.

Exhibit 1
OUTSTANDING PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022 and June 30, 2023[1]

Year Released	Audit Name	Agency	Recommendations	
			Total	Outstanding
2009	ISP's Division of Forensic Services	State Police	16	2
2012	State Police's Administration of the FOID Act	State Police	12	1
	Workers' Compensation Program	CMS	12	1
	IDOT's Life-Cycle Cost Analysis	IDOT	6	1
2013	CMS' Space Utilization Program	CMS	9	2
2014	State Moneys Provided to the Illinois Violence Prevention Authority for the Neighborhood Recovery Initiative	Illinois Criminal Justice Information Authority	19	9
	DCFS Missing Children	DCFS	9	8
2016	State Moneys Provided to the Illinois Criminal Justice Information Authority for Violence Prevention	Illinois Criminal Justice Information Authority	28	14
	DCFS Placement of Children	DCFS	4	4
2019	Morneau Shepell Contract	CMS	9	2
	DCFS Investigations of Abuse and Neglect	DCFS	13	8
	CMS Multiple Choice Exams	CMS	4	1
2020	ISC Selection Process	DHS	13	1
	EDGE Tax Credit Program	DCEO	6	5
2021	DCFS LGBTQ Youth in Care	DCFS	16	12
	Illinois Power Agency – Future Energy Jobs Act	Power Agency	1	1
	Vendor Payment Program	CMS	9	7
		Comptroller	8	8
	Prescription Monitoring Program	DHS	11	7
		Public Health	1	0
	FOID Card and Concealed Carry License Programs	State Police	6	4
2022	LaSalle Veterans' Home	Veterans' Affairs	2	2[2]
		Public Health	1	0

[1] The results of the follow-up are presented as part of the Illinois Office of the Auditor General compliance examinations for each applicable agency. Compliance examinations are conducted in even numbered years for some agencies and odd numbered years for other agencies. Therefore, the most recent follow-up was conducted as of June 30, 2022, or June 30, 2023.

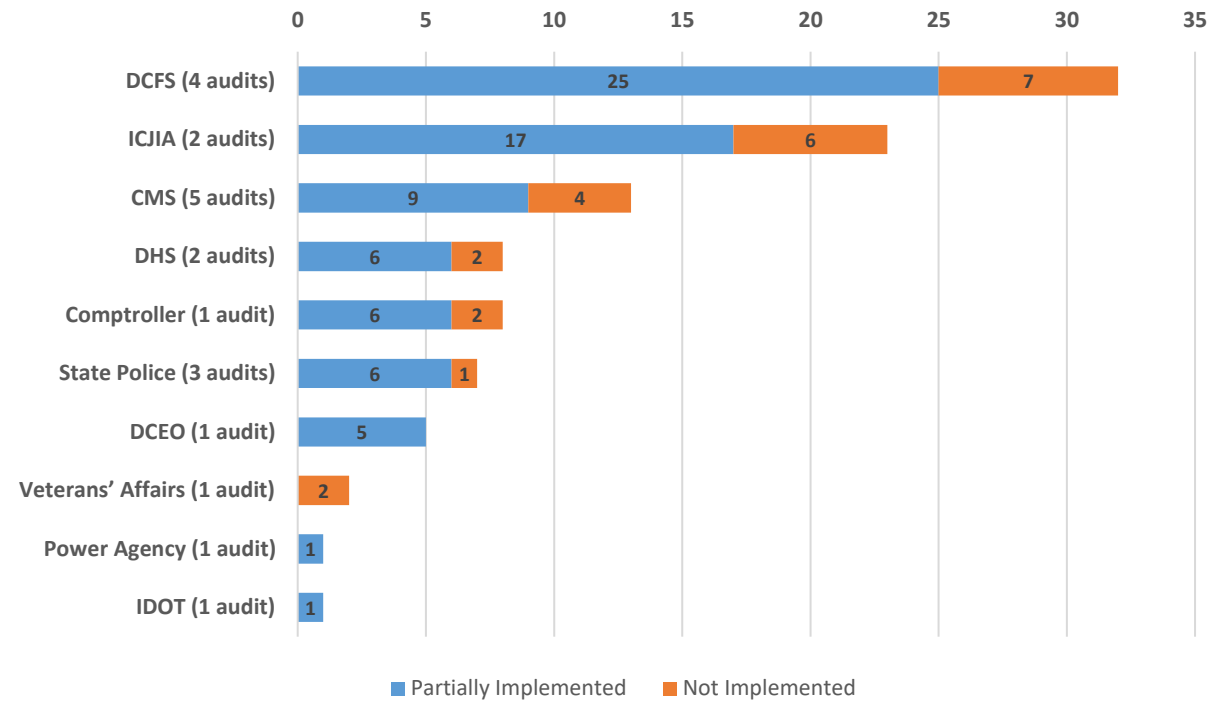
[2] The initial follow-up for Veterans' Affairs has not been conducted; it will be conducted as part of the June 30, 2024 compliance examination.

Source: Summary of OAG follow-up.

Exhibit 2 shows the number of outstanding recommendations by agency. Of the 100 outstanding recommendations, 24 are classified as not implemented while 76 are classified as partially implemented.

There are five agencies that have multiple audits with outstanding recommendations. The Department of Children and Family Services (DCFS) has the most outstanding recommendations: 32 recommendations not yet fully implemented from 4 different audits. The Illinois Criminal Justice Information Authority (ICJIA) has the second most outstanding recommendations: 23 recommendations not yet fully implemented from 2 different audits.

Exhibit 2
OUTSTANDING RECOMMENDATIONS BY AGENCY



Note: Some audits direct recommendations to multiple agencies.

Source: Summary of OAG follow-up.

The following sections discuss the follow-up on the audit recommendations for each performance audit in more detail. Each of the sections contain an exhibit showing the status of the audit recommendations. The sections also contain the results of the most recent follow-up that was conducted, which can also be found in the agency's compliance examination. **Exhibit 3** graphically explains the content of the follow-up sections.

Exhibit 3
EXPLANATION OF FOLLOW-UP SECTIONS

For each prior performance audit, the follow-up sections contain the same information. Each section contains an exhibit showing the status of the audit recommendations. The sections also contain the results of the most recent follow-up that was conducted, which can also be found in the agency's compliance examination. The graphic below explains the content of the follow-up sections.

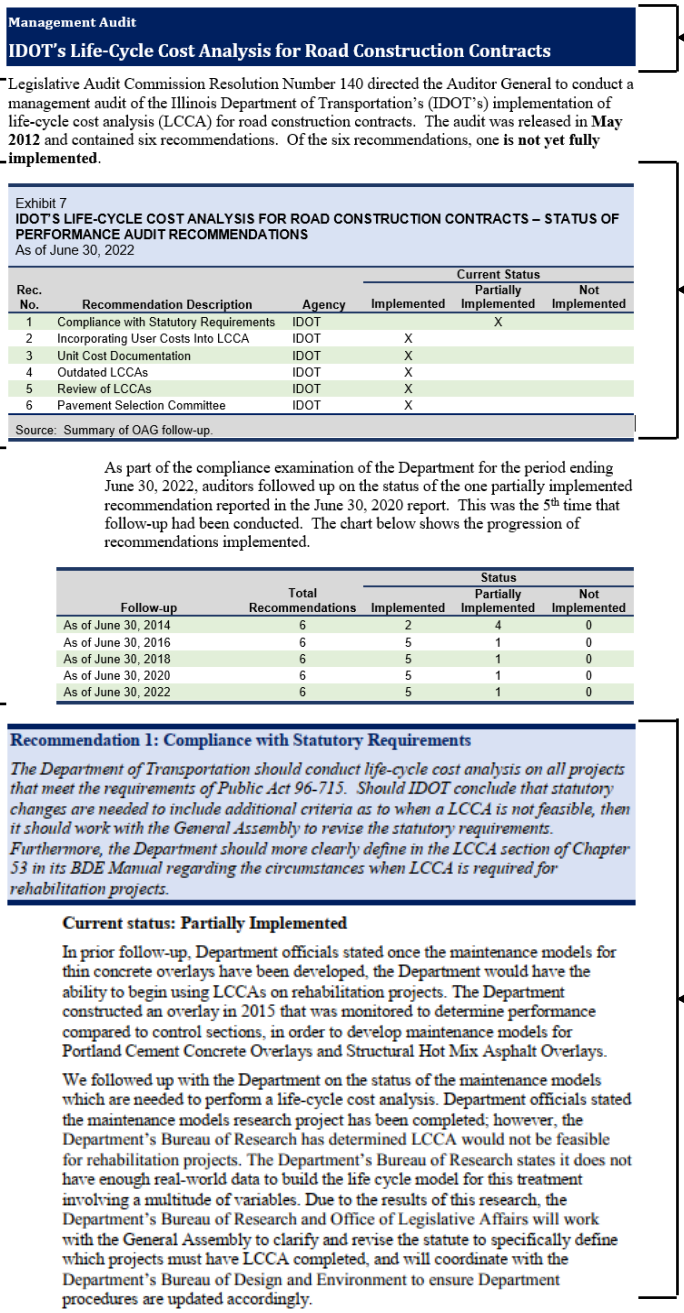
Summary including audit authority and original release date

Audit title

Exhibit showing all recommendations and current implementation status

Date of most recent compliance examination and progression of recommendations implemented

Sections for each recommendation showing the original recommendation, current status, and summary of the follow-up (this also appears in the most recent compliance examination)



Management Audit

IDOT's Life-Cycle Cost Analysis for Road Construction Contracts

Legislative Audit Commission Resolution Number 140 directed the Auditor General to conduct a management audit of the Illinois Department of Transportation's (IDOT's) implementation of life-cycle cost analysis (LCCA) for road construction contracts. The audit was released in **May 2012** and contained six recommendations. Of the six recommendations, one **is not yet fully implemented**.

Exhibit 7
IDOT'S LIFE-CYCLE COST ANALYSIS FOR ROAD CONSTRUCTION CONTRACTS – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status: Implemented	Current Status: Partially Implemented	Current Status: Not Implemented
1	Compliance with Statutory Requirements	IDOT		X	
2	Incorporating User Costs Into LCCA	IDOT	X		
3	Unit Cost Documentation	IDOT	X		
4	Outdated LCCAs	IDOT	X		
5	Review of LCCAs	IDOT	X		
6	Pavement Selection Committee	IDOT	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the one partially implemented recommendation reported in the June 30, 2020 report. This was the 5th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status: Implemented	Status: Partially Implemented	Status: Not Implemented
As of June 30, 2014	6	2	4	0
As of June 30, 2016	6	5	1	0
As of June 30, 2018	6	5	1	0
As of June 30, 2020	6	5	1	0
As of June 30, 2022	6	5	1	0

Recommendation 1: Compliance with Statutory Requirements

The Department of Transportation should conduct life-cycle cost analysis on all projects that meet the requirements of Public Act 96-715. Should IDOT conclude that statutory changes are needed to include additional criteria as to when a LCCA is not feasible, then it should work with the General Assembly to revise the statutory requirements. Furthermore, the Department should more clearly define in the LCCA section of Chapter 53 in its BDE Manual regarding the circumstances when LCCA is required for rehabilitation projects.

Current status: Partially Implemented

In prior follow-up, Department officials stated once the maintenance models for thin concrete overlays have been developed, the Department would have the ability to begin using LCCAs on rehabilitation projects. The Department constructed an overlay in 2015 that was monitored to determine performance compared to control sections, in order to develop maintenance models for Portland Cement Concrete Overlays and Structural Hot Mix Asphalt Overlays.

We followed up with the Department on the status of the maintenance models which are needed to perform a life-cycle cost analysis. Department officials stated the maintenance models research project has been completed; however, the Department's Bureau of Research has determined LCCA would not be feasible for rehabilitation projects. The Department's Bureau of Research states it does not have enough real-world data to build the life cycle model for this treatment involving a multitude of variables. Due to the results of this research, the Department's Bureau of Research and Office of Legislative Affairs will work with the General Assembly to clarify and revise the statute to specifically define which projects must have LCCA completed, and will coordinate with the Department's Bureau of Design and Environment to ensure Department procedures are updated accordingly.

Source: Summary of OAG follow-up.

Management and Program Audit

Illinois State Police's Division of Forensic Services

House Resolution Number 451 (from the 95th General Assembly) directed the Auditor General to conduct a management and program audit of the Illinois State Police's Division of Forensic Services. The audit was released in **March 2009** and contained 16 recommendations. Of the 16 recommendations, **2 are not yet fully implemented**.

Exhibit 4
ILLINOIS STATE POLICE'S DIVISION OF FORENSIC SERVICES – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Lab Conditions	State Police		X	
2	Fee Funding	State Police	X		
3	Lapsed and Transferred Funding	State Police		X	
4	Grant Funding	State Police	X		
5	Lack of Formal Staffing Studies	State Police	X		
6	DNA Backlog Reporting	State Police	X		
7	Backlog Reduction/Elimination Plan	State Police	X		
8	Lab Site Visits	State Police	X		
9	Notifying External Agencies with Results of Reviews	State Police	X		
10	Quality Assurance Questionnaire and Regional Advisory Board Meetings	State Police	X		
11	Notifying Investigative Entities of Coverdell Requirements	State Police	X		
12	Independent Investigations	State Police	X		
13	Drug Investigations	State Police	X		
14	Case Selection for Outsourcing	State Police	X		
15	Outsourced Cases	State Police	X		
16	Outsourcing Procurement Activity	State Police	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the two partially implemented recommendations reported in the June 30, 2020 report. This was the 7th time that follow-up had been conducted. The following chart shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2010	16	9	7	0
As of June 30, 2012	16	11	5	0
As of June 30, 2014	16	12	4	0
As of June 30, 2016	16	14	2	0
As of June 30, 2018	16	14	2	0
As of June 30, 2020	16	14	2	0
As of June 30, 2022	16	14	2	0

Recommendation 1: Lab Conditions

The Illinois State Police should develop a comprehensive plan to address the environmental issues at its forensic labs.

Current status: Partially Implemented

The Department's Division of Forensic Services continues to actively address all identified environmental issues at its forensic laboratories. This is accomplished either through planning via General Revenue budget requests or through remediation as urgent environmental issues are identified. The Division of Forensic Services personnel work closely with the Division of Justice Services, which is tasked with oversight of the Department's facilities. As noted previously, the Division of Forensic Services continues to plan for and address facility projects in accordance with established mechanisms within the State government system such as annual budget requests and capital development requests. Issues are prioritized to ensure immediate attention is given to facility issues, which may impact the safety and security of employees, equipment, and evidence. In Fiscal Year 2019, the Joliet Laboratory received funding from the Capital Development Board to conduct facility renovations to address urgent health and safety issues. Renovation of the existing facility commenced in August of 2022 with a projected completion date of Spring/Summer of 2023. Additionally, in Fiscal Year 2021, the Division of Forensic Services received funding from the Capital Development Board for the planning and construction of a new forensic laboratory to replace the existing aging, outdated Joliet Forensic Science Laboratory.

Recommendation 3: Lapsed and Transferred Funding

The Illinois State Police should ensure that resources provided by the General Assembly are fully utilized for the mission of the Division of Forensic Services, including the reduction of case backlogs, rather than allowing this funding to transfer or lapse. Additionally, the Illinois State Police should take the steps necessary to determine the funding level needed to operate its lab system.

Current status: Partially Implemented

During the current examination period, the Division of Forensic Services has continued to make modifications and improvements to the Laboratory Information System (LIMS) to facilitate the reduction of forensic case backlogs

through effective management and tracking of forensic case submissions. As of the end of Fiscal Years 2022 and 2021, the total forensic assignments on the backlog was 7,887 and 9,997, respectively. For Fiscal Year 2022, the Division of Forensic Services was appropriated a total of $48,847,400 and expended a total of $30,621,027.

Management Audit

Department of State Police's Administration of the Firearm Owner's Identification Act

House Resolution Number 89 (from the 97th General Assembly) directed the Auditor General to conduct a management audit of the Department of State Police's administration of the Firearm Owner's Identification Card Act. The audit was released in **April 2012** and contained 12 recommendations. Of the 12 recommendations, **1 is not yet fully implemented**.

Exhibit 5
STATE POLICE'S ADMINISTRATION OF THE FIREARM OWNER'S IDENTIFICATION ACT – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Guidance Over the FOID Card Program	State Police	X		
2	Reporting by Circuit Court Clerks	State Police	X		
3	Reporting by Hospitals, Nursing Homes, and Mental Health Facilities	State Police DHS	X		
4	Information Reported to NICS by the State Police	State Police DHS	X		
5	Parent/Guardian Information	State Police	X		
6	Customer Service	State Police		X	
7	Out-of-State Applicants	State Police	X		
8	Management Controls Over Eligibility Process	State Police	X		
9	Procurement Documentation	State Police	X		
10	Timeliness of FOID Card Approval and Denial	State Police	X		
11	Reporting by the State Police	State Police	X		
12	Overtime Costs Incurred by the State Police	State Police	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the one partially implemented recommendation reported in the June 30, 2020 report. This was the 6th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2012	12	2	6	4
As of June 30, 2014	12	6	3	3
As of June 30, 2016	12	10	2	0
As of June 30, 2018	12	11	1	0
As of June 30, 2020	12	11	1	0
As of June 30, 2022	12	11	1	0

Recommendation 6: Customer Service

The Department of State Police should work with its vendor to ensure that FOID cards are forwarded to the correct mailing address; and ensure that it has enough Customer Service Representatives to answer the questions of FOID card applicants.

Current status: Partially Implemented

In the prior examination, it was noted that due to multiple changes to the FOID Act since the original audit, the first portion of the recommendation is no longer applicable and was not followed up on during the current examination.

During the current examination period, a VoIP Call Center Solution had been developed and implemented. Customer service capabilities of the Department were expanded by the establishment of satellite offices in four district headquarters that are staffed with two full-time employees.

Management Audit

Workers' Compensation Program

House Resolution Number 131 (from the 97th General Assembly) directed the Auditor General to conduct a management audit of the workers' compensation program as it applies to State employees. The audit was released in **April 2012** and contained 12 recommendations directed to the Department of Central Management Services. Of the 12 recommendations, **1 is not yet fully implemented**.

Exhibit 6
WORKERS' COMPENSATION PROGRAM – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Workers' Compensation Data	CMS	X		
2	State Workers' Compensation Program Advisory Board	CMS	X		
3	Claims Reporting	CMS	X		
4	Claims Adjudication	CMS	X		
5	Determination for Subrogation Eligibility	CMS	X		
6	Periodic Data Matches	CMS	X		
7	CMS Adjuster Caseloads	CMS		X	
11	Contract Approval Limits	CMS	X		
12	Negotiating Settlement Contracts	CMS	X		
13	Medical Support for Settlement Injuries	CMS	X		
15	Communication	CMS	X		
20	CMS Conflict of Interest Policies	CMS	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the two partially implemented recommendations reported in the June 30, 2021 report. This was the 6th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2013	12	0	6	6
As of June 30, 2015	12	5	6	1
As of June 30, 2017	12	7	5	0
As of June 30, 2019	12	8	4	0
As of June 30, 2021	12	10	2	0
As of June 30, 2023	12	11	1	0

Recommendation 5: Determination for Subrogation Eligibility

The Department of Central Management Services should ensure that cases in which subrogation can be pursued are reviewed in a timely manner.

Current status: Implemented

In February 2023, a contract with a new Workers Compensation Third Party Administrator, Gallagher Bassett Services, Inc. went into effect. The contract between the Department and Gallagher Bassett Services, Inc. requires that the Workers Compensation Third Party Administrator issues a report each month to identify new cases with potential subrogation opportunities. Gallagher Bassett Services, Inc. provides claim summary reporting, which includes but is not limited to, open cases, new cases, closed cases, and problematic cases that have been open for more than one year with expenses in excess of $5,000 on a quarterly basis. Gallagher Bassett will also provide the Department with a complete electronic subrogation file within six months of the Statute of Limitations expiration date, which is two years.

We obtained two of the five (40%) monthly subrogation reports sent to the Department by Gallagher Bassett Services, Inc. The monthly reports identified all new subrogation opportunities. Gallagher Bassett Services, Inc. has procedures in place to identify when a new subrogation opportunity arises within the timeframe of the month. Additionally, we obtained the larger quarterly subrogation report provided to the Department. The report contained a listing of the cases where funds were recoverable, and the total amount recovered.

We inquired how the Department ensured that subrogation cases are reviewed in a timely manner. Once a viable subrogation opportunity is identified the subrogation flag must be activated and a subrogation note is entered into the claim file. Gallagher Bassett Services, Inc. will then gather all the materials necessary for subrogation pursuits and send lien notices to the responsible third parties.

Based on our review of the subrogation reports it appears that cases in which subrogation can be pursued were reviewed in a timely manner.

Recommendation 7: CMS Adjuster Caseloads

The Department of Central Management Services should track Adjuster caseloads and consider establishing caseload standards for Adjusters.

Current status: Partially Implemented

In February 2023, a contract with a new Workers Compensation Third Party Administrator, Gallagher Bassett Services, Inc. went into effect. According to the Gallagher Bassett Services, Inc. contract, they will maintain an average workload of approximately 150 active indemnity claims per adjuster and 250 open active medical only claims.

Gallagher Bassett Services, Inc. provides a weekly report with the weekly caseloads. The Department reviews these monthly to determine if action needs to be taken to address issues. To test compliance with the established caseload

standards we reviewed the monthly reports for Fiscal Year 2023 for the months March, May, and June. During March we noted 19 of 27 (70%) indemnity adjusters who had open claims exceeding the 150 open active indemnity claims limit. The average of these exceptions ranged from 158 to 406 active indemnity caseloads. During May we noted 20 of 30 (67%) indemnity adjusters who had open claims exceeding the 150 open active indemnity claims limit established in the contract with Gallagher Bassett. The average of these exceptions ranged from 160 to 332 active indemnity caseloads. During June we noted 20 of 30 (67%) indemnity adjusters who had open claims exceeding the 150 open active indemnity claims limit established in the contract with Gallagher Bassett. The average of these exceptions ranged from 155 to 329 active indemnity caseloads.

No resolution manager had a caseload exceeding 250 open active medical only claims at any of the valuation dates.

Management Audit

IDOT's Life-Cycle Cost Analysis for Road Construction Contracts

Legislative Audit Commission Resolution Number 140 directed the Auditor General to conduct a management audit of the Illinois Department of Transportation's (IDOT's) implementation of life-cycle cost analysis (LCCA) for road construction contracts. The audit was released in **May 2012** and contained six recommendations. Of the six recommendations, one **is not yet fully implemented**.

Exhibit 7
IDOT'S LIFE-CYCLE COST ANALYSIS FOR ROAD CONSTRUCTION CONTRACTS – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Compliance with Statutory Requirements	IDOT		X	
2	Incorporating User Costs Into LCCA	IDOT	X		
3	Unit Cost Documentation	IDOT	X		
4	Outdated LCCAs	IDOT	X		
5	Review of LCCAs	IDOT	X		
6	Pavement Selection Committee	IDOT	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the one partially implemented recommendation reported in the June 30, 2020 report. This was the 5th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2014	6	2	4	0
As of June 30, 2016	6	5	1	0
As of June 30, 2018	6	5	1	0
As of June 30, 2020	6	5	1	0
As of June 30, 2022	6	5	1	0

Recommendation 1: Compliance with Statutory Requirements

The Department of Transportation should conduct life-cycle cost analysis on all projects that meet the requirements of Public Act 96-715. Should IDOT conclude that statutory changes are needed to include additional criteria as to when a LCCA is not feasible, then it should work with the General Assembly to revise the statutory requirements. Furthermore, the Department should more clearly define in the LCCA section of Chapter 53 in its BDE Manual regarding the circumstances when LCCA is required for rehabilitation projects.

Current status: Partially Implemented

In prior follow-up, Department officials stated once the maintenance models for thin concrete overlays have been developed, the Department would have the ability to begin using LCCAs on rehabilitation projects. The Department constructed an overlay in 2015 that was monitored to determine performance compared to control sections, in order to develop maintenance models for Portland Cement Concrete Overlays and Structural Hot Mix Asphalt Overlays.

We followed up with the Department on the status of the maintenance models, which are needed to perform a life-cycle cost analysis. Department officials stated the maintenance models research project has been completed; however, the Department's Bureau of Research has determined LCCA would not be feasible for rehabilitation projects. The Department's Bureau of Research states it does not have enough real-world data to build the life cycle model for this treatment involving a multitude of variables. Due to the results of this research, the Department's Bureau of Research and Office of Legislative Affairs will work with the General Assembly to clarify and revise the statute to specifically define which projects must have LCCA completed, and will coordinate with the Department's Bureau of Design and Environment to ensure Department procedures are updated accordingly.

Management Audit

Department of Central Management Services' Administration of the State's Space Utilization Program

House Resolution Number 788 (from the 98th General Assembly) directed the Auditor General to conduct a management audit of the Department of Central Management Services' (CMS') administration of the State's space utilization program. The audit was released in **October 2013** and contained nine recommendations. Of the nine recommendations, two **are not yet fully implemented**.

Exhibit 8
CMS' ADMINISTRATION OF THE STATE'S SPACE UTILIZATION PROGRAM – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Master Record	CMS	X		
2	Annual Real Property Utilization Reports	CMS	X		
3	Exemptions from Filing Annual Real Property Utilization Reports	CMS	X		
4	Agency Reporting Excess and Surplus Real Property	CMS	X		
5	Automation of the Master Record	CMS	X		
6	Lease Documentation	CMS	X		
7	Monitoring of Space in State-Owned Facilities	CMS	X		
8	Disposal of Surplus Property	CMS		X	
9	Executive Order 10-10	CMS		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the two partially implemented recommendations reported in the June 30, 2021 report. This was the 5th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2015	9	5	4	0
As of June 30, 2017	9	7	2	0
As of June 30, 2019	9	7	2	0
As of June 30, 2021	9	7	2	0
As of June 30, 2023	9	7	2	0

Recommendation 8: Disposal of Surplus Property

The Department of Central Management Services should: take steps to ensure that it is more timely in completing the process of disposing of surplus property; follow the procedures outlined in State statute and administrative rules when disposing of surplus property including timely notification of State agencies; maintain proper documentation of the disposal process; develop strategies to dispose of surplus properties that have been in surplus for years; examine properties noted as surplus on the Annual Real Property Utilization Reports to determine if they should be disposed; and conduct a study of the disposal process to determine what changes need to be made to the process to increase efficiencies. If necessary, CMS should seek legislative changes to improve and streamline the process.

Current status: Partially Implemented

The Department filed legislation with the General Assembly to streamline the disposal of surplus property process. These proposed changes in legislation passed both Houses as of May 30, 2021, and became effective August 16, 2021, in Public Act 102-0280.

Memos were sent out on October 31, 2022, and October 31, 2021, notifying all State agencies of the declared surplus real property. Any State agency desiring to take ownership of these properties were requested to submit a written request to the Department, within 30 days, to have control of the surplus real property transferred to that agency.

In November 2022, approximately 196.55 acres of real property known as Stateville Correctional Center in the city of Crest Hill was removed from surplus and returned to the control of the Illinois Department of Corrections.

In December 2022, approximately 23.4 acres of real property in the City of Chicago, commonly known as the Damen Silos property was conveyed by the Department.

The Department is reviewing information from the Annual Real Property Utilization Reports to determine if there are additional surplus properties awaiting its action. The Department provided surplus property offerings letters as a list of properties that were identified as surplus and that should be disposed of.

On October 19, 2018, the Department entered into a contract with a vendor to provide the Department with the technical expertise to evaluate, identify, secure and dispose of surplus real property. The Department was unable to provide any studies of the disposal process performed since the contract went into effect. The Department intended to exercise its renewal option on this contract.

The Department was unable to provide any studies of the disposal process to increase efficiency.

Recommendation 9: Executive Order 10-10

The Department of Central Management Services should take steps to implement the directives contained in Executive Order 10-10 related to the sale of surplus property.

Current status: Partially Implemented

Executive Order 10-10 states the Governor's Office of Management and Budget (GOMB) and the Department shall review all vacant or unused real estate owned by the State. Following that review, GOMB and the Department shall develop and implement a comprehensive real estate strategy that identifies opportunities to use or repurpose vacant properties more efficiently and designates State properties to be sold at fair market value.

During the previous engagement the Department entered into a contract with a vendor on October 19, 2018, to assist with the development of a real estate strategy. As part of this contract the vendor will perform a redevelopment analysis, which entails analyzing whether a specific piece of surplus property is a candidate for redevelopment. Redevelopment may be aimed at increasing the return at sale, redevelopment as part of a public-private partnership, or for reuse by a State agency or other governmental entity. The vendor will also review, validate, and recommend the prioritization of the disposition of the properties, determining which have the greatest opportunity to maximize revenue to the State in the shortest period of time with no or minimal disruption to State services. The vendor did not perform this analysis during Fiscal Years 2020 or 2021. Once these analyses are completed the Department will work with GOMB to develop a comprehensive real estate strategy.

During the current engagement the Department was unable to provide any redevelopment analysis, which entails analyzing whether a specific piece of surplus property is a candidate for redevelopment. The Department was unable to provide any studies that reviewed, validated, or recommended the prioritization of the disposition of properties which had the greatest opportunity to maximize revenue to the State in the shortest period with no or minimal disruption to State services. Finally, the Department also stated that a comprehensive real estate strategy developed in coordination with GOMB is not available.

Performance Audit

State Moneys Provided to the Illinois Violence Prevention Authority for the Neighborhood Recovery Initiative

House Resolution Number 1110 (from the 97th General Assembly) directed the Auditor General to conduct a performance audit of the State moneys provided by or through the Illinois Violence Prevention Authority to the Neighborhood Recovery Initiative. The audit was released in **February 2014** and contained 19 recommendations. Of the 19 recommendations, **9 are not yet fully implemented**.

Exhibit 9
STATE MONEYS PROVIDED TO THE ILLINOIS VIOLENCE PREVENTION AUTHORITY FOR THE NEIGHBORHOOD RECOVERY INITIATIVE – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Implementation Schedule for the Neighborhood Recovery Initiative	ICJIA	X		
2	Budget Process for the Neighborhood Recovery Initiative	ICJIA	X		
3	Selection of Neighborhood Recovery Initiative Agencies	ICJIA	X		
4	Neighborhood Recovery Initiative Agency Proposal Evaluations	ICJIA	X		
5	Neighborhood Recovery Initiative Agency Payment Method	ICJIA		X	
6	Evaluation Contract with the University of Illinois	ICJIA			X
7	Monitoring of Lead Agency Personnel	ICJIA		X	
8	Participation Rates – Mentoring Plus Jobs and Parent Leadership Components	ICJIA		X	
9	Timesheets	ICJIA		X	
10	Staff Work Under Multiple Grants	ICJIA		X	
11	Support for Community Selection	ICJIA	X		
12	Approval for Neighborhood Recovery Initiative Contracts	ICJIA		X	
13	Timely Submission of Quarterly Reports	ICJIA		X	
14	Reentry Services Participants	ICJIA	X		
15	Background Checks	ICJIA	X		
16	Budget Reallocation Approvals	ICJIA	X		
17	Capital Equipment	ICJIA	X		
18	Expense Monitoring	ICJIA		X	
19	Recovery of Unspent Grant Funds	ICJIA	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Illinois Criminal Justice Information Authority (ICJIA) for the period ending June 30, 2023, auditors followed up on the status of the nine recommendations not yet fully implemented as reported in

the June 30, 2021 report. This was the 4th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2017	19	7	5	7
As of June 30, 2019	19	9	8	2
As of June 30, 2021	19	10	8	1
As of June 30, 2023	19	10	8	1

Recommendation 5: Neighborhood Recovery Initiative Agency Payment Method

ICJIA should utilize a payment method for NRI that is tied to actual expenditures of State dollars and not quarterly reports that are subsequently revised. Additionally, ICJIA should ensure that payments for NRI are only made pursuant to the contractual agreements.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure expenditures of the grantee were spent as originally budgeted for or were correctly paid if changes were made to any of the original budgets. No exceptions were noted. We also reviewed all quarterly fiscal reports for any budget revisions and discrepancies thereof. No exceptions were noted. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing expenditure detail, we noted ICJIA did not perform all site visits required during the examination period.

Recommendation 6: Evaluation Contract with the University of Illinois

ICJIA should take the steps necessary to enforce provisions of contractual agreements involving evaluation of the NRI program. Further, ICJIA should require community partners to comply with contractual agreements and submit the required data for evaluation or seek to remove the community partners from the program. ICJIA should also consider tying payments to contractual deliverables to ensure work is not only completed but also completed according to the agreed upon dates. Given the investment the State has in the NRI program, ICJIA should conduct an evaluation of how effective the NRI program has been in reducing violence levels in the applicable communities that received funding.

Current status: Not Implemented

As this recommendation pertained to evaluation of deliverables required by the applicable agreement with the grantee, we followed up on this recommendation by detail testing 60 grant agreements to ensure compliance with the grant agreements' requirements. During our testing, we noted several instances of noncompliance. In addition, ICJIA's grant specialists participate in the

subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing grant information at the grantee level, we noted (1) ICJIA did not perform all site visits required during the examination period, and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 7: Monitoring of Lead Agency Personnel

ICJIA should enforce provisions of the NRI contracts with lead agencies and ensure it is aware of the staff assigned to conduct NRI activities under the State grant.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. ICJIA implemented a timekeeping requirement requiring grantees to track and maintain time certifications, signed by the staff and supervisor, for grant-funded personnel and exceptions were noted regarding this requirement. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 8: Participation Rates – Mentoring Plus Jobs and Parent Leadership Components

ICJIA should either ensure that providers hire the required number of positions for NRI or determine if other levels need to be memorialized in contractual agreements. Additionally, when quarterly reports show problems with hiring practices, ICJIA should document how those problems are resolved.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. ICJIA implemented a timekeeping requirement requiring grantees to track and maintain time certifications, signed by the staff and supervisor, for grant-funded personnel and exceptions were noted regarding this requirement. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 9: Timesheets

ICJIA should ensure that NRI providers maintain contractually required timesheets on staff that perform NRI activities. Additionally, ICJIA should be consistent with respect to timesheets in all contractual agreements for NRI.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. ICJIA implemented a timekeeping requirement requiring grantees to track and maintain time certifications, signed by the staff and supervisor, for grant-funded personnel and exceptions were noted regarding this requirement. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 10: Staff Work under Multiple Grants

ICJIA should take the necessary steps to gather and monitor information to ensure that individuals are not paid in excess of 100 percent of their time for work on NRI and other State grant programs.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. ICJIA implemented a timekeeping requirement requiring grantees to track and maintain time certifications, signed by the staff and supervisor, for grant-funded personnel and exceptions were noted regarding this requirement. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 12: Approval for Neighborhood Recovery Initiative Contracts

ICJIA should ensure that approval of all contracts for NRI services is maintained and that timely approvals are completed. Additionally, ICJIA should only allow providers to initiate NRI services after an executed contract has been approved.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure each grant or subgrant/subcontract agreement was approved and signed prior to the start of services. Our testing results indicated, (1) ICJIA and/or the grantee did not sign the grant agreement

prior to the start date of the grant, and (2) ICJIA did not review or approve contracts with subcontractors.

Recommendation 13: Timely Submission of Quarterly Reports

ICJIA should ensure that lead agencies are appropriately monitoring partner agencies. ICJIA should ensure that lead agencies require partner agencies to submit quarterly reports that are timely and accurately approved and certified. Additionally, ICJIA should consider collecting and reviewing all supporting documentation to ensure State resources are appropriately expended on the NRI program.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. For 35 out of the 60 grants tested, the grantee used the services of subcontractors/subgrantees. Of those 35 subcontractors/subgrantees, our testing results indicated ICJIA did not review or approve the contracts for four grants. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing information regarding subcontractors/subgrantees, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 18: Expense Monitoring

ICJIA should develop procedures for its own review of expense support for NRI activities as well as procedures for lead agencies to utilize in monitoring expenses for NRI.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure expenditures of the grantee were spent as originally budgeted for or were correctly paid if changes were made to any of the original budgets. No exceptions were noted. We also reviewed all quarterly fiscal reports for any budget revisions and discrepancies thereof. No exceptions were noted. In addition, we noted ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing expenditure detail, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Management Audit

Department of Children and Family Services' Search for Missing Children

House Resolution Number 120 (from the 98th General Assembly) directed the Auditor General to conduct a management audit of the Department of Children and Family Services' (DCFS') search for missing children. The audit was released in **December 2014** and contained nine recommendations. Of the nine recommendations, eight **are not yet fully implemented**.

Exhibit 10
DEPARTMENT OF CHILDREN AND FAMILY SERVICES' SEARCH FOR MISSING CHILDREN – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Total Number of Missing Wards	DCFS	X		
2	CFS 906 Form	DCFS		X	
3	Data Accuracy	DCFS		X	
4	CIRU Notification	DCFS		X	
5	Caseworker Notification	DCFS		X	
6	Report Missing Wards	DCFS		X	
7	Complete All Agency Forms	DCFS		X	
8	Supervisory Review	DCFS		X	
9	Training and Monitoring	DCFS		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the eight recommendations not yet fully implemented as reported in the June 30, 2020 report. This was the 4th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2016	9	1	8	0
As of June 30, 2018	9	1	8	0
As of June 30, 2020	9	1	8	0
As of June 30, 2022	9	1	8	0

Recommendation 2: CFS 906 Form

DCFS should prevent overpayments by ensuring that CFS 906 forms are completed, submitted, and entered in a timely manner.

Current status: Partially Implemented

The auditors noted in 8 of the 60 (13.3%) instances where a child went missing that were selected for testing, the CFS 906 form had not been filed within 24 hours of when the child had been reported missing. For testing purposes, the auditors considered the file to be in compliance with the 24-hour rule if the date of the CFS 906 form was the day following the date the child went missing.

Further, the auditors noted in 9 of the 60 (15%) instances where a child went missing, the CFS 906 form could not be provided by the Department, thus the auditors could not confirm that the CFS 906 forms were completed timely, or at all.

Recommendation 3: Data Accuracy

DCFS should emphasize to all involved in the reporting and locating of missing children of the need to accurately enter information into case files and to correct discrepancies when identified.

Current status: Partially Implemented

During the current examination, the auditors noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, so the auditors could not compare the initial CFS 1014 forms to the notes in SACWIS to ensure their accuracy.

In addition, during fieldwork, the auditors also tested whether Department supervisors were conducting reviews of the initial CFS 1014 form. Department Procedure 329, Locating and Returning Missing, Runaway, and Abducted Children, provides the documentation of supervisor reviews through the submission of the CFS 1014 form. As a result of the Department being unable to provide the 8 initial CFS 1014 forms noted above, the auditors also could not test documentation of supervisor reviews.

Lastly, in 2 of the 52 (3.8%) instances where a child went missing, the initial CFS 1014 form were completed, however, there was no supervisory review noted on the forms.

Recommendation 4: CIRU Notifications

DCFS should improve controls to ensure that the Child Intake and Recovery Unit (CIRU) is immediately informed when a DCFS caseworker is notified that a ward has gone missing, as per Procedure 329.

Current status: Partially Implemented

Department Procedure 329 requires caseworkers to notify the CIRU within one hour of when they receive notification that a child is missing. The date when the CIRU is notified is documented in the initial CFS 1014 form; however, this form does not have a field to indicate the time.

During the current examination, the auditors noted in 16 of the 60 (26.7%) instances where a child went missing, the CIRU had not been notified within an hour of the child being reported missing. For testing purposes, if the auditors were unable to determine the time the CIRU was notified from the notes in SACWIS, they considered the file to be compliant if CIRU was notified the same day as the child was reported missing.

Further, as previously stated above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm CIRU was notified timely, or at all.

Recommendation 5: Caseworker Notification

DCFS should establish (1) a field in SACWIS to require caseworkers to enter the date and time when they first learned about a missing ward; (2) procedures for the caseworker to acknowledge notification of the missing ward; and (3) a process to ensure that searches are conducted for missing wards in a timely manner, including after business hours or on weekends.

Current status: Partially Implemented

During the current examination, the auditors noted the Department did include a field in SACWIS for the date and time caseworkers received notification of a missing child. However, as previously noted above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm the recording of the date and time the caseworkers received notification of a missing child.

Further, Department Procedure 329 requires caseworkers to notify law enforcement within three hours of learning that a child is missing and provide them with a photograph of the child. The auditors noted in 12 of the 60 (20%) instances where a child went missing, law enforcement was not notified within three hours of when the child had been reported missing, and thus a photograph of the child was not submitted to law enforcement within three hours of when the child had been reported missing. For testing purposes, the auditors considered the

file to be compliant if the CFS 1014 form's date was the same day when the child was reported missing, unless otherwise documented in the notes.

Finally, as previously stated above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm if law enforcement was notified timely, or at all.

Recommendation 6: Report Missing Wards

DCFS should report the missing wards to required parties within the time established in its procedures, including to NCMEC, juvenile courts, and parents/guardians and require supervisors to sign-off on the CFS 1014 to document their review.

Current status: Partially Implemented

Department Procedure 329 requires the notification of the National Center for Missing and Exploited Children (NCMEC) within three hours of when the child was reported missing.

During the current examination, the auditors noted in 22 of the 60 (36.7%) instances where a child went missing the NCMEC was not notified within 3 hours of when the child was reported missing.

Procedure 329 also states that the parents, guardian or legal custodian, juvenile court of jurisdiction and/or guardian ad litem should be notified within three hours of when the child was reported missing. The auditors noted in 16 of the 60 (26.7%) instances where a child went missing, the parents, guardian or legal custodian, juvenile court, and/or guardian ad litem were not notified within three hours of when the child was reported missing. For testing purposes, the auditors considered the file to be compliant if the date notified was the same day as the child was reported missing.

Finally, as previously stated above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm whether NCMEC, parents, guardian or legal custodian, juvenile court, and/or guardian ad litem were notified timely, or at all. The auditors also could not determine if the supervisor had reviewed the initial CFS 1014 for 8 instances.

Recommendation 7: Complete All Agency Forms

DCFS should ensure that all its internal forms are completed in a timely manner as specified in DCFS procedures, including the CFS 1014 Missing Children Recovery Report. In addition, DCFS should debrief missing wards when they are found, and document the interview.

Current status: Partially Implemented

Department Procedure 329 requires the caseworker or supervisor to complete a Missing Child DeBriefing form (CFS 680-A form) and a CFS 1014 - Child Recovery form, within two business days from the date the child returned.

During the current examination, the auditors noted in 26 of the 60 (43.3%) cases tested, the CFS 680-A form had not been completed in a timely manner. Specifically, the auditors noted the form was completed by the caseworker or supervisor 2 to 62 days after the two business day requirement.

In addition, the auditors noted in 8 of the 60 (13.3%) instances where a child went missing, the CFS 680-A form could not be provided by the Department, thus, the auditors could not confirm whether the form was completed timely, or at all.

Lastly, the auditors noted in 14 of the 60 (23.3%) instances where a child went missing, the CFS 1014 - Child Recovery form could not be provided by the Department, thus the auditors could not confirm whether the caseworker or supervisor had completed the CFS 1014 - Child Recovery form timely, or at all.

Recommendation 8: Supervisory Review

DCFS should comply with its written procedures which require that supervisory meetings with caseworkers be documented when searching for missing wards. Supervisors should review the documents completed by caseworkers and sign off to demonstrate their review.

Current status: Partially Implemented

Department Procedure 329 requires the supervisor to document their review via the submission of the initial CFS 1014 form and via a note in their supervisor file on a weekly or daily basis.

During the current examination, the auditors noted in 16 of 60 (26.7%) instances where a child went missing, the Department could not provide evidence of the supervisor's note in their file.

Recommendation 9: Training and Monitoring

Given the lack of documentation and noncompliance found in this audit, DCFS should: provide training to its caseworkers and supervisors on missing children; review its search procedures for missing children for possible modifications; and give the CIRU (or another unit within DCFS) the responsibility to monitor actions taken by caseworkers and supervisors to report and locate missing children, and to report to management the degree to which the Department's policies and procedures are being followed.

Current status: Partially Implemented

Department Procedure 329 was last revised in response to this original recommendation in FY18 and training has since been conducted to make caseworkers and supervisors aware of the revised requirements. As stated in the revised procedure, it is the CIRU responsibility for monitoring caseworkers' and supervisors' compliance with Procedure 329.

During the current examination, the auditors noted the Department could not provide documentation of any reports from caseworkers or supervisors to Department management, or any other monitoring mechanisms, ensuring the CIRU staff were being compliant with Procedure 329.

Performance Audit

State Moneys Provided to the Illinois Criminal Justice Information Authority for Violence Prevention

House Resolution Number 888 (from the 98th General Assembly) directed the Auditor General to conduct a performance audit of the State moneys provided by or through the Illinois Criminal Justice Information Authority (ICJIA) to all community based violence prevention programs, the After-School Program, and the Chicago Area Project. The audit was released in **April 2016** and contained 28 recommendations of which **14 are not yet fully implemented**.

Exhibit 11
STATE MONEYS PROVIDED TO THE ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY FOR VIOLENCE PREVENTION – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	NRI/CVPP Due Diligence in Provider Selection	ICJIA	X		
2	NRI/CVPP Fund Transfer to DHS	ICJIA		X	
3	NRI/CVPP Payments in FY15	ICJIA	X		
4	NRI/CVPP Failure to Require and Maintain Contracts	ICJIA			X
5	NRI/CVPP Contract Execution Timeliness	ICJIA		X	
6	NRI/CVPP Quarterly Reporting	ICJIA		X	
7	NRI/CVPP Salary Differences	ICJIA		X	
8	NRI/CVPP Site Visits by ICJIA	ICJIA			X
9	NRI/CVPP Background Checks	ICJIA	X		
10	NRI/CVPP Reentry Services to Ineligible Individuals	ICJIA		X	
11	NRI/CVPP Equipment Purchases	ICJIA			X
12	NRI/CVPP Evaluation Efforts	ICJIA		X	
13	NRI/CVPP Timekeeping Contract	ICJIA	X		
14	NRI/CVPP Expense Testing	ICJIA	X		
15	NRI/CVPP Use of Separate Accounts for Grant Funds	ICJIA	X		
16	NRI/CVPP Recovery Efforts	ICJIA	X		
17	ASP Contract Execution Timeliness	ICJIA			X
18	ASP Quarterly Reporting	ICJIA		X	
19	ASP Site Visits	ICJIA			X
20	ASP Equipment Purchases	ICJIA	X		
21	ASP Expense Testing	ICJIA	X		
22	CAP Funding Grant Agreement	ICJIA	X		
23	CAP Funding Salary Differences	ICJIA		X	
24	CAP Funding Quarterly Reporting	ICJIA		X	
25	CAP Funding Equipment Purchases	ICJIA	X		
26	CAP Funding Expense Testing	ICJIA	X		
27	CAP Funding Recovery Efforts	ICJIA	X		
28	CAP Funding Reconciliation	ICJIA	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of ICJIA for the period ending June 30, 2023, auditors followed up on the status of the 16 recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 4th time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2017	28	7	8	13
As of June 30, 2019	28	12	10	6
As of June 30, 2021	28	12	10	6
As of June 30, 2023	28	14	9	5

Recommendation 2: NRI/CVPP Fund Transfer to Department of Human Services

ICJIA should ensure full compliance with all interagency agreements. Additionally, it should take steps to ensure that funds being transferred to other State agencies for distribution to community based organizations do not overlap with the community based organizations' ICJIA funds for similar purposes.

Current status: Partially Implemented

During our detail testing of 60 grant agreements, we noted three grant agreements were with other State agencies. For the two grants tested, we noted noncompliance with specific provisions of the grant agreements. Regarding the issue of making duplicate payments to State agencies for the same type of purposes of the grants, we did not note any exceptions when reviewing the 60 grant agreements or during our detail testing of grant vouchers. ICJIA has implemented the use of Exhibit G in the Grant Accountability and Transparency Act (GATA) Uniform Grant Agreement, which requires grantees to list all State agency contracts into ICJIA's grant agreements to avoid duplicative funding to community-based organizations for the same scope of services. During our review of the 60 grant agreements, we did not note any exceptions regarding the compliance on the use of Exhibit G in the GATA Uniform Grant Agreement.

Recommendation 4: NRI/CVPP Failure to Require and Maintain Contracts

ICJIA should require, approve, and maintain copies of all contractual agreements for all services funded by or through the agency regardless of the amount or purpose of the agreement.

Current status: Not Implemented

During our detail testing of 60 grant agreements, we noted an exception that ICJIA did not review or approve contracts with some of its subcontractors.

Recommendation 5: NRI/CVPP Contract Execution Timeliness

ICJIA should ensure that there is timely execution of all contracts for grant services, including the NRI/CVPP program. Further, ICJIA should follow its own policies and not allow the contracts to be signed if not executed within six months of the start date. Additionally, ICJIA should consider only allowing service providers to initiate grant services after an executed contract has been approved.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure each grant or subgrant/subcontract agreement was approved and signed prior to the start of services. Our testing results indicated, (1) ICJIA and/or the grantee did not sign the grant agreement prior to the start date of the grant, and (2) ICJIA did not review or approve contracts with subcontractors.

Recommendation 6: NRI/CVPP Quarterly Reporting

ICJIA should enforce provisions of grant agreements and require timely fiscal reporting by providers that contain accurate approved budget numbers and explanations when the expenses change. Additionally, ICJIA, when it delegates its responsibility for community oversight to lead agencies, should implement the necessary controls to ensure lead agencies enforce contract provisions relative to timely fiscal reporting. Finally, ICJIA should always collect and review quarterly fiscal reports from all program providers to not only comply with contract provisions but to maintain adequate oversight of State dollars.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure expenditures of the grantee were spent as originally budgeted for or were correctly paid if changes were made to any of the original budgets. No exceptions were noted. We also reviewed all quarterly fiscal reports for any budget revisions and discrepancies thereof. No exceptions were noted. However, we noted quarterly fiscal reports for 37 out of 60 grant agreements tested were not timely submitted or not submitted at all.

Recommendation 7: NRI/CVPP Salary Differences

ICJIA should consider revising its grant process to require the identification of individuals who are to be charged to the grant. Additionally, ICJIA should consider revising its fiscal reporting to have grantees report the identities of the staff charged to the grant funds on a quarterly basis. Finally, ICJIA should revise its process to ensure that providers do not charge grant funds in excess of the amounts the providers actually pay the staff who work on the grant.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. Although ICJIA implemented a timekeeping requirement, requiring grantees to track and maintain time certifications, signed by the staff and

supervisor, for grant-funded personnel, exceptions were noted regarding this requirement. In addition, we noted ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 8: NRI/CVPP Site Visits by ICJIA

ICJIA should comply with its policy and conduct timely site visits of new program grantees for effective monitoring of the programs.

Current status: Not Implemented

During our review of ICJIA's site monitoring visits, we noted (1) ICJIA did not perform all site visits required during the examination period, and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 10: NRI/CVPP Reentry Services to Ineligible Individuals

ICJIA should take the steps necessary to ensure that providers are complying with participation requirements of grant agreements and not simply delegating oversight to other entities. Additionally, ICJIA should review all reentry service providers for Years 3 and 4 of the NRI/CVPP program to determine if ineligible clients were served, whether the ineligibility was because of parole status, age, or type of crime. Finally, ICJIA should recover State grant funds that would have been spent on these ineligible clients from the service providers.

Current status: Partially Implemented

We noted ICJIA management has begun to seek repayment and initiated recovery action against all ICJIA auditors site-tested exceptions. In addition, during our detail testing of 60 grant agreements, we noted ICJIA reviewed the fiscal reports received. In addition, we noted ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing expense information of the grantee, subcontractors, and subgrantees, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 11: NRI/CVPP Equipment Purchases

ICJIA should enforce provisions of grant agreements and ICJIA guidelines relative to the purchase of equipment by providing agencies. ICJIA should either require the mandatory correspondence and maintain that in its files, or not allow the purchase expenses by the providers. Finally, ICJIA should determine whether the dollar amount of the exceptions noted by auditors should be recovered from providing agencies.

Current status: Not Implemented

During our detailed testing of 60 grant agreements, we noted the grant agreements contained the applicable requirements and enforced them for all grants which were applicable. No exceptions were noted. In addition, we noted ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing expense information of the grantee, subcontractors, and subgrantees, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 12: NRI/CVPP Evaluation Efforts

ICJIA should require all vendors to comply with information requests necessary to conduct complete evaluation of State grant programs. Further, ICJIA should look to implement penalties on vendors who fail to comply with these information requests. Finally, ICJIA should require evaluation contractors to comply with contractual requirements and submit required deliverables or seek to recover funds if those deliverables are not submitted.

Current status: Partially Implemented

As this recommendation pertained to evaluation of deliverables required by the applicable agreement with the grantee, we followed up on this recommendation by detail testing 60 grant agreements to ensure compliance with the grant agreements' requirements. During our testing, we noted several instances of noncompliance. For instances in which noncompliance was noted, we further noted ICJIA did not implement penalties nor were grant payments withheld as a result of the noncompliance.

Recommendation 17: ASP Contract Execution Timeliness

ICJIA should ensure that there is timely execution of all contracts, including those for ASP services. Further, ICJIA should either follow its own policies and not allow the contracts to be signed after six months or change ICJIA policy. Additionally, ICJIA should consider only allowing service providers to initiate services, including ASP services, after an executed contract has been approved.

Current status: Not Implemented

We detail tested 60 grant agreements to ensure each grant or subgrant/subcontract agreement was approved and signed prior to the start of services. Our testing results indicated, (1) ICJIA and/or the grantee did not sign the grant agreement prior to the start date of the grant, and (2) ICJIA did not review or approve contracts with subcontractors.

Recommendation 18: ASP Quarterly Reporting

ICJIA should enforce provisions of grant agreements and require timely fiscal reporting by grantees. ICJIA should always collect quarterly fiscal reports from all program providers to not only comply with contract provisions but to maintain adequate oversight of State dollars.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure expenditures of the grantee were spent as originally budgeted for or were correctly paid if changes were made to any of the original budgets. No exceptions were noted. We also reviewed all quarterly fiscal reports for any budget revisions and discrepancies and noted noncompliance with specific provisions of the grant agreement.

Recommendation 19: ASP Site Visits

ICJIA should comply with its policy and conduct timely site visits of new program grantees for effective monitoring of the programs.

Current status: Not Implemented

During our review of ICJIA's site monitoring visits, we noted (1) ICJIA did not perform all site visits required during the examination period, and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 20: ASP Equipment Purchases

ICJIA should enforce provisions of grant agreements and ICJIA guidelines relative to the purchase of equipment by providing agencies of the After-School Program. ICJIA should either require the mandatory correspondence and maintain that in its files, or not allow the purchase expenses by the grantees. Finally, ICJIA should determine whether the dollar amount of the exceptions noted by auditors should be recovered from the grantees and seek all necessary recoveries.

Current status: Implemented

During our detail testing of 60 grant agreements, we noted four grant agreements in which equipment was purchased and a review was performed to verify if the equipment was purchased within 90 days of the grant start date or if the grantee properly maintained records for equipment purchases. No exceptions were noted. In addition, during the last quarter of fiscal year 2021, the Authority's FSGU implemented a new site visit policy in monitoring State and local programs funded with State or federal funds administered by the Authority. The revised site visit policy states grants in which 100 percent of the funds are used for equipment purchases (and related items) do not require a site visit.

Recommendation 23: CAP Funding Salary Differences

ICJIA should consider revising its grant process to require the identification of individuals who are to be charged to the grant. Additionally, ICJIA should consider revising its fiscal reporting to have grantees report the identities of the staff charged to the grant funds on a quarterly basis. Finally, ICJIA should revise its process to ensure that providers do not charge grant funds in excess of the amounts the providers actually pay the staff who work on the grant.

Current status: Partially Implemented

We detail tested 60 grant agreements to ensure requirements of each grant were followed. ICJIA implemented a timekeeping requirement requiring grantees to track and maintain time certifications, signed by the staff and supervisor, for grant-funded personnel and exceptions were noted regarding this requirement. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 24: CAP Funding Quarterly Reporting

ICJIA should enforce provisions of grant agreements and require timely fiscal reporting by providers that contain accurate approved budget numbers and explanations when the expenses change. Additionally, ICJIA, when it delegates its responsibility for community oversight to another agency, should implement the necessary controls to ensure that agency enforces contract provisions relative to timely fiscal reporting. Finally, ICJIA should always collect quarterly fiscal reports from all program providers to not only comply with contract provisions but to maintain adequate oversight of State dollars.

Current status: Partially Implemented

During our detail testing of 60 grant agreements, we noted noncompliance with specific provisions of the grant agreements. In addition, ICJIA's grant specialists participate in the subgrantees/subcontractors site visits with the grantees. However, during our review of ICJIA's site monitoring visits, which is one of ICJIA's control mechanisms for reviewing personnel timesheets, we noted (1) ICJIA did not perform all site visits required during the examination period and (2) of the site visits conducted, site visit documentation was determined to be inadequate.

Recommendation 25: CAP Funding Equipment Purchases

ICJIA should enforce provisions of grant agreements and ICJIA guidelines relative to the purchase of equipment by providing agencies of the ICJIA funding to Chicago Area Project. ICJIA should either require the mandatory correspondence and maintain that in its files, or not allow the purchase expenses by the grantees. Finally, ICJIA should determine whether the dollar amount of the exceptions noted by auditors should be recovered from the grantees and seek all necessary recoveries.

Current status: Implemented

During the last quarter of fiscal year 2021, the Authority's FSGU implemented a new site visit policy in monitoring state and local programs funded with State or federal funds administered by the Authority. The revised site visit policy states grants in which 100 percent of the funds are used for equipment purchases (and related items) do not require a site visit.

Performance Audit

Department of Children and Family Services' Placement of Children

Senate Resolution Number 140 (from the 99th General Assembly) directed the Auditor General to conduct a performance audit of the Department of Children and Family Services' (DCFS) compliance with its obligations to place children in its care in placements consistent with their best interests. The audit was released in **September 2016** and contained four recommendations. **None of the four recommendations are fully implemented**.

Exhibit 12
DEPARTMENT OF CHILDREN AND FAMILY SERVICES' PLACEMENT OF CHILDREN – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Administrative Rules and Procedures	DCFS		X	
2	Internal Forms and Case Files	DCFS		X	
3	Planning Meeting and Matching Process	DCFS		X	
4	Tracking Information	DCFS		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the four recommendations not yet fully implemented as reported in the June 30, 2020 report. This was the 3rd time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2018	4	0	1	3
As of June 30, 2020	4	0	4	0
As of June 30, 2022	4	0	4	0

Recommendation 1: Administrative Rules and Procedures

The Department of Children and Family Services should review existing administrative rules and internal policies and procedures on the placement of children. The Department should make necessary revisions to update the rules and procedures to reflect current practice and to implement any needed changes. The Department should also examine areas that lack policies and procedures on the placement of children and implement procedures as needed.

Current status: Partially Implemented

As noted in the compliance examination for the two years ended June 30, 2020, the Department has implemented policies, procedures, and forms regarding the

children who are psychiatrically hospitalized (Procedures 301.110) and children in emergency shelters (Procedures 301.55). However, the auditors continue to note as they did in the prior examination report, that while the Department has implemented policies regarding specific payments for children in detention facilities, it lacks detailed procedures regarding the temporary placement of children in these detention facilities.

Recommendation 2: Internal Forms and Case Files

The Department of Children and Family Services should ensure that required forms are being utilized and that required documentation is consistently maintained in case files. The Department should also explore the feasibility of maintaining forms in its primary case management system.

Current status: Partially Implemented

During the current examination, Department management stated the Department no longer utilized the Discharge and Aftercare Plan (PHT 965-1 form), however, the current Department Procedures 301.110 still refer to the use of this form.

In addition, the auditors noted the ERC Intake & Referral (CFS 1901 form) form continues to be under development alongside other clinical work by the Child Services within the Department.

Lastly, Department management stated, as it did in the prior examination, the internal placement of children forms are not currently maintained in the Statewide Automated Child Welfare Information System (SACWIS); however, it is currently engaged in a multi-year program for the new Comprehensive Child Welfare Information System (CCWIS) that will replace the current SACWIS to modernize child case management and address the issues of paper form maintenance. As of June 30, 2022, CCWIS program began, however, completion of the development and full implementation of CCWIS is expected to be done in 2026, with releases to production every 6 to 9 months.

Recommendation 3: Planning Meeting and Matching Process

The Department of Children and Family Services should implement policies and procedures for its matching process to ensure that the planning meeting is held promptly and to improve the timeliness of the matching process.

Current status: Partially Implemented

The auditors noted that little progress appears to have been made during FY22 regarding this recommendation. As was reported in the prior examination, when children are admitted to an emergency shelter, the shelter is considered a temporary placement. The Department holds a planning meeting, which is called the Clinical Intervention for Placement Preservation (CIPP) meeting to determine the level of care and possible placements for the child. The Department implemented a policy in Department Procedures 301.55 requiring the meeting to

be held within 15 days of shelter admission, to ensure the planning meeting is promptly held. This meeting determines the recommended level of care for the child. The Department management further states the Department's Placement Administration, with the Department of Innovation and Technology, is currently in the final stages of testing or implementing a new application called Match Maker. Match Maker will allow for a more timely and efficient matching process and will allow matches to providers to be driven by the provider's profile based on services and population they serve including capacity. Match Maker will allow the placement team efficient communication concerning referral status while collecting data on responsiveness and outcomes from providers. As of June 30, 2022, the Department is in the process of testing and implementing the Match Maker.

Updated program plans for FY24 outline an expected time from referral to admission into congregate care settings.

Recommendation 4: Tracking Information

The Department of Children and Family Services should make necessary changes to track information in its computer systems to ensure processes are working and better monitor children in its custody. These changes should enable DCFS to readily report information.

Current status: Partially Implemented

The auditors noted that little progress appears to have been made during FY21 and FY22 regarding this recommendation. As was reported in the prior examination, Department management stated the Department is currently engaged in a multi-year program to implement CCWIS. CCWIS will replace and modernize a vast majority of information technology systems utilized by the Department, which includes the current case management solutions known as the Statewide Automated Child Welfare Information System (SACWIS) and the Child & Youth Centered Information System (CYCIS). CCWIS is expected to automate many of the manual paper-based processes the Department currently relies on for day-to-day operations. As of June 30, 2022, CCWIS had begun, however, completion of the development and full implementation of CCWIS is expected to be done in 2026, with releases to production every 6 to 9 months.

Performance Audit

Procurement and Administration of the Contract with Morneau Shepell

House Resolution Number 522 (from the 100th General Assembly) directed the Auditor General to conduct a performance audit of the procurement and administration of the contract with Morneau Shepell. The audit was released in **March 2019** and contained nine recommendations. Of the nine recommendations, two **are not yet fully implemented**.

Exhibit 13
PROCUREMENT AND ADMINISTRATION OF THE CONTRACT WITH MORNEAU SHEPELL – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Vendor Information Not Shared with Evaluators	CMS	X		
2	Conflict of Interest Disclosures	CMS	X		
3	Outlier Evaluation Assessment	CMS	X		
4	Need for the Custom Benefit Solution	CMS		X	
5	Scope of the Request for Proposals	CMS	X		
6	Request for Proposals Timeline and Lack of Competition	CMS	X		
7	Contract and Performance Guarantee Oversight	CMS	X		
8	Performance Guarantee Reporting	CMS	X		
9	Custom Benefit Solution Performance Issues	CMS		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department of Central Management Services (CMS) for the period ending June 30, 2023, auditors followed up on the status of the two recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 2nd time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2021	9	7	2	0
As of June 30, 2023	9	7	2	0

Recommendation 4: Need for the Custom Benefit Solution

CMS should conduct a cost-benefit analysis before procuring any new major system. This analysis should include an examination of whether the State currently has resources that could provide the services in a cost effective manner.

Current status: Partially Implemented

In the previous engagement, the Department implemented a procurement policy in October 2019, which includes a provision that the Bureau of Benefits conduct a cost-benefit analysis before procuring any new major system including an examination of whether the State currently has resources that could provide services in a cost-effective manner.

During the current engagement, the Healthcare Portfolio Manager stated that the Bureau did not procure any new major system. Therefore, auditors could not test to ensure the Department conducted a cost-benefit analysis before procuring any new major system.

Recommendation 9: Custom Benefit Solution Performance Issues

CMS should develop a tool to be used in the procurement process to help identify the parties affected by the implementation of new procurements and document what role those parties played in the procurement to ensure all relevant parties are included in the process. CMS should also ensure all controls are tested prior to implementation of any major new system.

Current status: Partially Implemented

In the previous engagement, the Department reported the Bureau of Benefits does not have any immediate future plans to procure any new major systems impacting multiple stakeholders. The Department also reported for any future procurements that involve coordination with multiple stakeholders, Bureau of Benefits will conduct a kick-off meeting to identify those stakeholders affected by implementation of any new programs or systems and ensure all affected stakeholders receive appropriate communication. Additionally, the Department reported the Bureau of Benefits will ensure all controls are tested prior to implementation of any major new system.

During the current engagement, auditors could not conduct testing to ensure all controls were tested prior to implementation of major new system because the Bureau of Benefits did not conduct any such procurement during the audit period. Auditors could also not verify that there was a meeting of impacted stakeholders as the Bureau has not procured any new major systems.

Performance Audit

Department of Children and Family Services Investigations of Abuse and Neglect

House Resolution Number 418 (from the 100th General Assembly) directed the Auditor General to conduct a performance audit of the Department of Children and Family Services (DCFS) to review and assess the Department's protocols for investigating reports of child abuse and neglect. The audit was released in **May 2019** and contained 13 recommendations. Of the 13 recommendations, **8 are not yet fully implemented**.

Exhibit 14
DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVESTIGATIONS OF ABUSE AND NEGLECT – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Child Abuse and Neglect Data	DCFS		X	
2	Investigator Assignments	DCFS		X	
3	Child Endangerment Risk Assessment Protocol	DCFS		X	
4	Hotline and Intake	DCFS		X	
5	Investigation Timeliness	DCFS			X
6	Investigation Extensions	DCFS		X	
7	Assessing the Need for Services	DCFS		X	
8	Recommendations for Services	DCFS	X		
9	Intact Family Services Monitoring	DCFS	X		
10	Intact Family Services Coverage	DCFS	X		
11	Intact Family Services Referrals	DCFS	X		
12	Norman Cash Assistance	DCFS		X	
13	Community Based Services	DCFS	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the 10 recommendations not yet fully implemented as reported in the June 30, 2020 report. This was the 2nd time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2020	13	3	4	6
As of June 30, 2022	13	5	7	1

Recommendation 1: Child Abuse and Neglect Data

The Department of Children and Family Services should continue to take steps to improve the quality of the data contained in its child abuse and neglect information systems and statistical reports. These steps should include: ensuring that proper controls are in place for SACWIS data entry, or any future child abuse and neglect information systems, in order to ensure that data is collected and is reliable; and maintaining updated manuals including data field definitions.

Current status: Partially Implemented

During the current examination, according to the Department, it has taken steps to improve the quality of the Child Abuse and Neglect Data in SACWIS including:

- Several SACWIS releases have made improvements to data quality; and
- Data Field definitions are being assembled into a Data Dictionary.

According to Department officials, there were data improvements done as part of a SACWIS release, however, no documentation was provided to the auditors to show what changes were made and the degree of data quality improvement. Also, Department officials indicated it is in the process of implementing the new Comprehensive Child Welfare Information System (CCWIS) that will replace the current SACWIS to modernize child case management, data clean up, and developing a Data Quality Plan. Further, during the examination period, the auditors noted a Data Dictionary was developed, which has defined the SACWIS fields.

Recommendation 2: Investigator Assignments

The Department of Children and Family Services should take steps to ensure investigator assignments are in compliance with the requirements of the B.H. Consent Decree.

Current status: Partially Implemented

During the current examination, according to the Department, it hired 568 new investigators during FY21 and FY22. On March 12, 2021, the Department established an implementation plan to address investigator caseloads. The implementation plan has two phases, which include hiring, onboarding, and retention of child protection investigators (Phase I) and assessing whether the steps taken in Phase I have brought the Department into compliance with Paragraph 26(a) of the B.H. Consent Decree, or whether the Department must take further action to achieve Compliance (Phase II). On March 31, 2022, the Department submitted its first annual report on Implementation Plan to Address Investigator Caseloads with the Clerk of the United States District Court for the Northern District of Illinois, Eastern Division. Based on the review of the report, the Department has exerted efforts to comply with the requirements of B.H. Consent decree, which includes increasing the number of case investigators, satisfaction of required meetings and reporting, as well as improving processes to effectively handle caseloads. Additionally, the Department has provided regular

updates to Plaintiffs' counsel and the Special Master regarding "elevated support sites" where (1) 30.0 percent or more of the investigators at the site were assigned more than 15 new investigations in one month; and (2) the vacancy percentage at the site was 6.0 percent of greater. The parties continue to meet on a monthly basis to address the Department's efforts on the strategies in the implementation plan and remain committed to achieving the goals set out in the implementation plan as well as Paragraph 26(a) of the Restated Consent Decree.

Recommendation 3: Child Endangerment Risk Assessment Protocol

The Department of Children and Family Services should: ensure that CERAPs are completed for investigations and that they are completed in a timely manner; ensure that CERAPs are completed and that they are completed in a timely manner when Intact Family Services are provided; and evaluate the reliability and validity of the CERAP annually and develop written procedures related to CERAP training as is required by the Children and Family Services Act.

Current status: Partially Implemented

During the current examination, the auditors reviewed investigations data for FY21 and FY22 and found that 3.73 percent of initial CERAPs were not completed in a timely manner. The auditors also reviewed a sample of 25 investigations to determine if CERAPs were being completed timely. The testing results indicated all the initial and final CERAPs were completed timely.

In addition, the Department provided a copy of the FY21 Annual Evaluation of the CERAP prepared by the University of Illinois' Children and Family Research Center to the auditors and they noted the predictive reliability of the CERAP was reviewed as part of the evaluation. The FY22 Annual Evaluation was held by the statutory advisory group due to the beginning of the use of the new safety assessment tool, SAFE model. Due to the nature of the changes to the current safety assessment tool, the advisory group did not complete a report for 2022. The advisory group requested the General Assembly for a pause in CERAP reporting due to the lack of data available for the new SAFE model. The advisory group plans to report again in 2025, when data becomes available.

Further, the auditors noted the CERAP training was part of the Department's Office of Learning and Professional Development training for child protection employees. Each child protection employee is required to successfully pass the CERAP examination with a minimum score of 70 percent.

Recommendation 4: Hotline and Intake

The Department of Children and Family Services should: develop formal written procedures for call backs including required timeframes for creating intakes; ensure that the process for completing call backs is in accordance with written procedures by answering and returning hotline calls in a timely manner; begin maintaining complete information regarding the time it takes to return the hotline calls of those reporting allegations of child abuse or neglect for an amount of time that would allow for long-term analysis; and continue to increase the utilization of online reporting as appropriate.

Current status: Partially Implemented

During the current examination, the Department developed procedures for callbacks including required timeframes for creating intakes. In addition, training was provided to employees on creation of callbacks. The Department maintains call back information in SACWIS and subsequently provided the auditors with a download of call back information for FY21 and FY22. The auditors' analysis of the data provided showed significant improvements, noting the call backs for FY21 and FY22 dropped to 432 and 36, respectively.

Department officials also stated the Department is continuing to develop and use on-line reporting. According to the Department, it received 24,396 on-line reports during FY21 and 39,117 during FY22.

Recommendation 5: Investigation Timeliness

The Department of Children and Family Services should take actions to ensure that critical investigation timeframes are completed in accordance with procedures, including initiating investigations, contacting the alleged victim and perpetrator, submitting investigations for supervisory review, and completing the investigation.

Current status: Not Implemented

The Abused and Neglected Child Reporting Act (ANCRA) requires investigations to begin within 24 hours of receipt of the report (325 ILCS 5/7.4(b)(2)), which is defined by Department administrative rules as "the time the report was received at the State Central Register" (89 Ill. Adm. Code 300.90).

The Department's administrative rules require in-person contact with the alleged victim be made within 24 hours (89 Ill. Adm. Code 300.90).

The Department's administrative rules further require that, within seven days, there must be in-person contact with the alleged perpetrator (89 Ill. Adm. Code 300.90).

Lastly, Department policies require the Child Protection Specialist to submit the completed investigation and final determination to the Child Protection Supervisor within 55 days of receipt of the report. If a 30-day extension to complete the investigation is necessary, the Child Protection Specialist is required to submit (prior to the 55th day) an extension request to the Child Protection Supervisor who will evaluate the request (Procedures 300.50a).

During the current examination, the auditors reviewed FY21 and FY22 investigations to determine the timeliness of initiating investigations, contacting the alleged victim and perpetrator, submitting investigations for supervisory review, and completing the investigation. The auditors' testing results showed the following:

- 0.6% of all investigations had untimely initiation;
- 40.0% of all investigation had untimely victim contact;
- 37.9% of all investigations had untimely perpetrator contact;
- 51.7% of investigations without an extension were not submitted for supervisor review within 55 days; and
- 5.3% of all investigations were completed in an untimely manner.

Based on the above, although the Department has established rules and procedures for timeliness requirements, it is not ensuring that the timeliness requirements are being met.

Recommendation 6: Investigation Extensions

The Department of Children and Family Services should comply with rules and procedures and ensure: extensions are requested prior to the 55th day of the investigation; that extensions are given only for good cause; extensions are requested and approved by appropriate staff; and extension requests contain all required information.

Current status: Partially Implemented

During the current examination, Department officials stated all requests and approvals for extensions are documented in the SACWIS. In the narrative section on the extension request, the Child Protection Specialist lists the reasons the investigation cannot be completed within 55 days, activities to be completed, who is responsible for completing each activity, and the expected date of completion. The extension requests are reviewed and approved by the Child Protection Supervisor and Area Administrator. The date and time of the Area Administrator's approval of additional extensions must be documented in a contact note.

The auditors sampled 10 FY21 and FY22 investigations that had at least one extension. The auditors' testing results noted all 10 investigations' extensions were properly approved, for a good cause, and contain all required information. However, the auditors also noted that for 9 of 10 investigations the initial extension request was not submitted within 55 days. The testing results noted the initial extension requests were submitted 7 to 157 days after the 55-day requirement.

The auditors also reviewed the 10 investigations with the most extensions and found that:

- These 10 investigations had a total of 180 extensions at the time we received our investigations data;
- None of the initial requests for an extension were submitted within 55 days; and
- All investigations were extended for a good cause and were properly approved.

Recommendation 7: Assessing the Need for Services

The Department of Children and Family Services should: make the Level of Intervention a required field in SACWIS and revise the Level of Intervention options to more accurately reflect current practices, and include a rationale for indicated investigations in which there is a Level of Intervention of "No Service Needed."

Current status: Partially Implemented

During the current examination, Department officials stated the Level of Intervention is required for each investigation.

The auditors analyzed data provided by the Department regarding the Level of Intervention and found the following:

- The Level of Intervention is a required field in SACWIS, however, of 181,442 investigations completed during FY21 and FY22, 13,387 (7.4%) had a blank Level of Intervention; and
- No changes have been made to the Level of Intervention options in SACWIS (Intact Family Services is not an option that can be selected and there is no rationale when "no services" are recommended).

The auditors also reviewed a sample of 25 indicated investigations and found that the rationale for the Level of Intervention was inaccurate for 14 of 25 (56.0%) investigations. Specifically, the auditors noted the investigations had a blank Level of Intervention.

Recommendation 8: Recommendations for Services

The Department of Children and Family Services should: formally document when services are offered and whether those services are refused; and consider establishing guidelines or policies to assist Child Protection Specialists and Supervisors regarding services to be offered for indicated allegations.

Current status: Implemented

According to Department procedures, the investigator has the responsibility to discuss and offer the family Intact Family Services if the final finding of indicated has been recommended. The family should also be informed of community services (Procedures 300.130(a)(2)(A)).

In September 2022, subsequent to the examination period, the Department's Procedure 300 was updated to include procedures on documentation of services

being offered or refused and guidelines to assist Child Protection Specialists and Supervisors regarding services to be offered for indicated allegations.

The Department's SACWIS has a text box on the investigation Decision tab to enter the name, address, and contact person of the provider to which the family has been referred. The narrative box would always be available for use but would be a required entry if the Level of Intervention is either "Referral for Community-Based Services" or "No Service Needed".

The auditors reviewed a sample of 25 indicated investigations to determine whether there was documentation that services were offered or refused. The auditors' review found all investigations' case files contained documentation that Intact Family Services (IFS) were offered and refused, if applicable.

Recommendation 12: Norman Cash Assistance

The Department of Children and Family Services should document all purchases made with Norman Cash Assistance funds. The Department should also update its cash assistance request approval policies to reflect the current organizational structure of the agency.

Current status: Partially Implemented

During the current examination, the Department had updated procedures for the Norman Cash Assistance Program, however, the updated procedures and modifications were pending review and final approval as of June 30, 2022. According to Department officials, the proposed changes seek to increase the amounts of Norman Cash Assistance that various positions can approve. These changes will also provide more clarity on the cash assistance approval protocol and provide flexibility to assist families in a more streamlined fashion. These considerations were in review with the Office of Child and Family Policy as of the end of the auditors' fieldwork.

The Department also provided the auditors a list of 13,237 Norman Cash expenditures for FY21 and FY22. The auditors reviewed a sample of 10 Norman Cash expenditures to determine if documentation and approval of the expenditure was available. The Department provided documentation and approval forms for the 10 expenditures and the testing results indicated all expenditures were properly approved.

Recommendation 13: Community Based Services

The Department of Children and Family Services should follow existing Department procedures including: documenting referrals for community based services including the duration and frequency of the services and the conditions/circumstances that the services are designed to mitigate; and verifying whether the family is following through with the community services.

Current status: Implemented

In October 2022, subsequent to the examination period, the Department implemented Enterprise Service Request 183, which added a narrative field and a requirement for an explanation of Level of Interventions when values of "Referral for Community-Based Services" or "No Services Needed" is selected as a Level of Intervention in SACWIS. This requirement will not allow the investigation to be completed until this element is satisfied with a response. This is not a traditional note but the narrative created is directly linked to the Level of Intervention that speaks to the referral to community base services and is only required in the two instances mentioned.

The auditors also reviewed a sample of 25 indicated investigations to determine if community services referrals were being documented and whether services were being followed through. The auditors' review found that all investigations had services offered, all with IFS cases. In addition, the auditors noted 11 of the cases which were marked "Referral for Community-Based Services" received community-based services.

Performance Audit

Department of Central Management Services Multiple Choice Exams

House Resolution Number 816 (from the 100th General Assembly) directed the Auditor General to conduct a performance audit of the Department of Central Management Services to review and assess the Department's automated multiple choice exams for specific position titles listed in the audit resolution. The audit was released in **December 2019** and contained four recommendations. Of the four recommendations, **one is not yet fully implemented**.

Exhibit 15
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES MULTIPLE CHOICE EXAMS – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Retention of Appropriate Validation Documentation	CMS	X		
2	Policies and Procedures	CMS		X	
3	Review of Survey Responses Applicable to Exam Content	CMS	X		
4	Retesting Within 30 Days	CMS	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the four recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 2nd time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2021	4	0	1	3
As of June 30, 2023	4	3	1	0

Recommendation 1: Retention of Appropriate Validation Documentation

The Department of Central Management Services should ensure a system is in place to track when a validity study was conducted for each title and retain appropriate documentation to confirm that each exam has been properly validated.

Current status: Implemented

Auditors asked Department staff to provide a list of content validity studies for each of the Group A titles and when each study was conducted. Department officials noted that they could potentially provide the information requested through a search of electronic and paper files, but it would be unduly burdensome

and time consuming given the number of exams, limited staff resources, and other pressing projects. Department officials added that data could be provided for specific titles. Due to these limitations, auditors selected a sample of six group A positions titles for tests administered during Fiscal Year 2023. During testing we noted the six tests administered tested retained appropriate documentation to confirm that each exam has been properly validated.

Recommendation 2: Policies and Procedures

The Department of Central Management Services Test Development Section should draft policies and procedures to clarify steps for employees when: developing new examinations; conducting validity studies; and conducting test analyses.

Current status: Partially Implemented

Department officials use the *Uniform Guidelines on Employee Selection Procedures* (29 CFR 1607) and internal checklists for developing position title examinations. The *Uniform Guidelines* provide a framework for determining the proper use of tests and other selection procedures. The Test Development Section also utilizes a checklist for implementing written and automated exams and revising written and automated exams. These checklists are helpful for guiding staff on the steps that need to be accomplished, but the checklist items are fairly technical in nature and do not provide guidance on how to complete them. Policies and procedures would help outline these circumstances and general decision-making while still allowing flexibility. Policies and procedures would also help communicate to Department employees when a validity test should be conducted and circumstances in which employees should consider conducting another validity study on a position title. This could be especially helpful to new employees.

At the time of the performance audit, there were only three employees in the Department's Test Development Section, all of whom had been doing the work a substantial number of years and collected a large amount of institutional knowledge. As a result, losing one or more of these employees could have created a gap in knowledge. Translating some of that institutional knowledge into policies and procedures could help reduce knowledge lost when employees leave or retire. Policies and procedures could also help in the training of new employees, which according to Department officials, takes a very long time. Policies and procedures also help to conform alignment with management's expectations and reduce the risk of process-related errors.

Department officials explained that although their methodologies for validity studies are consistent, how each study is conducted depends on the project. This flexibility allows the Department to customize validity studies to specific position titles. The Department essentially conducts validity studies, or a streamlined version, depending on time constraints, staff resources, prior work done on the position title, and ability of agencies to provide subject matter experts.

During the current examination, Research and Test Development staff worked on the development of supplemental procedures for developing new examinations, conducting validity studies and conducting test analysis; however, the procedures are still pending. The Research and Test Development Section recently moved from a mainframe to a PC-based Statistical Package for the Social Sciences platform, which has caused significant changes in the way statistical analyses is conducted. Research and Test Development staff began the process to update the supplemental procedures, however, due to loss of staff, work-assignment priorities, and limited resources, procedures have not been completed or formalized.

Recommendation 3: Review of Survey Responses Applicable to Exam Content

The Department of Central Management Services Division of Examining and Counseling should create a policy to ensure that any survey responses related to exam content are provided to the Test Development Section.

Current status: Implemented

During the current examination, we noted Research and Test Development staff generate survey response reports monthly since the Division of Examining (now Hiring Resources and Career Services) is no longer responsible for the survey response reports. The monthly reports are accomplished via the reports functionality within the WinCATS (Windows Computer Assisted Testing System) test administration system. The Department reviews and documents the survey ratings and comments; comments or issues related to exam content are documented and processed by Research and Test Development staff; if there are any significant comments or concerns related to the administration of the exams at the test centers, they are forwarded to the Career Services Test Centers.

We reviewed the monthly survey response reports for two months during the examination period. During our review, we noted that each report received contained a title page, which includes a brief overview of the period the reports were run for, the criteria, and the responses from each test broken down by the testing facility. Additionally, the overview page contains information indicating if the report was forwarded to any Career Services Test Centers. We noted that each report tested was properly distributed to the Career Services Test Centers when necessary. Since the Research and Test Development section is now responsible for running the survey response reports it is not necessary to develop a policy for the Division of Examining (now Hiring Resources and Career Services) to forward survey responses to the Research and Test Development section.

Recommendation 4: Retesting Within 30 Days

The Department of Central Management Services should document all instances in which an applicant is allowed to retake tests for the same position title inside of the 30-day restriction and the reason for the retest. In these instances, when necessary, the Department should seek waivers from the Director to maintain compliance with Illinois Personnel Rules.

Current status: Implemented

We conducted an analysis of exam data provided by the Department for Fiscal Year 2022 and Fiscal Year 2023 and found that thirty-nine applicants consisting of 211 entries (out of 73,615 examinations) appeared to allow the test taker to take multiple tests for the same position title within 30 days. Upon inquiry with the Department, the Department provided evidence these were all due to instances where the test was completed one day but the information failed to load in the system until the next day and/or where the test results failed to load and were reloaded when discovered by IT (usually 2-3 days later). It appears the Department documented these instances in which the applicant appeared to retake the test within the 30-day restricted period.

We did note four applicants were allowed to take multiple tests for the same position (consisting of 12 test entries) within 30 days of the original test in Fiscal Year 2022. Multiple retests within 30 days ranged from 15 days after the original exams to 28 days after the original exams. Upon follow up, Department officials stated that it appeared the four test takers were allowed to retest in error, and that there were no special requests or approvals to retest provided by the Director. We did not note any retests within 30 days in Fiscal Year 2023. Since the error rate was insignificant in Fiscal Year 2022 and there were no instances in Fiscal Year 2023, we will consider this recommendation implemented.

Management Audit

ISC Selection Process

House Resolution Number 214 (from the 101st General Assembly) directed the Auditor General to conduct a management audit of the Department of Human Services' (DHS') process for selecting Independent Service Coordination (ISC) agencies for the Fiscal Year commencing July 1, 2019. The audit was released in **April 2020** and contained 13 recommendations. Of the 13 recommendations, **1 is not yet fully implemented**.

Exhibit 16
ISC SELECTION PROCESS – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Information Sharing with the General Assembly	DHS	X		
2	Planning - Necessity of NOFO	DHS	X		
3	Planning - Scoring Parameters	DHS	X		
4	Planning - Development of Administrative Rules	DHS	X		
5	Planning - Policies and Procedures	DHS	X		
6	Planning - Evaluation Team	DHS	X		
7	Planning - NOFO Issues	DHS	X		
8	Planning - Transition	DHS			X
9	Compliance Process Issues	DHS	X		
10	Evaluation - Outlier Scoring	DHS	X		
11	Evaluation - Inconsistent Selection Criteria	DHS	X		
12	Evaluation - Scoring Irregularities	DHS	X		
13	Evaluation - Appeal Review Process	DHS	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2023, auditors followed up on the status of the 10 recommendations not yet fully implemented as reported in the June 30, 2021 report. This was the 2nd time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2021	13	3	8	2
As of June 30, 2023	13	12	0	1

Recommendation 2: Planning - Necessity of NOFO

DHS should verify and document the necessity for conducting competitive grant NOFOs prior to issuing the NOFO.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, DHS did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 3: Planning - Scoring Parameters

DHS should conduct adequate planning in developing scoring parameters for evaluators to follow when conducting competitive grant procurements.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 6: Planning - Evaluation Team

DHS should take steps during the process for selecting evaluation team members to ensure that the members have sufficient time to conduct the evaluations. Additionally, DHS should ensure that individuals with a real or perceived bias do not serve as evaluators on competitive grant procurements.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 7: Planning - NOFO Issues

DHS should ensure that all applicable procedural manuals and rules are complete and up to date before conducting competitive grant procurements.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 8: Planning - Transition

DHS should better follow its own transition plan, both in time and activities, for changes or transitions in any system it maintains. DHS should ensure that it has and maintains all applicable data needed for any transition. Additionally, when DHS seeks outside resources to assist with change, it should allow enough time to receive and consider any feedback it receives.

Current status: Not Implemented

During the current audit, we found that the Department had not conducted any system transitions. The Department acknowledged the need for planning; however, we were unable to conduct any testing to ensure such a plan was followed.

Recommendation 9: Compliance Process Issues

DHS should follow all requirements in the administrative rules when conducting a competitive grant procurement process.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 10: Evaluation - Outlier Scoring

DHS should determine what constitutes a significant difference in scoring and maintain documentation of discussion of scoring differences among evaluators to provide evidence that the scoring process detailed in the Notice of Funding Opportunity was followed.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 11: Evaluation - Inconsistent Selection Criteria

DHS should comply with administrative rules and only award competitive grants based on the criteria presented in Notices of Funding Opportunity. DHS should also consider implementing consistent selection processes across all Department units that are utilizing competitive grant procurements.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 12: Evaluation - Scoring Irregularities

DHS should develop controls for the competitive procurement of grants that include a verification that evaluators followed guidance provided in scoring parameters.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 13: Evaluation - Appeal Review Process

DHS should develop policies and procedures for conducting the competitive grant appeal process. These procedures should include maintaining documentation to support how appeal decisions were determined. Additionally, DHS should consider whether a review of evaluation scores should be part of determining the integrity of the process.

Current status: Implemented/Not Repeated

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Performance Audit

Economic Development for a Growing Economy (EDGE) Tax Credit Program

House Resolution Number 381 (from the 101st General Assembly) directed the Auditor General to conduct a performance audit of the Department of Commerce and Economic Opportunity's (DCEO's) Economic Development for a Growing Economy (EDGE) tax credit program. The audit was released in **June 2020** and contained six recommendations. Of the six recommendations, five **are not yet fully implemented**.

Exhibit 17
EDGE TAX CREDIT PROGRAM – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	EDGE Program Act Modifications	DCEO	X		
2	EDGE Program Act Eligibility Criteria	DCEO		X	
3	EDGE Program Application Documentation	DCEO		X	
4	EDGE Program Monitoring Documentation	DCEO		X	
5	Compliance with Laws, Rules, and Agreements	DCEO		X	
6	Timeliness of Tax Credit Process	DCEO		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the six recommendations. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2022	6	1	5	0

Recommendation 1: EDGE Program Act Modifications

The Illinois Department of Commerce and Economic Opportunity should work with the General Assembly to enact necessary changes to sections of the Economic Development for a Growing Economy Tax Credit Act (35 ILCS 10/) and the Administrative Code (14 Ill. Adm. Code 527) that are either no longer valid or are not feasible.

Current status: Implemented

The performance audit found the EDGE Tax Credit Act (35 ILCS 10/5) (Act) includes requirements and practices no longer used by DCEO. Section 5-40 of the Act, effective August 11, 1999, is titled "Determination of Amount of the Credit"

and gives criteria to consider in determining the amount of the credit to be awarded, such as the potential impact on the economy of Illinois and the capital investment attributable to the project. These factors do not influence the amount of the tax credit, since the tax credit is determined by a set percentage found in Section 5- 5 of the Act. According to DCEO officials, the formulas delineated in Section 5-5 Definitions are used to calculate the tax credit amounts for businesses with EDGE agreements and not the criteria found in Section 5-40.

Section 5-70(6) of the Act requires the EDGE Annual Reports to include copies of the original agreements. This currently is not being done by DCEO. Due to the number and length of these agreements, it is not feasible for DCEO to include them in its Annual Report. However, although not included in its Annual Report, DCEO does post each of the agreements to its website.

Changes were made to the EDGE Tax Credit Act to address the concerns identified in the audit. References to the Illinois Economic Development Board's Business Investment Committee and related provisions were stricken from the EDGE Act by P.A. 102-330, effective January 1, 2022.

Recommendation 2: EDGE Program Act Eligibility Criteria

The Illinois Department of Commerce and Economic Opportunity should seek clarification from the General Assembly related to specific guidance on what evidence is necessary to determine proof of incentives available from other states and guidance related to residency requirements for the EDGE Tax Credit Program.

Current status: Partially Implemented

The performance audit found the Act did not include specific information necessary to adequately administer the program. That included specific guidance on what evidence is necessary to determine proof of incentives available from other states and guidance related to residency requirements. Auditors reviewed the Act and determined the following deficiencies:

- The Act does not provide clear guidance on what evidence, if any, is required as evidence of other state business incentive offers or proof that the business is actually considering another state for the project. The *Review of the Application* sections of the Act (Sections 5-25(b)(3) and (4)) discuss evidence that the credit is essential and the cost differential between Illinois and a competing state. However, the language in the Act is unclear what evidence, if any, is necessary or required.
- The Act does not discuss whether the businesses with the new projects are required to hire Illinois residents or whether residents from surrounding states qualify toward the new employee count. According to DCEO, the tax credits are to support **job creation, capital investment and improve the standard of living for all Illinois residents**, thus implying that Illinois residents are to be the beneficiary of these jobs created by the EDGE tax credits. Further, the Act does not state that Illinois residents must be hired, but it discusses hiring "the required number of New employees in Illinois" and notes the project

shall be "**economically sound and will benefit the people of the State of Illinois by increasing opportunities for employment and strengthen the economy of Illinois.**"

DCEO noted it reviewed the statute and the Department's policy and determined it is not to include a residency requirement or contact other states for proof of incentives.

DCEO noted that there currently is no statute under the EDGE Act or administrative rule that requires an applicant to contact a competing state for an EDGE application in support of an EDGE tax credit. DCEO requires EDGE applicants to provide a certified statement that the credit is essential to the applicant's decision to move forward with the project (a representation repeated in the EDGE agreement) and provide a detailed explanation (with a supporting cost differential) demonstrating that the project has a viable out-of-state option and the project would be more economical outside Illinois. DCEO's EDGE application materials require the company to provide a financial analysis that utilizes a scope of work for a proposed project and compares the cost of the project at an out-of-state location to a proposed Illinois site. This financial and gap analysis is used to determine EDGE eligibility and ensure that EDGE's "but for" requirements are addressed and that the financial value of an EDGE tax credit is needed to offset the cheaper cost of doing business in an out-of-state location. Regarding residency, DCEO noted there remains no statutory requirement that the positions factored into EDGE credit eligibility be filled by Illinois residents other than the credit has no value for positions filled by persons for whom no withholding taxes are paid.

According to DCEO officials, it engaged the General Assembly with proposed legislation. The proposed legislation was not implemented during the time period of the audit. As a result, this recommendation was partially implemented.

Recommendation 3: EDGE Program Application Documentation

The Illinois Department of Commerce and Economic Opportunity should develop internal controls, hire adequate staff, and develop policies and procedures to ensure that it receives and maintains all application documentation required by the Economic Development for a Growing Economy Tax Credit Act (35 ILCS 10/) and the Administrative Code (14 Ill. Adm. Code 527).

Current status: Partially Implemented

The performance audit found that during the testing of applications for the EDGE program, auditors were unable to find an example of a project from 2018 that was not missing at least one piece of required documentation. It appeared that a lack of internal controls, lack of program staff, the loss of staff with institutional knowledge of the program, and a lack of policies and procedures for the EDGE program were the cause of the lack of complete application documentation.

For the current audit, DCEO noted that it has hired an EDGE Program Manager, who is overseeing the collection and records management of all necessary EDGE

application and certification materials. The Department stated it also has a number of skilled Business Development staff members that assist with the collection, organization, and maintenance of EDGE materials. Further, DCEO is in the process of hiring an Industrial and Community Development Representative and has a Graduate Public Service Intern starting in August 2022. Additionally, DCEO has leveraged a Personal Services Contract to deepen its subject matter expertise and train and adopt a continuous improvement model for EDGE processes, as well as contracted temporary administrative support to file, scan and organize previous year's EDGE program materials.

DCEO noted it currently utilizes a Customer Relations Management Software that can be used throughout all processes of the EDGE Program. The Program has received licenses for its Business Development team members in Salesforce, a Customer Relations Management software, and is currently working to adopt Salesforce throughout its business development pipeline. DCEO noted it intends to transition from the Customer Relations Management Software to the Salesforce platform to upload all program documents, including the application, reports, and certifications. The timeline to train staff on use of the system is late 2022 and early 2023.

Since the controls and new system were not in place for review during this audit, the recommendation was partially implemented.

Recommendation 4: EDGE Program Monitoring Documentation

The Illinois Department of Commerce and Economic Opportunity should develop internal controls, hire adequate staff, and develop policies and procedures necessary to reconcile its EDGE program monitoring documentation sources and generate an accurate listing of active EDGE agreements and tax credits issued. Additionally, DCEO should create a unique project numbering system and maintain complete and accurate programmatic documentation necessary to report on effectiveness such as jobs created or retained and the revenue impact of the program.

Current status: Partially Implemented

The performance audit found that due to conflicting EDGE programmatic information from multiple sources provided by DCEO, auditors were unable to accurately conduct an analysis of the amount of tax credits approved, the number of jobs created or retained, and the total amount of capital investment. Therefore, an analysis of the amount of tax credits approved and the number of jobs created or retained by the EDGE program was not included within the report. Auditors concluded that the lack of controls, lack of program staff, the loss of staff with institutional knowledge of the program, and a lack of policies and procedures for the EDGE program were the cause of the lack of complete and accurate monitoring documentation.

For the current audit, DCEO stated it has made progress towards building out the Business Development bureau and the EDGE program management team. This

includes hiring a full-time EDGE Program Manager, Assistant Director for Business Development, and support provided via a Personal Services Contract.

DCEO noted it leveraged a Personal Services Contract to deepen its subject matter expertise and train and adopt a continuous improvement model to EDGE processes. DCEO also noted it has contracted temporary administrative support to file, scan, and organize previous year's EDGE program materials.

DCEO stated it manages the EDGE tax certification process by requesting EDGE annual reports, Agreed Upon Procedures Reports for first-time claimants, and other documentation to ensure it is tracking annual EDGE tax certificates including total EDGE annual credit value, number of jobs created and retained, total payroll, investment total and total EDGE certification value overall. The tax credit certification process entails a structured and detailed review of an EDGE recipient's payroll report to ensure eligibility of reported jobs and calculation of incremental income tax.

DCEO also noted it publicly posts EDGE agreements to its website, including a summary of the EDGE agreement execution date, project location, number of new employees job target, number of retained employees job target, estimated value of credit, and if applicable, the underserved location status. DCEO stated it has instituted a policy regarding a naming convention for all projects, supported and supplied documentation. The system consists of Agreement Year, Company Name, Location, Type of Document (ex. 2022 Smith Brothers Jacksonville Agreement).

Since the controls and new system were not in place for review during this audit, the recommendation was partially implemented.

Recommendation 5: Compliance with Laws, Rules, and Agreements

The Illinois Department of Commerce and Economic Opportunity should comply with the Economic Development for a Growing Economy Tax Credit Act and should: evaluate the EDGE program on a biennial basis as required by Section 5-75; provide sufficient personnel for operation of the EDGE program as required by Section 5-10(g); seek clarification by the General Assembly on how to proceed with the makeup of the Business Investment Committee, Section 5-25, since the Illinois Economic Development Board was repealed on July 20, 2018; develop procedures to obtain documentation that substantiates any offers or prospects from other states as required by Section 5-25; and ensure that the information in its Annual Reports is complete and accurate.

Current status: Partially Implemented

The performance audit found that while DCEO was meeting many of the basic requirements of the EDGE Tax Credit Act, it was not in compliance with several applicable sections of the Act due to a lack of internal controls. In addition, DCEO did not have any policy and procedure manuals to help employees administer the program. Auditors concluded that since DCEO was not in compliance with laws, rules, and agreements, it cannot effectively administer the EDGE tax credit program.

For the current audit, DCEO noted it has continued to release a biennial report on the effectiveness of the EDGE program and released the 2021 Biennial Report on the EDGE Tax Credit Program. In addition, DCEO stated it made significant progress towards adding key team members to the Business Development bureau and the EDGE program management team.

Finally, DCEO noted it is working to update and finalize its EDGE policy guide and training manual. DCEO stated both tools provide guidance and resources for the DCEO's management of the EDGE program and the individual retained utilizing a Personal Services Contract will help finalize and implement the updated EDGE policy manual by the end of the 2022 calendar year.

Since the policy guide and training manual were not in place for review during this audit, the recommendation was partially implemented.

Recommendation 6: Timeliness of Tax Credit Process

The Illinois Department of Commerce and Economic Opportunity should ensure that businesses are providing the required information, and it is issuing tax credits within the required timeframes outlined in the EDGE agreements.

Current status: Partially Implemented

According to the performance audit report, a lack of controls, lack of program staff, and a lack of policies and procedures for the EDGE program caused tax credits to be processed and provided to businesses in an untimely manner. As a result, Illinois businesses enrolled in the EDGE tax credit program did not receive their contractually earned tax credits timely from DCEO.

For the current audit, DCEO indicated it has made progress towards building out the Business Development bureau and the EDGE program management team. That included hiring a full-time EDGE Program Manager. As stated above, DCEO also indicated it has leveraged a number of skilled subject matter experts within Business Development.

DCEO indicated it works diligently to manage hundreds of active EDGE agreements, which includes reviewing and processing their annual EDGE reports necessary to issue EDGE agreement recipients with their annual tax certificate on the correct and allowable timeline. DCEO noted that companies that do not complete their EDGE annual reports in a timely fashion are required to submit reasons for their submission delay and are required to receive an extension through the Business Development Committee. It was further noted that review of EDGE annual reports includes, but is not limited to, the verification of the number of jobs created or retained and capital investment made against the commitments made in the EDGE agreement.

DCEO noted that for companies that have a December 31 tax year end date, the Department's records show that there were approximately 41 companies that were not issued EDGE tax certificates within the required 60 days. This information is as of July 1, 2022.

Many of these companies submitted incomplete information necessary to develop an EDGE tax certificate. This due diligence is completed by the Business Development team in partnership with Legal. Companies that had significant delays beyond the required 60 days were required to receive approval for late submission from the Department.

Since EDGE tax certificates were not issued within the required 60 days during this audit, the recommendation was partially implemented.

Performance Audit

Department of Children and Family Services LGBTQ Youth In Care

Senate Resolution Number 403 (from the 101st General Assembly) directed the Auditor General to conduct a performance audit of the Department of Children and Family Services' compliance with its obligations to protect and affirm children and youth who are lesbian, gay, bisexual, transgender, questioning, or queer (LGBTQ). The audit was released in **February 2021** and contained 16 recommendations. Of the 16 recommendations, **12 are not yet fully implemented**.

Exhibit 18
DEPARTMENT OF CHILDREN AND FAMILY SERVICES LGBTQ YOUTH IN CARE – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Computer Systems and Tracking	DCFS			X
2	Reviewing Rights with Youth in Care	DCFS			X
3	LGBTQ Procedures	DCFS			X
4	LGBTQ Training	DCFS	X		
5	Oversight and Monitoring of Appendix K	DCFS		X	
6	Complaints	DCFS	X		
7	Child/Caregiver Matching Process	DCFS			X
8	Shelter Bed Availability	DCFS		X	
9	Foster Home Recruitment	DCFS	X		
10	LGBTQ Youth in Care Information	DCFS			X
11	Foster Care Files	DCFS	X		
12	Sibling Visitation Plans	DCFS		X	
13	Normalcy Activity Documentation	DCFS			X
14	Emergency Placements	DCFS		X	
15	Psychiatric Lockouts	DCFS		X	
16	Waiting for Placement Report	DCFS		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the 16 recommendations. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2022	16	4	6	6

Recommendation 1: Computer Systems and Tracking

The Department of Children and Family Services should ensure that it is accurately capturing youth in care data. Additionally the Department should consider: implementing a single case management system for all youth in care; and electronically tracking clinical referrals, which would include LGBTQ referrals.

Current status: Not Implemented

The OAG's February 2021 audit found that the Department was reliant on outdated, inadequate, and sometimes nonexistent computer systems for tracking and maintaining data and files for youth in care. Having outdated, and in some cases non-existent, electronic systems to track data for youth in care made it difficult to collect and analyze information related to certain aspects of the audit resolution. It also made it difficult for the Department to track and produce relevant information. In some cases information must be continuously manually manipulated in order to produce the information that is available.

The Department utilized multiple computer systems, primarily SACWIS (Statewide Automated Child Welfare Information System) and CYCIS (Child and Youth Centered Information System). Officials maintained a separate database for youth in care that is populated with data from both SACWIS and CYCIS. Maintaining two case management systems that require data to be pulled from both and combined increases the risk that inaccurate data may be produced. Having two case management systems can lead to data not matching between the two systems. For instance, permanency goals are listed in both SACWIS and CYCIS. There are different SACWIS and CYCIS codes for the permanency goals and the language might not match between the two sources.

The OAG auditors also found that the Division of Clinical Practice did not effectively track LGBTQ youth in care because there is no computer system that tracks clinical referrals. During the audit period the LGBTQ Coordinator was located in the Division of Clinical Practice. Because there were no fields in SACWIS that capture LGBTQ data, the only way LGBTQ youth in care are tracked was through referrals to the Division of Clinical Practice. Referrals were received in a variety of ways, including through faxed or emailed referral forms, phone calls, or emails. Information on youth in care with referrals was tracked through a shared file directory with access limited to clinical staff who need to know the information. Additionally, the LGBTQ Coordinator and the Deputy Director of Behavioral Health each maintained separate spreadsheets of the LGBTQ youth in care that have been referred to the Division of Clinical Practice. The use of a shared file directory and spreadsheets maintained by individual employees means that referrals or services received by youth in care cannot be effectively tracked, particularly over a length of time.

During the current examination, the OAG auditors found that the Department had not implemented a single case management system. According to Department officials, the new Comprehensive Child Welfare Information System (CCWIS) will be the sole case management system for DCFS. According to the

Department, the new CCWIS program, which started in July 2022, after the audit period, includes a data cleansing of the child welfare data for movement to the new system. This should improve the quality of child welfare data. Additionally, the program includes the development of a Data Quality Plan for the Department to monitor data quality.

The OAG auditors found that the Department also had not implemented an electronic clinical referral system. According to Department officials, the CCWIS program will include the ability for case workers to submit and track referrals to providers electronically.

Recommendation 2: Reviewing Rights with Youth in Care

The Department of Children and Family Services should ensure that all Department and private agency caseworkers review the CFS 496-1 form (Illinois Foster Child and Youth Bill of Rights form) with all youth in care within the first 30 days of coming into care, every six months prior to the administrative case review, and annually as is required by statute and Department procedures.

Current status: Not Implemented

The OAG's February 2021 audit found that the Department was not ensuring that caseworkers review the Foster Children's Bill of Rights Act with youth in care as is required by law and in accordance with Department procedures. Each youth in care, by law, has the right to receive a copy of the Foster Children's Bill of Rights and have it fully explained by the Department when they are placed in the care of the Department (20 ILCS 521/5(28)).

In order to document the review of the Foster Children's Bill of Rights with the youth in care, the Department utilizes the Illinois Foster Child and Youth Bill of Rights form (CFS 496-1 form).

To determine if a CFS 496-1 form was being completed for each youth in accordance with applicable statutes and Department procedures, the OAG auditors requested the files for a random sample of 68 youth that were in the care of the Department during 2017-2018. The OAG auditors also requested the files of 91 youth in care that the Department identified as LGBTQ. The OAG auditors received 132 of the 159 files requested. Four youth in care did not require a 496-1 form during 2017-2018.

- For 71 of 128 (55.5%) youth in care, the OAG auditors could not document that a CFS 496-1 form was ever reviewed with the youth in care during 2017-2018.
- For 52 of 128 (40.6%), a signed form was in the file but there were also missing forms. Only 5 of 128 (3.9%) files had all the required CFS 496-1 forms.

Failing to review the CFS 496-1 forms with youth in care means that youth in care and/or their caregivers might be unaware of the youth's rights and where to seek help for addressing potential violations of those rights.

During the current examination, the OAG auditors found that the Department has not improved in reviewing CFS 496-1 forms. The OAG auditors requested files for 25 youth in care, and 24 required CFS 496-1 forms. The Department provided a total of 19 forms for 16 youth in care that were completed during FY21 and FY22. For 8 youth (33.3%), the OAG auditors noted the Department could not demonstrate a CFS 496-1 form was ever reviewed with the youth in care during FY21 and FY22.

Recommendation 3: LGBTQ Procedures

The Department of Children and Family Services should conduct a review of all statutes, administrative rules, Department procedures, and forms to ensure a consistent LGBTQ policy throughout the Department and to eliminate any conflicts within existing procedures.

Current status: Not Implemented

The OAG's February 2021 audit found that the Department did not implement the requirements of DCFS Procedures 302 Appendix K (Appendix K) in a timely manner. Further, the Department failed to monitor the requirements of Appendix K including whether Purchase of Service (POS) agencies have adopted LGBTQ policies that are at least as extensive as Appendix K. Other Department procedures also have not been updated to reflect the requirements in Appendix K. Although Appendix K was updated in May 2017, the Department did not implement some requirements in a timely manner and others had not been fully implemented as of December 31, 2018.

The OAG auditors also found that the Department did not have consistent policies for the treatment of LGBTQ youth in care. The requirements of Appendix K have not been incorporated into other procedures such as those for licensing foster homes, permanency planning, and placement and visitation services.

During the current examination, the OAG auditors found that none of the statutes, administrative rules, or Department procedures had been updated since the release of the performance audit. Additionally, while the Department provided drafts of updates to procedures, including Procedure 302 Appendix K, and forms, all the provided drafts were in the process of finalization and not yet implemented. Therefore, no changes were made to DCFS statute, rules, procedures, or forms by June 30, 2022.

Recommendation 4: LGBTQ Training

The Department of Children and Family Services should fully implement and provide the training required by Appendix K. This would include: ensuring that all required individuals have completed training; ensuring that annual training is given as required to all child welfare workers, including those at POS agencies; continuing to work to revise PRIDE training for foster parents to include training for LGBTQ competency; and requiring employees of residential facilities that serve youth in care of the Department to complete LGBTQ competency training.

Current status: Implemented

The OAG's February 2021 audit found that the Department did not implement the training requirements contained in the Foster Children's Bill of Rights Act and those of Appendix K to Procedures 302 in a timely manner. Although Appendix K to Procedures 302 was updated in May 2017 to require training in LGBTQ competency, the Department did not begin training staff until more than two years later in June 2019. The OAG auditors found that there are a large number of staff that have not received the training required by Appendix K. For example, according to the Office of Learning and Professional Development, for FY18 there were 2,812 POS agency staff that needed to receive ongoing training for their child welfare employee licenses alone and, as of January 22, 2020, only 1,390 POS agency employees had completed the training (49.4%). Further, the Department was not timely in updating training materials for certain populations that were required to receive training in LGBTQ competency. The Department also does not require staff at residential facilities to receive training in LGBTQ competency.

During the current examination, the OAG auditors found that the Department had policies in place to ensure all required individuals had completed the training, revised the training for foster parents, and is providing LGBTQ training to employees of residential facilities.

According to Department officials, the Department tracks "Office of Learning and Professional Development (OLPD) offered trainings through Virtual Training Center (VTC). Supervisors and managers are responsible for ensuring their staff complete required trainings. The VTC sends out reminders to the identified target staff and their supervisor of record via email until the required training is complete." The Department provided a report that showed that as of November 18, 2021, 80.0 percent of DCFS and POS direct service staff, supervisors, and managers had completed the required LGBTQ training. The Department provided data that showed that as of June 30, 2022, 2,974 Department employees, and 3,830 POS employees had completed the training.

The Department provided an information transmittal dated October 25, 2021 that stated that "LGBTQI+ Children and Youth in Care Training is now a mandatory part of the required in-service training for Foster Family Home License." The training is required to be completed as part of the required in-service training for the Foster Family Home License. The license shall not be renewed until the

training was completed. The Department also provided a copy of the LGBTQI+ caregiver training.

The Department is now providing LGBTQ training to employees of residential facilities. The Department provided a training report that showed that 851 employees at 46 facilities had completed the training.

Recommendation 5: Oversight and Monitoring of Appendix K

The Department of Children and Family Services should provide oversight and monitoring of POS agencies for compliance with Appendix K and ensure that all agencies have established policies at least as extensive as those required by their contract and Appendix K.

Current status: Partially Implemented

The OAG's February 2021 audit found that employee and contractor oversight was inadequate to ensure accountability or corrective actions. The OAG auditors contacted the Department's Office of Affirmative Action and the Office of the Inspector General (OIG) to discuss any investigations or actions taken involving LGBTQ discrimination by an employee. According to the Department's Office of Affirmative Action and the OIG there have been no allegations reported alleging discrimination against a youth in care on the basis of sexual orientation or gender identity.

The OAG auditors also found the Department's oversight and monitoring of POS agencies was insufficient and that the Department was not ensuring that agencies had established policies required by Appendix K and their contract agreements. Appendix K requires all agencies to adopt LGBTQ policies that are at least as extensive as Appendix K (including, without limitation, policies providing for employee discipline, up to and including termination, for conduct in violation of the non-discrimination policy). Contract agreements for FY18 and FY19 required that all children and youth be treated in a manner consistent with the Department's non-discrimination guidelines as outlined in the Department's rules and procedures, including but not limited to Appendix K.

The OAG auditors conducted a survey of POS agencies and received survey responses from 51 of those agencies. Of these 51 agencies responding, 39 (76.5%) responded that they had implemented policies that were at least as extensive as Appendix K. Only 14 agencies provided copies of their policies and several of these were either established after the survey was sent or did not discuss discrimination against youth in care.

During the current examination, the OAG auditors found that the Department had provided some oversight and monitoring of POS agencies, however, the Department had not yet ensured that every POS agency has policies that are at least as extensive as Appendix K. The Department's Agency Performance Monitoring and Execution Team (Team) developed field education related to Appendix K and the audit. The goal was to have every POS agency, DCFS leadership and staff receive the training during FY22. A shortened practice tip

sheet/info sheet was developed by Team and distributed in April 2021 to all POS agencies. Additionally, in September 2021 the Department released an information transmittal. The information transmittal was distributed to all POS permanency and intact family services workers and supervisors, foster home licensing representatives and supervisors, ILO/TLP program administrators and staff, and congregate care facility administrators and staff. The information transmittal provided guidance and reaffirmed expectations as it related to support and well-being of LGBTQI+ youth in care. The Team also identified key stakeholders per agency and provided training information for existing staff. According to Department officials, the Department obtained copies of policies from sampled POS agencies to verify policies are as extensive as Appendix K.

Recommendation 6: Complaints

The Department of Children and Family Services should: update the computer system used by the Advocacy Office to log and track complaints; and track recommendations made by youth and the experiences of youth in care that have reported violations.

Current status: Implemented

The OAG's February 2021 audit found that the Department's Advocacy Office computer system was outdated and needed to be improved. Although complaint information was provided for 2017-2018, it had to be compiled manually. The current system also did not allow for case tracking to ensure that the desired outcome is achieved. The Advocacy Office also did not track recommendations made by youth or the experiences of youth in care that have reported violations. The CFS 496-1 form is used to inform youth of care of their rights and how to report violations of those rights. The Department does not document any recommendations from youth in care nor are there any requirements for the Department to track recommendations.

During the current examination, the OAG auditors noted the Department implemented a case management system for the Advocacy Office. According to Department officials, the Case Management System provides the ability for a report that tracks recommendations made by youth in care. The Department provided a download of FY22 complaints to the OAG auditors, which showed a total of 9,958 were received. The data included fields for type of complaint and the outcome.

Recommendation 7: Child/Caregiver Matching Process

The Department of Children and Family Services should follow its matching procedures and ensure that a formal and documented matching process is being utilized for all placements. That process should include an assessment of any sexual orientation or gender identity needs for the youth in care.

Current status: Not Implemented

The OAG's February 2021 audit found that the Department did not follow its procedure that required the use of the Child/Caregiver Matching Tool (CFS 2017

form) for every placement (Procedure 315.75) and to complete required forms for matching youth with placements. Our review of youth in care files for 2017-2018 showed that the required CFS 2017 form was rarely utilized to match youth with caregivers that were willing and capable to provide a stable placement.

The OAG auditors sampled a total of 159 youth in care case files for youth that were in the care of the Department during 2017 and 2018. This included a random sample of 68 youth in care as well as 91 youth in care that the Department identified as LGBTQ. The OAG auditors received 132 of 159 files requested. As part of that review the OAG auditors checked to see if there was documentation that the CFS 2017 form was being utilized as is required and whether the youth's sexual orientation or gender identity was taken into account during the matching and placement process. File testing showed that the form was used very rarely. The OAG auditors determined there were 97 youth that had a new placement during 2017-2018. For the 97 youth files that auditors determined should have contained at least one CFS 2017 form for 2017-2018, the Department could only provide 7 (7.2%). The seven forms were completed between January 2017 and December 2018, with four completed in 2017 and three completed in 2018.

The OAG auditors followed up with the Department on the issues of missing CFS 2017 forms. According to the Department, the use of the CFS 2017 form was suspended in February 2017 in the Lake County and Mt. Vernon Immersion Sites "in an effort to streamline work processes for direct service staff." The practice of suspending the use of the CFS 2017 form was also "informally" rolled out statewide. However, the CFS 2017 form is the only form required by procedures to be used for assessing placements. Without following Department procedures and utilizing the CFS 2017 form, it is unclear how the Department is assessing whether caregivers are capable and willing to provide a stable placement for the youth.

During the current examination, the OAG auditors found that the Department had not implemented changes to the child/caregiver matching process. According to Department officials, the Department has not changed nor updated its procedures requiring a CFS 2017 Form. Additionally, the Department has not updated the procedures for the matching process.

The OAG auditors also noted the Department's matching process does not include any consideration of sexual orientation and gender identity expression (SOGIE). According to Department officials, the new CCWIS will include SOGIE.

Recommendation 8: Shelter Bed Availability

The Department of Children and Family Services should take steps to increase the available number of shelter beds throughout the State.

Current status: Partially Implemented

The OAG's February 2021 audit found that the number of emergency shelter beds in Illinois decreased dramatically between FY15 and FY19, leaving some areas of the State with no beds for youth in crisis. The Department's Statewide Emergency

Shelter System was established to provide children/youth with a safe, nurturing and therapeutic environment during a time of crisis. The Department contracts with private agencies across the State to serve as emergency shelters and to provide the children/youth in the emergency shelter with daily activities including social, emotional, medical, educational and recreational activities. An emergency shelter is intended to serve as a temporary, short-term placement for children/youth and is not considered a long term placement.

The Department provided the OAG auditors with the available number of shelter beds by region for the period FY15-FY19. The total number of shelter beds dropped from 163 in FY15 to 47 in FY19. Cook region shelter beds dropped from 109 in FY15 to 30 in FY18 and FY19. As of FY19, the Central and Northern regions had no shelter beds. The amount of expenditures for Youth Emergency Shelters decreased from $12.9 million in FY17 to $5.4 million in FY19. It is unclear where youth in crisis are taken when no shelter beds exist or when no shelter beds are available. Without an adequate number of shelter beds available, the Department may not always be able to initially place youth in care in an adequate setting. Further, when youth are not properly placed it can put their safety at risk.

During the current examination, the OAG auditors found that as of June 30, 2022 there were a total of 53 shelter beds statewide, an increase of 6 from FY19. The Cook region had 34 beds, the Southern region had 12, the Northern region had 7, and the Central region had no shelter beds. Both the Cook and Northern regions increased the number of beds from FY19 to FY22, whereas the Southern region decreased the number of beds, and there was no change in the Central region. While there was an overall increase in the number of shelter beds, the Southern region saw a decrease and there are still no shelter beds in the Central region.

Recommendation 9: Foster Home Recruitment

The Department of Children and Family Services should continue its efforts to recruit foster homes that are affirming of LGBTQ youth in care.

Current status: Implemented

In The OAG's February 2021 audit, the OAG auditors reported that although the Department had taken some steps to recruit foster homes that are affirming of LGBTQ youth in care, these efforts had not been successful in leading to licensure. The Department provided documentation of events held to specifically recruit LGBTQ affirming foster parents, but documentation provided showed that none of these resulted in a foster parent obtaining a license.

During the current examination, the OAG auditors found that the Department attended multiple Pride events during FY21 and FY22. The Department Chief of LGBTQI+ attended the Illinois State Fair in August 2021 and assisted in recruiting foster parents. Twenty-one inquiries were submitted online within one week of this effort. During FY22, the Department attended four LGBTQI+ specific events, including the Springfield Pride Festival, the Lake County Pride

Festival, the Aurora Pride Festival, and the Chicago Pride Parade. According to the Department, a total of 73 inquiries were received at the events and within one week of those events.

According to the Department, while many recruitment events during FY21 were cancelled due to COVID-19, Department officials attended a total of 88 events during FY21 and FY22. These events included other events that were not specific to any Pride events. The Department held both in person and virtual recruitment presentations. During FY21 and FY22 the Department collected a total of 13,908 inquiries and 2,861 qualified potential foster parents were referred to be licensed.

Recommendation 10: LGBTQ Youth in Care Information

The Department of Children and Family Services should solicit information from youth in care willing to provide it regarding their sexual orientation and gender identity for purposes of placement as well as identifying and offering any necessary services.

Current status: Not Implemented

In the OAG's February 2021 audit, the OAG auditors reported that the Department did not have a formal process in place to identify LGBTQ youth. Therefore, the OAG auditors could not determine with any accuracy the total number of LGBTQ youth in care. As part of our initial documents request, the OAG auditors asked for any data reports generated related to LGBTQ youth in care. DCFS officials responded that, "There are no fields within our system that capture information on LGBTQ, either for youth, clients or providers. As such, there are no reports that provide information on this data."

The OAG auditors asked Department officials responsible for LGBTQ coordination during the audit period to provide us with a list of LGBTQ youth in care for 2017 and 2018. A Department official provided a list that included a broad sweep of the referrals received within the Division of Clinical Practice with LGBTQ circumstances. This manual process was used by the Department to identify LGBTQ youth in care since data regarding sexual orientation and gender identity are not captured in SACWIS. The data provided by the Department was not always accurate and included some youth who were not in the care of the Department but were referred to the Division of Clinical Practice because of an investigation or adoption involving an LGBTQ youth. After analyzing the information provided, we determined that there were 91 unique LGBTQ youth on the list provided by the Department.

However, the 91 LGBTQ youth on the Department's list was not a complete and accurate number. During fieldwork testing the OAG auditors identified eight youth who were listed as LGBTQ by the Department but there was no documentation they actually identified as LGBTQ. The OAG auditors also identified 17 additional youth in care who may have identified as LGBTQ who were not on the list provided by the Department. These youth were identified during fieldwork testing and in information received from the Department's Monitoring Unit and the Advocacy Office. Further, as part of our survey, POS

agencies were asked if they were aware of any LGBTQ youth in care and how many. Thirty-four agencies that provided case management services responded with a total of approximately 200 youth in care.

During the current examination, the OAG auditors noted the Department had not started collecting information on LGBTQ youth in care as of June 30, 2022. The Department provided screenshots of what the pages in SACWIS will look like, but according to Department officials, it would not be implemented until October 2022. The Department did provide information on a survey that was distributed to youth in care in order to gather data on LGBTQ youth, however it was an anonymous survey and was still in progress as of June 30, 2022.

Recommendation 11: Foster Care Files

The Department of Children and Family Services should ensure that all foster care files are properly maintained.

Current status: Implemented

In the OAG's February 2021 audit, the OAG auditors reported that the Department was unable to provide all requested youth in care files. Auditors requested the hard copy files for the 68 sampled youth in care and 91 LGBTQ youth in care. The list was initially sent to the Department on April 29, 2020, and the first files were received June 19, 2020. Files continued to be received through August 13, 2020. The Department had to obtain the files from Department and POS agency field offices in all four regions across the State. The Department was provided the list of files that were not provided on September 15, 2020, and the Department requested time to provide more files. The Department was able to provide 26 additional files. Auditors received 132 of the 159 total requested files (83.0%). Auditors did not receive 10 of 91 (11.0%) of the LGBTQ files and 17 of 68 (25.0%) of the general population sample. Of the 27 files that were not received, 24 were closed cases. The Department had five months to provide the files yet could not provide 17.0 percent of the files.

All youth in care files, whether open or closed, should be maintained in an easily accessible location. During testing auditors found examples of youth in care coming back into care after failed adoptions or coming into care multiple times. In these instances it is necessary to have the old files available to caseworkers to learn the history of the youth in care.

During the current examination, the Department provided the OAG auditors documentation of 25 of 25 requested files for testing.

Recommendation 12: Sibling Visitation Plans

The Department of Children and Family Services should: ensure that sibling visitation plans are created for all youth in care who require one; ensure that all sibling visitation plans are completed in a timely manner; and clarify the timeliness requirement between the Juvenile Court Act of 1987, the Illinois Administrative Code, and Department Procedures.

Current status: Partially Implemented

In the OAG's February 2021 audit, the OAG auditors reported that the Department did not always create sibling visitation plans in a timely manner. Data provided by the Department showed that there were 6,189 sibling visitation plans involving 8,703 youth in care that were in effect during 2017 and 2018. Most plans were in effect for one year. Whether the sibling visitation plans were being followed was included as part of sample testing. Forty-eight of 159 youth in care (30.2%) had a sibling visitation plan. Of the 48 youth in care with a sibling visitation plan, 25 had documentation to show that the sibling visitation plans were being followed. There were seven youth in care without a sibling visitation plan that should have had one.

The Juvenile Court Act of 1987 requires that when a child comes into care and the child has siblings in care, the Department shall file with the court a sibling placement and contact plan within 10 days, excluding weekends and holidays (705 ILCS 405/2-10(2)). Department rules (89 Ill. Adm. Code 301.220(c)) and Department Procedure 301.230 require that when siblings enter care and are not in joint placement, the caseworker shall complete and file a Visitation and Contact Plan with the juvenile court within 10 days. The timeliness requirements between the statute and administrative rules/procedures do not match. The statute requires 10 business days (excluding weekends and holidays) whereas the administrative rules require 10 calendar days.

There were 14 cases sampled where a youth or sibling came into care during 2017-2018 and needed a sibling visitation plan (6 LGBTQ). Of those 14 cases, 8 (4 LGBTQ) had a plan established more than 10 calendar days after the temporary custody date. Failing to create sibling visitation plans in a timely manner can lead to youth in care not maintaining familial ties with their siblings.

During the current examination, the OAG auditors found that the Department is creating sibling visitation plans when required, but not all plans were created in a timely manner. Additionally, the Department did review the timeliness requirement between the Juvenile Court Act of 1987, Department rules, and Department procedures. Auditors sampled 25 youth in care; of those sampled that required a sibling visitation plan, there were none missing a sibling visitation plan. Auditors also sampled 10 youth in care who came into care during FY22 and had a sibling visitation plan. For the 10 youth in care, 6 (60.0%) had a plan established more than 10 calendar days after the temporary custody date.

The Department reviewed the various provisions of the Juvenile Court Act of 1987, the Illinois Administrative Code and department procedures related to the

Sibling Visitation Plan to address the time frames in which the Sibling Visitation Plans should be completed by to determine whether any changes are required to be made to the department's procedures. The Department determined that no change was required. The Department stated that procedures are purposely more restrictive than the Juvenile Court Act of 1987.

Recommendation 13: Normalcy Activity Documentation

The Department of Children and Family Services should ensure that discussions of normalcy activities are documented in case contact notes, as required by Department Policy Guide 2017.07.

Current status: Not Implemented

In the OAG's February 2021 audit, the OAG auditors reported that caseworkers were not documenting discussions of normalcy activities as required by Department Policy Guide 2017.07. Caseworkers should discuss normalcy parenting with the caregiver at each monthly home visit, and those discussions should be documented in contact notes. Auditors found that for 75 youth in care sampled, there was some evidence of normalcy activities, including 54 LGBTQ youth in care. However, auditors also found that 82 of 95 (86.3%) youth in care did not have consistent documentation of caseworkers discussing normalcy activities and recording the discussion in contact notes. For some youth in care reviewed, normalcy activities were not applicable.

The Department defines normalcy as "allowing youth in care the opportunity to participate in age-appropriate enrichment, extra-curricular and social activities." According to the Children and Family Services Act (20 ILCS 505/7.3a(c)(1)), each child who comes into the custody of the Department is fully entitled to participate in appropriate extracurricular, enrichment, cultural, and social activities in a manner that allows the child to participate in his or her community to the fullest extent possible.

For youth in care sampled, it was sometimes difficult to track normalcy activities due to several factors, including whether a youth in care could participate. Not all youth in care could participate in normalcy activities, either due to age or being in psychiatric hospitals or detention facilities.

During the current examination, the OAG auditors found that normalcy discussions were not being consistently documented during the monthly home visits. Auditors tested 25 youth in care, and found that for 3 youth in care, normalcy activities were not applicable. For the remaining 22 youth in care, 17 had some discussion of normalcy, however, 20 of 22 (90.9%) youth in care did not have consistent documentation of caseworkers discussing normalcy activities and recording the discussion in contact notes.

Recommendation 14: Emergency Placements

The Department of Children and Family Services should: ensure that youth in care are not placed in emergency shelters after a psychiatric hospitalization in accordance with Department procedures; and consistently and accurately track emergency placements.

Current status: Partially Implemented

In the OAG's February 2021 audit, the OAG auditors reported that youth in care were remaining in emergency shelters and emergency foster care placements for more than 30 days. Department Procedure 301.55(b) states that placement in an emergency shelter should not exceed 30 days. Of the 159 youth in care the OAG auditors reviewed, there were 23, including 22 LGBTQ youth, who had an emergency placement. Twelve of 22 LGBTQ youth in care (54.5%) remained in an emergency placement for more than 30 days. Nine of the youth in care were in shelters, two in emergency foster care, and one youth in care had placements in both a shelter and emergency foster care that were longer than 30 days.

The OAG auditors also found that youth were placed in shelters after being discharged from psychiatric hospitalizations in violation of Department procedures. Department Procedure 301.55(c)(3) states that, "children/youth shall not be placed into an emergency shelter directly from a stay in a psychiatric inpatient unit." During testing the OAG auditors identified 1 placement where a youth in care was placed in an emergency shelter after discharge from a psychiatric hospital out of 23 shelter placements. While reviewing other shelter placements, auditors identified an additional two youth in care who were placed in a shelter after a psychiatric hospitalization discharge.

The Department also was not accurately recording emergency placements. During testing auditors noticed inconsistencies in how the Department listed emergency placements. Auditors found that youth were placed in emergency shelters, but the placements were not listed as shelters. By not listing placements as emergency shelters the Department makes it difficult to accurately track placements. Also, by listing the same emergency shelter as multiple foster home placements it can make it appear as though a youth in care has not remained in an emergency placement for longer than 30 days.

During the current examination, the OAG auditors found that the Department did not place youth in a shelter after discharge from a psychiatric hospital, and there were inconsistencies in the tracking of emergency placements. During testing, auditors did not find any examples of the Department placing a youth in a shelter after discharge from a psychiatric hospital. There were still inconsistencies in how emergency placements are tracked. Emergency placements can be classified as different types of placements, for example:

- An emergency shelter was "Youth Emergency Shelters," "Institution Private," and "Intensive Placement Stabilization";
- An emergency shelter was "Youth Emergency Shelters" and "Group Home"; and

- An emergency placement was both "Group Home," and "Intensive Placement Stabilization."

Recommendation 15: Psychiatric Lockouts

The Department of Children and Family Services should ensure that protective custody of psychiatric lockout patients is taken within 48 hours as required by Department Procedures 300.

Current status: Partially Implemented

In the OAG's February 2021 audit, the OAG auditors reported that the Department was not taking psychiatric lockout youth in care into protective custody in a timely manner, as required by Department procedures. A psychiatric lockout occurs when a youth is psychiatrically hospitalized and the parents/guardians refuse to pick up the youth when the youth is ready for discharge. Procedures 300 require that if a lockout cannot be resolved within 48 hours, the youth shall be taken into protective custody.

OAG auditors reviewed all youth who came into care and an investigation was initiated for a psychiatric lockout during 2017 and 2018 and found that in 142 of 161 instances (88.2%) the Department was not taking protective custody within 48 hours. For 44.7% of cases the youth was taken into protective custody more than one month after the investigation began, with a maximum of 182 days. This causes the youth in care to be listed as beyond medical necessity for fewer days than is actually the case.

During the current examination, the OAG auditors found that the Department improved on taking protective custody within 48 hours. Auditors sampled 25 youth who came into care and an investigation was initiated for a psychiatric lockout during FY22. In 16 of 25 instances (64.0%) the Department did not take custody within 48 hours. In four cases (16.0%), the youth was taken into protective custody more than one month after the investigation began, with a maximum of 76 days.

While the Department is still not taking custody within 48 hours for more than half of the sampled youth, there was improvement from the previous audit, particularly with cases taking more than one month.

Recommendation 16: Waiting for Placement Report

The Department of Children and Family Services should: ensure the Youth in Care Waiting for Placement reports are filed in a timely manner; ensure the Youth in Care Waiting for Placement reports meet the statutory requirements of the Act; and verify that the data used to create the Youth in Care Waiting for Placement reports is accurate and that accurate data is provided to the General Assembly.

Current status: Partially Implemented

In the OAG's February 2021 audit, the OAG auditors reported that Department was not providing accurate and complete information to the General Assembly in

the required Youth in Care Waiting for Placement annual report. Public Act 100-0087 amended the Children and Family Services Act to require that no later than December 31, 2018, and on December 31 of each year thereafter through December 31, 2023, the Department shall prepare and submit an annual report, covering the previous fiscal year, to the General Assembly regarding youth in care waiting for placements. The report must include data on three types of placements:

- emergency placements, including shelters and emergency foster homes, for longer than 30 days;
- psychiatric hospitalization beyond medical necessity; and
- remaining in a detention center or Department of Juvenile Justice (DJJ) facility solely because the Department cannot locate an appropriate placement (20 ILCS 505/2.2).

The Department filed the December 31, 2019 report (for FY19) on January 13, 2020, almost two weeks after the deadline.

The Department is required to provide data on the number of youth in care who remained in a detention facility or Department of Juvenile Justice facility solely because the Department cannot locate an appropriate placement for the youth. However, the reports the Department has filed with the General Assembly contain data on youth who remained in a detention facility more than 15 days past their discharge date, and there is nothing in the statute that allows for the Department to exclude youth who remained less than 15 days. The reports filed by the Department do not provide a clear explanation why the decision was made to only report youth held longer than 15 days. While conducting an analysis of the FY19 shelter/emergency placement and detention/DJJ data, inaccuracies were discovered including:

- 29 youth in care who should not have been listed in the report because they were listed as being in an emergency placement since 2016 or 2017 but were shown in SACWIS as not having any shelter placements during FY19;
- 12 youth in care who should not have been listed in the report because they had a detention/DJJ release date before the beginning of FY19; and
- 13 youth in care who should not have been listed in the report because they were listed as still being held in a detention facility but were shown in SACWIS as having been released from the facility prior to the beginning of FY19.

These problems caused the number of youth in care who are listed in the Waiting for Placement report to the General Assembly to be overstated. Auditors could not draw conclusions about the beyond medical necessity data because an analysis could not be conducted due to data limitations. The data provided by the Department did not include the discharge date nor the date the youth was beyond medical necessity. Therefore, no date calculations could be conducted nor could the number of days beyond medical necessity be verified.

Auditors compared the FY19 waiting for placements data to the fieldwork testing data for the 159 sampled youth in care. Even though the audit period only covered the first six months of FY19, out of seven youth in care who were beyond medical necessity, three were not included in the beyond medical necessity data provided by the Department.

During the current examination, the OAG auditors found that the Department provided the FY20 (due December 31, 2020) and FY21 (due December 31, 2021) Youth in Care Waiting for Placement Reports. Both reports were filed late, the FY20 report on September 17, 2021 and the FY21 report on May 4, 2022. The FY21 report included information on the length of stay for emergency placements, beyond medical necessity, and remaining beyond release date. The FY20 and FY21 reports also no longer reference youth remaining in detention beyond 15 days, and instead just refers to beyond the release date. The data used to create the FY21 report includes examples of youth held for less than 15 days beyond the release date. The Department filed the reports late, however, the reports were updated to include required information and follow statutory language.

The Department provided the OAG auditors with the data used to create the FY21 report and the auditors found that there were still issues with data accuracy. The shelter care data included 15 cases where the youth in care had not been in a shelter for more than 30 days as of the end of the fiscal year. Additionally, the detention data had examples of duplicate entries and inaccurate scheduled release dates or placement dates.

Performance Audit

Illinois Power Agency – Future Energy Jobs Act

Legislative Audit Commission Resolution Number 153 directed the Auditor General to conduct a performance audit of the Illinois renewable portfolio standard and the Illinois Power Agency's management of the Renewable Energy Credit procurement process and Adjustable Block Program. The audit was released in **May 2021** and contained one recommendation. **The recommendation is not yet fully implemented**.

Exhibit 19
ILLINOIS POWER AGENCY – FUTURE ENERGY JOBS ACT – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Renewable Energy Percentage-Based Procurement Goals	Illinois Power Agency		X	

Source: Summary of OAG follow-up.

As part of the compliance examination of the Department for the period ending June 30, 2022, auditors followed up on the status of the recommendation. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2022	1	0	1	0

Recommendation 1: Renewable Energy Percentage-Based Procurement Goals

The Illinois Power Agency should continue to work to meet the renewable energy percentage-based procurement goals required by 20 ILCS 3855/1-75(c)(1)(B).

Current status: Partially Implemented

During the current examination, the Agency did not meet the percentage-based renewable energy goals identified in the Illinois Power Agency Act. Section 1-75(c)(l)(B), required the procurement of renewable energy credits to be at least 20.5 percent of the electricity consumed by customers of the three large investor-owned utilities in Illinois by June 1, 2022. Agency officials stated that procured renewable energy as a percentage of the overall energy produced would be about 10 percent.

There are two ways in which renewable energy projects are procured: (1) competitively and (2) through the Adjustable Block Program. During the

performance audit conducted pursuant to Legislative Audit Commission Resolution Number 153, auditors concluded the process in place was both efficient and maximized the dollars spent to increase the renewable portfolio standard in Illinois for the competitive procurement process. However, auditors could not find criteria to use to determine whether funds were maximized or whether they were spent efficiently for the Adjustable Block Program.

After the Audit Report was released on May 11, 2021, the General Assembly passed Public Act 106-0662 (commonly known as the Climate and Equitable Jobs Act or CEJA), which was enacted in September of 2021 and addressed many of the structural issues of the Illinois Renewable Portfolio Standard that led to this audit being conducted.

This included changes to 20 ILCS 3855/l-75(c)(l)(B) including extending the percentage-based goals beyond 2025 to 2040, adding further emphasis on prioritizing procurements that lead to the development of new renewable energy resources, and a focus on new prioritization of the resource mix to be procured.

According to Agency officials, the Agency has not met the percentage-based goals but has made progress in working toward meeting the percentage-based goals by being able to reopen programs, and by conducting new procurements. The Agency's current Long-Term Plans includes a forecast of ongoing and projected activities designed to reach the 2030 target of 40 percent. Due to the length of time needed to develop renewable energy projects, particularly large-scale wind and solar facilities, there is a lag between when renewable energy credits are contracted for, and when the facilities that will produce them actually come online. Through CEJA, the RPS was significantly updated with increased funding, new project categories for the Adjustable Block Program, a new procurement structure for utility-scale renewable procurements, and the adoption of standards related to labor and equity. IPA noted that all of these new provisions added new complexity to administering the RPS. The Agency reopened the Adjustable Block Program in December of 2021 (as it had been closed to new applications to due funding constraints) and 18,200 new project applications have been approved as of May 18, 2023, representing 473 MW of solar capacity, and an additional 250 MW of previously waitlisted community solar projects were able to move forward. Of that 473 MW, only 84.9 MW have been completed and energized by project developers with the balance in various stages of development and construction. The Agency has conducted two procurements for renewable energy credits from utility-scale wind and solar projects in 2022, which will lead to the development of an additional 962.75 MW of Solar and 200 MW of wind, with the next procurement event scheduled for June 2023.

To support meeting the procurement goals of the RPS, the Agency's biannual Long-Term Renewable Resources Plan was also updated and approved by the Illinois Commerce Commission in July of 2022 providing a framework for the Agency's renewable energy activities for 2022 and 2023, and will be updated starting in the summer of 2023, leading to ICC approval in February of 2024. Additionally, the Agency implemented other procurements proscribed by Public Act 102- 0662, including the Coal to Solar procurement, which will support

another 228.6 MW of solar projects, and the Carbon Mitigation Credit procurement, which provides financial stability for three nuclear powerplants and which avoided their closure, which would have been a significant setback to the State's goal of reducing carbon emissions as well as a loss of thousands of jobs and millions of dollars of local property taxes.

According to Agency officials, while challenges remain for the growth of the renewable energy industry in Illinois, including ongoing funding challenges for utility-scale projects, interconnection delays, and supply chain issues, overall, since the release of the performance audit, significant progress has been made.

Performance Audit

Vendor Payment Program

Public Act 100-1089 directed the Auditor General to conduct a performance audit of the Vendor Payment Program. The audit was released in **June 2021** and contained 11 recommendations directed to both the Department of Central Management Services (CMS) and the Illinois Office of the Comptroller (IOC). Of the nine recommendations directed to CMS, **seven are not yet fully implemented**. Of the eight recommendations directed to the IOC, **none are fully implemented**.

Exhibit 20
VENDOR PAYMENT PROGRAM – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Program Administrative Responsibilities	CMS		X	
		IOC		X	
2	Qualified Purchaser Application Period	CMS			X
3	Lack of Documentation to Support Qualified Purchaser Decisions	CMS			X
4	Deferred Payment Reserve Accounts	CMS			X
		IOC		X	
5	Financial Backer Disclosures	CMS		X	
		IOC		X	
6	Misdirected Payments	IOC		X	
7	Monthly Reporting Deficiencies	CMS		X	
		IOC			X
8	Ineligible Accounts Receivable	CMS	X		
9	Violation of Program Terms - Monitoring	CMS			X
		IOC		X	
10	Vendors with More Than One Qualified Purchaser	CMS	X		
		IOC		X	
11	Prompt Pay Interest	IOC			X

Source: Summary of OAG follow-up.

As part of the compliance examination of the IOC for the period ending June 30, 2022, auditors followed up on the status of the eight recommendations directed to the IOC. As part of the compliance examination of CMS for the period ending June 30, 2023, auditors followed up on the status of the nine recommendations directed to CMS. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2022 – IOC	8	0	6	2
As of June 30, 2023 – CMS	9	2	3	4

Recommendation 1: Program Administrative Responsibilities

CMS and the IOC should determine which activities each agency has responsibility for under the Vendor Payment Program and memorialize those responsibilities in an Intergovernmental Agreement.

CMS Current status: Partially Implemented

During the 2021 performance audit, auditors noted the Department and the IOC, while having authority to administer the Vendor Payment Program (Program), do not have any agreement that details the responsibilities of each agency in administering the Program.

During the current examination, the Department stated, "PA 102-291 (eff. 8-6-21) clarified the Department as the program administrator by removing the IOC from the 'authorized to establish and implement' paragraph the Office of the Auditor General relied upon to produce this finding. Taking this into considering, the Department does not see a need for an Interagency Agreement (IGA)."

During the Vendor Payment Program Audit follow-up at the IOC, the IOC provided auditors with a copy of the draft IGA the IOC submitted to the Department, which outlined the roles of each agency in relation to the Program. However, the draft IGA is neither final nor executed.

Auditors disagree with the Department's assertion that the IGA is not necessary. The statute and Program Terms still include the IOC in several administrative functions in consultation with the Department including performance reviews, the ability to terminate both qualified purchasers and/or sub-participants, and the ability to terminate the Program. In order to make any Program related decisions, the Department and the IOC would both need to be actively involved with the above administrative duties.

Additionally, the Department does not include all qualified purchasers' financial backer disclosures on their website. The Department's website defers to the IOC's website for access to all qualified purchasers' financial backer disclosures. As for the qualified purchasers' monthly reporting, both the Department's and IOC's websites contain this information.

IOC Current status: Partially Implemented

CMS and the IOC, while having authority to administer the Vendor Payment Program (Program), do not have any agreement that details the responsibilities of each agency in administering the Program.

During the current follow-up of the audit, the IOC stated Public Act 102-291, effective August 6, 2021, clarified that CMS is the administrator of the Program. The IOC also sent a draft Intergovernmental Agreement (IGA) to CMS on May 25, 2022, and according to the IOC, it has yet to receive a response.

We reviewed Public Act 102-291 and the portion of the State Prompt Payment Act (Act) relevant to the Program (30 ILCS 540/8) and found that the reference to the State Comptroller was removed, and CMS is now solely authorized to establish and implement the Program. Additionally, we reviewed the draft IGA submitted by the IOC to CMS with the stated intent of outlining the roles of each agency in relation to the Program. The draft IGA gives CMS the entire role of Program administration and limits the IOC's Program responsibilities. However, the **draft IGA is neither final nor executed**.

Recommendation 2: Qualified Purchaser Application Period

CMS should comply with State rules and define an application period when it seeks to add qualified purchasers to the Vendor Payment Program.

CMS Current status: Not Implemented

During the 2021 performance audit, the Department failed to document the application periods for those seeking to become qualified purchasers in the Program. The failure led to the Department to inform an Illinois-based minority-owned firm that attempted to become a potential qualified purchaser that the application period was closed. However, the Department subsequently approved four other qualified purchasers over the next three months immediately following this communication.

During the current examination period, the Department stated that they have not pursued additional qualified purchasers for some time and has no plan to do so in the future. The Department also stated, should circumstances change, a documented selection process will be developed at that time.

Recommendation 3: Lack of Documentation to Support Qualified Purchaser Decisions

CMS should perform the review necessary and document the selection process, including testing of applicant information technology capabilities, for qualified purchasers in the Vendor Payment Program.

CMS Current status: Not Implemented

During the 2021 performance audit, the Department identified criteria for selection, however, that criteria was not consistently followed. In addition, the Department could not tell auditors who specifically made the decisions to approve entities seeking to become qualified purchasers and the Department had not maintained documentation to support how qualified purchasers for the Program were selected. Furthermore, from what documentation was available, it appeared the Department allowed and facilitated the purchase of receivables by a qualified

purchaser that did not have all formalized documentation submitted for selection to the Program.

During the current examination period, the Department stated that they have not pursued additional qualified purchasers for some time and has no plan to do so in the future. The Department also stated, should circumstances change, a documented selection process will be developed at that time.

Recommendation 4: Deferred Payment Reserve Accounts

CMS and the IOC should enforce the requirement of the maintenance and review of Deferred Payment Reserve Accounts under the Vendor Payment Program. Additionally, the IOC and CMS should make a definite determination as to whether the existing qualified purchasers are exempt from maintaining a Deferred Payment Reserve Account.

CMS Current status: Not Implemented

During the 2021 performance audit, the Department and the IOC did not enforce Program Terms relative to Deferred Payment Reserve Accounts for the Program.

During the current examination period, the Department stated that the Deferred Payment Reserve Account is a Program requirement but is not mandated by law or rule. The Department believes the requirement is currently in place and being met through the annual Qualified Purchasers' financial disclosures. The Department also stated that the accounts reported as part of the disclosures are Trust Funds set up to illustrate available funds for investment and collateralization.

Auditors agree that the deferred payment reserve account is a Program requirement not found in law or rule. Auditors also note that the deferred payment reserve account requirement found in the Program Terms was the criteria used in the original recommendation and those Terms remain unchanged. However, auditors disagree with the Department's position that the trust fund information detailed in the financial backer disclosures meets the deferred payment reserve account requirement. Auditors also note that the Department's current position was not mentioned during the original performance audit. The requirements, as reported in the original audit, includes that the account: will be maintained as a not-interest-bearing account; will be maintained and tracked by the qualified purchaser with an ongoing accounting of the funds; and **will have a copy of accounting promptly furnished to the Department and the IOC on a monthly basis, no later than 30 days after the end of each month** and otherwise upon request of the Department and/or the IOC from time to time. The trust information reported in the disclosures does not contain the level of detail as required by the Program Terms and the monthly requirement detailed above cannot be met with the annually filed financial backer disclosures.

IOC Current status: Partially Implemented

CMS and the IOC have not enforced Program Terms relative to Deferred Payment Reserve Accounts for the Vendor Payment Program (Program).

During the current follow-up of the audit, the IOC referred to their original response to the audit, which states that all administrative duties related to the operation of the Program do and always have rested with CMS. The IOC also stated that Public Act 102-291 clarified CMS as the administrator of the Program and the IOC further emphasized that this recommendation relates entirely to the function of CMS.

We reviewed Public Act 102-291 and the portion of the State Prompt Payment Act (Act) relevant to the Program (30 ILCS 540/8) and agree that the reference to the State Comptroller was removed and CMS is now solely authorized to establish and implement the Program.

However, in their original response, the IOC agreed that it would seek to clarify the IOC's role via an IGA with CMS. As previously noted, **the IGA is neither final nor executed**. Additionally, the definition of the Deferred Payment Reserve Account is found within the Program Terms. We would note that those Program Terms were the criteria used during the original audit and those Terms remain unchanged and still include the IOC as having responsibility.

Recommendation 5: Financial Backer Disclosures

CMS and the IOC should clarify when the General Assembly expects financial backer disclosures to be filed for the Vendor Payment Program. Additionally, CMS and the IOC should consider revising the joint administrative rules to codify financial backer disclosures, including when those disclosures need to be filed. Finally, CMS and the IOC should ensure that all qualified purchasers are submitting all required information on the financial backer disclosures, and in a timely manner.

CMS Current status: Partially Implemented

During the 2021 performance audit, the Department and the IOC allowed qualified purchasers to submit financial backer disclosures after the fact. Disclosures due July 1, 2020, had yet to be published by the Department by March 31, 2021. The IOC published the disclosures on March 31, 2021. Therefore, the public had 639 days of not knowing who was providing financial backing for qualified purchasers participating in the Program. Auditors found that disclosures were not always filed timely and that the Department and the IOC do not know whether the disclosures are accurate.

During the current examination period, legislation passed (30 ILCS 540/9) to amend the submission date from July 1 to August 1 annually. The Department said they considered the potential of codifying the Financial Disclosure official due date, but said this information is in statute and contained within the Program Terms. For these reasons, the Department said codifying the due date is an unnecessary diversion of State resources and they are choosing to forego codifying the date. As for the terms of the Financial Disclosure information and the timeliness, the Department said they receive the information at the same time as the IOC and if any information is missing, it will be requested of the qualified purchaser with the expectation of a reasonably timely response.

Auditors found that Public Act 102-289, with an effective date of August 6, 2021, indeed clarified when financial backer disclosure reports are to be filed for the Program. Public Act 102-289 changed the due date of the disclosure reports from annually on July 1 to annually on August 1. Additionally, Public Act 102-289 added the following language, 'for the previous fiscal year' regarding what information is to be reported.

As recommended, the Department considered codifying the disclosures, including the date the disclosures need to be filed. After consideration, the Department said they chose not to pursue such codification.

During testing auditors found 1 of 4 (25%) disclosures were not timely filed. The disclosure was filed 129 days late.

IOC Current status: Partially Implemented

CMS and the IOC allow qualified purchasers to submit financial backer disclosures after the fact. Disclosures due July 1, 2020, had yet to be published by CMS by March 31, 2021. The IOC published the disclosures on March 31, 2021. Therefore, the public had 639 days of not knowing who was providing financial backing for qualified purchasers participating in the Vendor Payment Program (Program). We found that disclosures were not always filed timely, and that CMS and the IOC do not know whether the disclosures are accurate.

During the current follow-up of the audit, we found that Public Act 102-289, with an effective date of August 6, 2021, clarified when financial backer disclosure reports are to be filed for VPP. Public Act 102-289 changed the due date of the disclosure reports from annually on July 1 to annually on August 1. Additionally, Public Act 102-289 added the following language, 'for the previous fiscal year' regarding what information is to be reported.

We found the joint administrative rules were not revised to codify when financial backer disclosures need to be filed.

We found the disclosures were timely filed, but a few disclosures are still lacking some required ownership detail.

Recommendation 6: Misdirected Payments

The IOC should take the steps necessary to eliminate sending payments under the Vendor Payment Program to the incorrect entity. Additionally, the IOC should consider having vendors and qualified purchasers contact the IOC when State payments have been misdirected. Finally, the IOC should determine the cost of processing payments on hardcopy warrants for the Program to determine whether it is the most cost effective process.

IOC Current status: Partially Implemented

While the IOC allows State vendors to receive payments electronically, qualified purchasers under the Vendor Payment Program (Program) do not have the same opportunity. Qualified purchasers reported over $7.2 million in payments made under the Program were mailed to a party other than the qualified purchaser. We

found payments mailed to an incorrect qualified purchaser; an incorrect sub-participant; and the vendor as opposed to the qualified purchaser.

During the current follow-up of the audit, the IOC stated the IOC routinely gives verbal reminders on user group calls with agency personnel to encourage care in inputting data on vouchers. The IOC also stated this issue has been discussed in the building of a new SAMS system. The IOC maintains it processes all payments at the direction of the paying agency and cannot change payee information on agencies' vouchers. The IOC reported that it **has not determined the cost of processing payments on hardcopy warrants for the Program** to determine whether it is the most cost-effective process.

Recommendation 7: Monthly Reporting Deficiencies

CMS and the IOC should take the steps necessary to make all monthly reporting criteria be consistent for the Vendor Payment Program. Additionally, CMS and the IOC should confirm that all required information is submitted by the qualified purchasers on the monthly reports.

CMS Current status: Partially Implemented

During the 2021 performance audit, the Department and the IOC did not take the necessary actions to confirm that all qualified purchasers have complied with the monthly reporting requirements for the Program. This resulted in missing data on the monthly reporting that occurred during FY19 and FY20. Additionally, the guidance on what should be reported is inconsistent with the directives from the State Prompt Payment Act (Act).

During the current examination, the Department reported that it ensures the monthly information contains all applicable fields and includes the contract number for monthly reporting purposes.

Auditors reviewed the Act, joint IOC and Department administrative rules, and the Program Terms and found that the monthly reporting criteria remain inconsistent. As previously reported, the joint IOC and Department administrative rules and the Program Terms did not include the criteria from the Act relative to the aggregate number and dollar value of invoices purchased by the qualified purchaser for which no voucher has been submitted. Additionally, auditors reviewed several Fiscal Year 2023 monthly reports and still found missing reporting requirements including: State contract numbers and vouchers numbers.

The Department stated they created a new electronic application that will allow vendors to upload information directly; however, the application is not officially live yet and the Department of Innovation and Technology is working with Qualified Purchasers to ensure correct coding is implemented at the Qualified Purchaser level. According to the Department, this application will electronically pull the needed contract numbers that were once inaccessible via the State's Enterprise Resource Planning system.

IOC Current status: Not Implemented

CMS and the IOC have not taken the necessary actions to confirm that all qualified purchasers have complied with the monthly reporting requirements for the Program. This has resulted in missing data on the monthly reporting that occurred during FY19 and FY20. Additionally, the guidance on what should be reported is inconsistent with the directives from the State Prompt Payment Act (Act).

During the current follow-up of the audit, the IOC reported that it had taken the steps necessary to make all monthly reporting criteria consistent for VPP and confirmed that all required information is submitted by the qualified purchasers on the monthly reports.

We reviewed the Act, the joint IOC and CMS administrative rules, and the Program Terms and found that the monthly **reporting criteria remain inconsistent**. As previously reported, the joint IOC and CMS administrative rules and the Program Terms did not include the criteria from the Act relative to the aggregate number and dollar value of invoices purchased by the qualified purchaser for which no voucher has been submitted. Additionally, we reviewed several FY22 monthly reports and still found missing reporting requirements including State contract numbers, invoice dates, and voucher numbers.

Recommendation 8: Ineligible Accounts Receivable

CMS should enforce the requirements of the State Prompt Payment Act relative to only eligible receivables being included in the assignment agreements submitted by qualified purchasers. If CMS believes the inclusion of receivables less than 90 days old is appropriate it should seek changes to the Act and the Vendor Payment Program Terms.

CMS Current status: Implemented

During the 2021 performance audit, the Department allowed qualified purchasers in the Vendor Payment Program (Program) to submit, for approval acknowledgment, receivables, which were not yet eligible under the State Prompt Payment Act (Act).

During the current examination, the Department stated it will not accept any receivable for processing that has not aged for 90 days. Auditors reviewed all assigned receivables reported by the qualified purchasers on their monthly reports and found that only one of the four qualified purchasers to have a receivable assigned in Fiscal Year 2023. Auditors compared the proper bill dates and the IOC assigned dates for the 164 assigned receivables with this date and found that all receivables assigned were greater than 90 days old.

Recommendation 9: Violation of Program Terms – Monitoring

CMS and the IOC, as the parties responsible for the Vendor Payment Program, should ensure that qualified purchasers operate under the Program Terms relative to the payment process.

CMS Current status: Not Implemented

During the 2021 performance audit, the Department and the IOC allowed qualified purchasers to operate the payment process under the Program in violation of the Program Terms. This can result in one qualified purchaser having a competitive advantage over another if its payment terms are more generous than another qualified purchaser.

During the current examination, auditors found that the Department allowed a qualified purchaser to utilize a payment process **without** having required that purchaser to properly demonstrate its ability to accurately estimate penalty payments prior to payment as required by the Program Terms. The Program terms layout a 90/10 two payment process whereby 90 percent of the receivable purchase price is to be paid as an initial payment to the vendor within 10 days of the Department's acknowledgement and the remaining 10 percent of the receivable purchased is to be paid within 5 days of the qualified purchaser receiving the payment from the State for the prompt payment interest penalty.

The Program Terms allow a qualified purchaser to utilize a three payment process but **only if the qualified purchaser is able to demonstrate to the Department that it can accurately estimate each of the penalty amounts prior to payment.** Auditors found that the qualified purchaser made the initial payment of 90 percent of the receivable to the vendor. The State then paid the total amount of the receivable to the qualified purchaser but did not include the prompt pay interest. The qualified purchaser made a second payment to the vendor toward the remaining 10 percent of the receivable in the amount of interest accrued at the time the receivable was paid to the qualified purchaser. The qualified purchaser then made the third and final payment to the vendor for the balance of the receivable when the State paid the qualified purchaser the entire amount of the prompt pay penalty. Auditors tested the payment process utilized for 30 receivables assigned to the only qualified purchaser having receivables assigned in Fiscal Year 2023. Auditors found that a three payment process was utilized for 20 out of 30 receivables tested.

Auditors asked the Department if the qualified purchaser had made the required demonstration in order to use the three payment process. In response, the Department cited the total outstanding assigned penalty amount, which is included as part of the qualified purchasers' monthly reporting as evidence that the qualified purchaser was able to demonstrate the penalty amounts.

Auditors noted that the amount cited by the Department only includes an overall amount of outstanding assigned penalties and does not show the individual penalty amounts as required by the Terms. Additionally, auditors do not believe this total outstanding assigned penalty amount was the intent of the language in

the Terms. Each qualified purchaser is already required to report this amount on a monthly basis regardless of the payment process. Had it been the intent of the Terms to use this amount for a payment process of more than two payments, there would have been no need to include such additional language in the Terms.

Further, with regard to the Program Terms, the Department stated, "*the Department is also of the position that the agency does not have a monitoring and enforcement role in relation to the performance of this program. Since the inception of the program, the Department's primary responsibility and function in the execution of the program has been to validate the existence of vouchers that were eligible for use…the Department does not have an enforcement capability in the program and* ***does not believe it is the duty of the agency to monitor Qualified Purchaser activity and enforce the program terms on a continual basis.***" Considering the Department's position that is does not believe it is their duty to monitor Qualified Purchaser activity or enforce the Program Terms, it seems impossible that the Department is confirming the accuracy of each of the penalty amounts estimated by the qualified purchaser prior to payment as required by the Terms.

IOC Current status: Partially Implemented

CMS and the IOC have allowed qualified purchasers to operate the payment process under the Program in violation of the Program Terms. This can result in one qualified purchaser having a competitive advantage over another if its payment terms are more generous than another qualified purchaser.

During the current follow-up of the audit, the IOC referred to their original response to the audit. The IOC also stated that Public Act 102-291 clarified CMS as the administrator of VPP and the IOC further stated that this recommendation relates entirely to the function of CMS.

We reviewed Public Act 102-291 and the portion of the State Prompt Payment Act (Act) relevant to the Program (30 ILCS 540/8) and agree that the reference to the State Comptroller was removed and CMS is now solely authorized to establish and implement the Program.

However, in their original response, the IOC agreed that it would seek to clarify the IOC's role via an IGA with CMS. As previously noted, **the IGA is neither final nor executed**. Additionally, at least a portion of the Act (30 ILCS 540/8(g)) still includes the IOC as having monitoring responsibility, "*Each qualified purchaser's performance and implementation of its obligations under subsection (f) shall be subject to review by the Department and the State Comptroller at any time to confirm that the qualified purchaser is undertaking those obligations in a manner consistent with the terms and conditions of the Program.*" We note that changes to the Act address establishing and implementing the Program, not monitoring responsibilities.

Recommendation 10: Vendors with more than one Qualified Purchaser

CMS and the IOC should follow the Program Terms for the Vendor Payment Program and only allow participating vendors to utilize a single qualified purchaser unless that qualified purchaser has violated terms of the assignment agreement or Program. Additionally, CMS should maintain documentation to support why it approved to allow a participating vendor to utilize more than one qualified purchaser at a time.

CMS Current status: Implemented

During the 2021 performance audit, the Department and the IOC did not enforce the Program Terms when they allowed participating vendors to sell receivables among different qualified purchasers.

During the current examination, the Department stated it will not allow any vendor to have more than one qualified purchaser. The Department further stated that this requirement is also public information in the Illinois Administrative Code (74 Ill. Adm. Code 900.125).

Auditors reviewed all assigned receivables by the qualified purchasers on their monthly reports and found that only one of the four qualified purchasers to have a receivable assigned in Fiscal Year 2023. Therefore, all participating vendors were only utilizing a single qualified purchaser.

IOC Current status: Partially Implemented

CMS and the IOC did not enforce the Program Terms when they allowed participating vendors to sell receivables among different qualified purchasers.

During the current follow-up of the audit, the IOC referred to their original response to the audit. The IOC also stated that Public Act 102-291 clarified CMS as the administrator of VPP and the IOC further stated that this recommendation relates entirely to the function of CMS.

However, in their original response, the IOC agreed that it would seek to clarify the IOC's role via an IGA with CMS. As previously noted, **the IGA is neither final nor executed**.

Recommendation 11: Prompt Pay Interest

The IOC should develop a plan for when interest penalty payments should be made under the Vendor Payment Program.

IOC Current status: Not Implemented

The IOC does not have a plan for payment of interest penalties under the Vendor Payment Program (Program). This lack of a plan has resulted in delayed payments, which has a negative impact on both qualified purchasers and State vendors. In our sample of interest payments during FY19-FY20, payments were made between 0 and 547 days from when the State agencies requested the payments.

During the current follow-up of the audit, we found that the IOC has not implemented this recommendation and **continues to disagree with the OAG's recommendation** to develop a plan for when interest penalty payments should be under the Program. The IOC maintains a "plan" is not written per se, but rather a directive of the Comptroller, and which is practiced on an ongoing basis as the Office releases vouchers from funds that require planning from the IOC's cash management team.

The IOC continues to disagree with the OAG and has made no changes since the original audit to address this Recommendation.

Performance Audit

Illinois Prescription Monitoring Program

Legislative Audit Commission Resolution Number 154 directed the Auditor General to conduct a performance audit of the Illinois Prescription Monitoring Program. The audit was released in **September 2021** and contained 11 recommendations directed to both the Department of Human Services (DHS) and the Illinois Department of Public Health (IDPH). Of the 11 recommendations directed to DHS, **7 are not yet fully implemented**. The single recommendation directed to IDPH was not repeated.

Exhibit 21
ILLINOIS PRESCRIPTION MONITORING PROGRAM – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	Fully Implemented Administrative Rules and Interfacing EHRs	DHS	X		
2	Imposing Fines	DHS		X	
3	Lack of Controls Over the Data	DHS		X	
4	Accurate Licensing Data	DHS		X	
5	Sports and Accident Injury Data Reviews	DHS	X		
		IDPH	X		
6	Update the ILPMP Policies and Procedures Manual	DHS		X	
7	Ensure Dispenser Requirements are Completed as Required	DHS			X
8	Ensure Prescribers are Registered with the ILPMP as Required	DHS		X	
9	Program Assessment Issues	DHS	X		
10	Monitoring Issues	DHS		X	
11	ILPMP Committee Weaknesses	DHS	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of DHS for the period ending June 30, 2023, auditors followed up on the status of the 11 recommendations directed to DHS. As part of the compliance examination of IDPH for the period ending June 30, 2023, auditors followed up on the status of the single recommendation directed to IDPH. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2023 – DHS	11	4	6	1
As of June 30, 2023 – IDPH	1	1	0	0

Recommendation 1: Fully Implemented Administrative Rules and Interfacing EHRs

The Department of Human Services should fully implement an ILPMP in accordance with State requirements by ensuring all EHRs are fully interfaced with the ILPMP, as required.

Current status: Not Repeated

The Illinois Controlled Substances Act (Act) required all Electronic Health Record (EHR) systems to interface with the ILPMP by January 1, 2021. In the original performance audit, auditors found all EHRs were not fully implemented and able to interface with the ILPMP by January 1, 2021, as required.

As of June 30, 2023, all EHRs were not fully implemented and able to interface with the ILPMP. However, the Department was in the process of pursuing legislative remedy from this requirement. As of June 30, 2023, Senate Bill 0285 had passed both houses in the General Assembly and had been sent to the Governor for approval. Senate Bill 0285 would amend the Act to state, "*It is the responsibility of any new, ceased, or unconnected healthcare facility and its selected Electronic Health Record system or Pharmacy Management System to make contact with and ensure integration with the Prescription Monitoring Program.*" Senate Bill 0285 would reassign the responsibility for ensuring integration of patient information from the ILPMP and/or the Department to the healthcare facilities and software vendors. Although as of June 30, 2023, the recommendation was not implemented, because Senate Bill 0285 was signed by the Governor and became effective as Public Act 103-0477 on August 3, 2023, the status of this recommendation is not repeated and does not need to be followed up on during the next compliance examination.

Recommendation 2: Imposing Fines

The Department of Human Services should: update the Illinois Administrative Code to align with the Illinois Controlled Substances Act related to imposing fines; and develop a formal plan to help ensure dispensing reporting requirements are being implemented as required.

Current status: Partially Implemented

During the original audit period, the Illinois Controlled Substances Act and the Illinois Administrative Code did not agree on imposing fines for willful failure to report the dispensing of a controlled substance. According to the Act, DHS may impose a fine; however, the Administrative Code stated DHS shall impose a fine.

In addition, there was no formal plan in place to ensure compliance with dispensing reporting requirements.

The Illinois Administrative Code was updated to align with the Act, and both the Administrative Code and the Act state the Department **may impose** a civil fine of $100 per day for willful failure to comply with statutory reporting requirements. However, the Department did not have a formal plan in place to ensure compliance with dispensing reporting requirements by the end of the compliance examination period (or June 30, 2023). Therefore, the status of this recommendation was **partially implemented**.

Recommendation 3: Lack of Controls Over the Data

The Department of Human Services should establish general information technology controls over the data and correct the significant deficiencies related to contractual services, business processes, change control, disaster recovery, and security. Until these deficiencies are corrected, the ILPMP data and reporting with respect to that data cannot be relied upon.

Current status: Partially Implemented

In February 2019, the ILPMP implemented a new feature called *MyPMP*. The ILPMP implemented the *MyPMP* service into the website and planned to eventually integrate this service with EHR systems (*PMPnow*). *MyPMP* is a dashboard display containing summarized patient information for a prescriber. To follow up on the status of this recommendation, IS auditors reviewed documents related to contractual services, business processes, security, change control, and disaster recovery.

Contractual Services

In order to develop and implement the website, *PMPnow*, and Prescription Information Library (PIL) database, DHS contracted with three entities to provide various services: LogiCoy, Eastern Illinois University, and Hanson Information Systems, Inc. Review of the contracts found:

- **LogiCoy** – Our review of the contract and amendments noted DHS did not provide for auditing or reviewing of LogiCoy's internal controls over the security and development of the connections or Prescription Monitoring Program website.
  - DHS provided a System and Organizational Controls (SOC) 2, type 2 report for the period of August 1, 2021 through July 31, 2022. However, DHS did not provide an analysis of the LogiCoy SOC 2 report deviations or Complementary User Entity Controls. In addition, DHS provided a SOC 2, type 2 report for the period August 1, 2022 through July 31, 2023.
- **Hanson Information Systems, Inc.** – The contract is for providing hosting services for the PIL database and website. Although the contract required Hanson to undergo a SOC examination, Hanson had not.

Business Processes

It was noted that DHS receives data from various sources. When reviewing Business Processes, IS auditors identified the following:

- In the event of errors, DHS was not aware if anyone followed up with the dispenser on noted errors.
- According DHS staff, not all dispensers were providing data. Additionally, they were not conducting follow-up with these dispensers to determine why they were not complying with the Act.

DHS developed the *Illinois Prescription Monitoring Program Policies and Procedures Manual 2023* (Manual) to provide guidance related to several areas. The Manual included updated policies and business process information. However, the IS review of the Manual noted that it did not document:

- The controls for internal users to request access.
- The controls for terminating users.
- The requirement for user access reviews.
- The controls (change controls) for correcting the data (updated policy provided after examination period; see Change Control section below).

Security

In order to determine if a user's information was being properly validated, we obtained the population of users. Our analysis of the users' information noted 90,017 users, of which 23,736 were active prescribers, dispensers, or designees. Our review of the active users noted the following:

- **9,621 of 23,736 (41%)** active accounts did not have a DEA license number as required by 77 Ill. Adm. Code 2080.205(n).

We also found five other categories of exceptions during our review of the 23,736 active prescribers, dispensers, or designees, which indicates a possible internal control weakness over account authorization. We found that:

- **57** accounts did not have an address as required by 77 Ill. Adm. Code 2080.205(n).
- There were **6** accounts shown as active that did not have an authorization date, 5 of which were denied or pending.
- There were **10** accounts that had never logged in.
- **694** accounts had not changed their password in one year or more.
- **89** accounts with a last login date of more than 12 months old.

According to the ILPMP Policies and Procedures Manual, if an account had been inactive for a period of more than 12 months, the ILPMP administrator system shall automatically de-activate the account. According to DHS officials, when a user tries to login to the PMP website, the system checks the last login date, and if

it is more than 12 months the user will not be able to access any patient prescription data. The Manual also requires a password change every 180 days. According to DHS officials, if a user logs in and is prompted by the system to change the account password but does not complete the required password change, the user cannot access patient prescription data.

Change Control

DHS did not have a formalized internal control process to control changes to the PIL. Because there were no policies or procedures in place, we were unable to design suitable audit procedures to determine if changes to the PIL were properly controlled. DHS stated there was an ad-hoc process, but nothing was formalized. DHS was able to provide a spreadsheet, which tracked change requests and contained fields to show the details of the request, as well as the status of implementing the change. However, this process was not documented in the ILPMP Policies and Procedures Manual during the compliance examination period. DHS was able to provide an updated policy dated April 22, 2024, which does appear to formalize this process.

In addition, we noted both developers have access to the production environment, thus creating a separation of duties weakness. However, DHS officials noted that there are two developers for the program website, which allows for vacations, sick time coverage, and peer review. DHS officials also stated that there are internal controls in place that act as safeguards against unauthorized changes, such as restrictions on available commands and monitoring functions.

Disaster Recovery

The *IT Incident and Recovery Plan* (Plan) for the ILPMP, dated September 2023, stated, "This document delineates our policies and procedures for technical disaster recovery, as well as our process level plans for recovering critical technology infrastructure." The Plan documented the contact information for the Emergency Response Team and Disaster Recovery Team.

The Recovery Plan Practice and Exercising section stated, "Practice and exercise should be practiced monthly with IT Staff members on how to diagnose, troubleshoot and resolve issues." The section also stated the key services were to be restored within four hours of the incident and business as usual recovery would be within 8-24 hours. Auditors found the Department had a detailed disaster recovery plan for the ILPMP, and the finding related to disaster recovery was **not repeated**.

In conclusion, IS auditors found improvements to the ILPMP Policies and Procedures Manual and the disaster recovery plan; however, IS auditors found issues with the data and IT controls. More specifically, IS auditors' follow-up found the following:

- ***9,621 of 23,736 (41%)*** *active accounts did not have a verified DEA number as required by administrative code.* ***Additionally, we noted five other areas in which internal control weaknesses allowed accounts to have an active status***

when they should not have been authorized, or should have been automatically unauthorized or de-activated.

- *DHS did not provide an analysis of LogiCoy's SOC 2 report deviations or Complimentary User Entity Controls for the time period August 1, 2021 through July 31, 2022. In addition, DHS provided a SOC 2, type 2 report for the period August 1, 2022 through July 31, 2023. Hanson Information Systems, Inc. did not undergo a SOC examination, which was a requirement of the contract.*
- *DHS stated that not all dispensers were providing data as required, and DHS was unaware if follow up was being conducted on dispenser errors.*
- *The ILPMP Policies and Procedures Manual lacked specific controls and requirements needed for user access and change controls.*

Because of the internal control weaknesses found when reviewing the ILPMP data, we are not able to rely on the data with respect to our testing of the Illinois Prescription Monitoring Program. The status of this recommendation was **partially implemented**.

Recommendation 4: Accurate Licensing Data

The Department of Human Services should establish a process to ensure the licensing data utilized by the ILPMP does not contain invalid or outdated information. The Department of Human Services should consider establishing an interagency agreement with the Department of Financial and Professional Regulation outlining each agency's responsibilities related to the licensing data.

Current status: Partially Implemented

In the original audit period, DHS and DFPR had not established an interagency agreement outlining each agency's responsibilities related to prescriber and dispenser licensing data. Periodic reviews of valid licenses were not being conducted after licenses were added to the ILPMP. In addition, there was not a process in place to check licensing data utilized by the ILPMP for invalid or outdated information.

DHS established a *Data Sharing Agreement* with IDFPR. According to DHS, the agreement outlined each agency's responsibilities related to the licensing data, and the licensing data was to be provided to DHS on a weekly basis. Due to time constraints encountered during this follow-up period, auditors were unable to perform the testing needed against the PIL data. Therefore, the follow up on Recommendation 4 will be conducted during the next follow-up period, and the status of this recommendation is **partially implemented**.

Recommendation 5: Sports and Accident Injury Data Reviews

The Department of Human Services and the Department of Public Health should establish a process to conduct data reviews of sports and accident injuries as required by the Act. In addition, the Department of Human Services should alert prescribers whose discharged patients were dispensed a controlled substance about the risk of addiction and applicable guidelines.

DHS Current status: Not Repeated

The Controlled Substances Act required DHS and the Illinois Department of Public Health (DPH) to coordinate continuous reviews of ILPMP and DPH data to determine if a patient may be at risk of opioid addiction. In addition, the ILPMP was required to alert the patient's prescriber as to the addiction risk and urge each to follow the Centers for Disease Control and Prevention guidelines related to the patient's injury. According to DHS, "this portion of the statute will sunset on January 1, 2024."

According to DHS, DPH provided DHS with sports injury data on June 13, 2023. In addition, DHS and DPH were meeting to ensure DHS could link the data to the ILPMP. The ILPMP had not sent any alerts to prescribers whose discharged patients were dispensed a controlled substance about the risk of addiction and applicable guidelines by the end of the compliance examination period (or June 30, 2023). However, the related statutory requirement ceased to be effective on January 1, 2024. Therefore, even though the recommendation was not implemented as of June 30, 2023, the status of this recommendation is considered not repeated for purposes of this report and does not need to be followed up on during the next compliance examination period.

IDPH Current status: Not Repeated

The Controlled Substances Act required DHS and DPH to coordinate continuous reviews of ILPMP and DPH data to determine if a patient may be at risk of opioid addiction. In addition, the ILPMP was required to alert the patient's prescriber as to the addiction risk and urge each to follow the Centers for Disease Control and Prevention guidelines related to the patient's injury. According to DHS, "this portion of the statute will sunset on January 1, 2024."

According to DHS, DPH provided DHS with access to patient data on June 13, 2023 in FY23. In addition, DHS and DPH were meeting to ensure DHS could link the data to the ILPMP. The ILPMP had not sent any alerts to prescribers whose discharged patients were dispensed a controlled substance about the risk of addiction and applicable guidelines by the end of the audit period (or June 30, 2023). However, according to the Controlled Substances Act, the subsection (a-2) requiring sharing data and alerting prescribers for sports and accident injury patients prescribed opioids became inoperative on or after January 1, 2024. Therefore, the current status of this recommendation was noted as not repeated for the purposes of this review and does not need to be followed up on during the next audit.

Recommendation 6: Update the ILPMP Policies and Procedures Manual

The Department of Human Services should update the ILPMP Policies and Procedures Manual as it is currently outdated. The updates should include current policies related to law enforcement requests.

Current status: Partially Implemented

During the original audit period, the Illinois Prescription Monitoring Program Policies and Procedures Manual (Manual) was outdated and did not include current practices. For example, the Manual did not include current information about law enforcement requests. In addition, the Manual referenced previous employees and old information.

To follow up on this recommendation, auditors reviewed the previous version of the Manual and compared it with an updated Manual provided by DHS. Auditors found that DHS had updated the Manual and had developed a system to periodically review and update the Manual. Auditors found the Manual contained updated information on law enforcement requests, and DHS corrected the other basic issues identified in the performance audit.

The review of the Manual as part of the follow-up related to the *Review of General IT Controls* was discussed under Recommendation 3. DHS developed the Manual to provide guidance related to several IT areas. Our IS review of the Manual noted the Manual did not document:

- the controls for internal users to request access;
- the controls for terminating users;
- the requirement for user access reviews; and
- the controls (change controls) for correcting the data (updated policy provided after examination period; see Change Control section).

Due to the Manual being outdated related to these IT issues, the status of this recommendation was **partially implemented**.

Recommendation 7: Ensure Dispenser Requirements are Completed as Required

The Department of Human Services should ensure dispensers are submitting specific information as required by the Illinois Controlled Substances Act and the Illinois Administrative Code. This includes addressing the following discrepancies with meeting these requirements: ensuring dispensers are submitting specific information to the ILPMP by the end of the next business day after a controlled substance is dispensed; ensuring the following required information is submitted by dispensers: Patient ID, Patient Location Code, Patient Name, Birthdate, Date Sold, and Prescriber's Full Name; beginning to collect and ensure the following additional required information is submitted by dispensers: Date Dispensed, Dispenser's DEA Number, Dispenser's Full Name, and Dispenser's Address; following up on problematic information submitted by dispensers so such information does not end up in the active PIL data including: records with patients over 110 years old, records with an animal species code, and/or records

with an invalid patient name; and ensuring the following required information for LTC cases is submitted by dispensers on a weekly basis and the fields needed for their submission are created including: Diagnosis Code, Name of Medication, Date Discharged, Changes to Medicine, Reason for Admission, Date Admitted, Pre-existing Conditions, Patient Ethnicity, Patient Height, and Patient Weight.

Current status: Not Implemented

In the performance audit of the Illinois Prescription Monitoring Program, auditors found the Department did not monitor whether pharmacies were submitting the information timely, and the Department did not ensure dispensers were submitting all required information. Effective August 20, 2021, the Controlled Substances Act required DHS to collect various patient, dispenser, and prescriber information by the end of the business day on which a controlled substance was dispensed, rather than the end of the next business day as was previously required.

According to the Department, as of June 30, 2023, the Department had not developed a process to monitor timeliness.

Additionally, DHS stated that they do not require the following fields to be submitted by dispensers (even though these fields are still currently required by the Administrative Code):

- prescriber's full name;
- dispenser's full name; and
- dispenser's address.

The Department noted that the removal of these fields from the Administrative Code would require an Administrative Rule change, which had not been made. Finally, the Department noted that they are still in the process of determining the scope for ensuring the required information for LTC cases was submitted on a weekly basis. Therefore, the status of this recommendation was **not implemented**.

Recommendation 8: Ensure Prescribers are Registered with the ILPMP as Required

The Illinois Department of Human Services should ensure all prescribers possessing an Illinois Controlled Substance license are registered with the ILPMP as required by the Illinois Controlled Substances Act.

Current status: Partially Implemented

The Illinois Controlled Substances Act (Act) required all prescribers register with the Illinois Prescription Monitoring Program (ILPMP). However, during the original audit period, auditors found all prescribers were not registered with the ILPMP, and in December 2020, 68 percent of licensed prescribers were registered with the ILPMP.

According to DHS, the ILPMP had taken steps to increase awareness of the registration requirement and had sent a notification email in September 2022.

According to DHS, the Department had seen a large increase in registrations. DHS stated, "…the numbers used internally to determine compliance come directly from IDFPR. The total number of IL CS license holders as of July 2023 was 73,916 and the total number of IL CS license holders registered is 54,919 and non-registered is 18,997 for a 74.2% compliance rate and 25.8% non-compliance rate with the Act." Therefore, the status of this recommendation was **partially implemented**.

Recommendation 9: Program Assessment Issues

The Department of Human Services should address the identified program assessment issues and related deficiencies by: ensuring reports used for program assessment contain complete and accurate information and following up when such reports show significant changes, incorrect calculations, and/or missing information; and establishing an interagency agreement with the Department of Public Health to reinstate the process of exchanging data in more depth through the Opioid Data Dashboard and providing additional program assessment information to cover significant drug-related issues such as deaths, abuse, and overprescribing.

Current status: Implemented

DHS updated the grant monitoring and reporting information in the ILPMP Policies and Procedures Manual to ensure reporting was complete and accurate. DHS and DPH also entered into an intergovernmental agreement for a term of September 1, 2021, through August 31, 2023, for data sharing purposes. According to DHS, DHS and DPH were sharing data for the Opioid Data Dashboard during the compliance examination period. Auditors reviewed information provided documenting data transmitted for the Opioid Data Dashboard, and the status of this recommendation was noted as **implemented** for the purposes of this review and does not need to be followed up on during the next examination period.

Recommendation 10: Monitoring Issues

The Department of Human Services should address the identified monitoring issues and related deficiencies by: performing sufficient tracking of monitoring reports required by the Illinois Administrative Code including error reports, zero reports, and personal information reports; ensuring all monitoring reports required by intergovernmental agreements are completed as outlined in the agreements; and sufficiently monitoring ILPMP contractors through System and Organization Controls reports or internal control reviews.

Current status: Partially Implemented

During the original audit period, auditors found the Department had not performed sufficient tracking of monitoring reports required by the Illinois Administrative Code including for error reports, zero reports, and personal information reports. The Department had also not ensured all monitoring reports required by intergovernmental agreements were completed as outlined in the agreements. Finally, the Department had not sufficiently monitored ILPMP

contractors through System and Organization Controls reports or internal control reviews.

To follow up on this recommendation, the Department provided the following reports for this compliance examination period: zero, error, and information on personal information requests. According to the Department, the ILPMP followed up with pharmacies to correct errors detected. The pharmacy submission timeliness report was not fully implemented during the compliance examination period, and the report was under continuing development and implementation.

The ILPMP updated the Policies and Procedures Manual to include a process for interagency agreements and grant management. The interagency agreement for the grant noted in the prior audit report ended in August 2019, which was not within the current compliance examination period.

According to the Department, the ILPMP was working with the Department contract division to determine how to monitor contractors through System and Organization Controls (SOC) reports. However, such SOC reports and analysis could not be provided for support when requested during the IS review for this audit follow-up. Therefore, the status of this recommendation was **partially implemented**.

Recommendation 11: ILPMP Committee Weaknesses

The Department of Human Services should address the identified ILPMP Committee weaknesses by: ensuring the Illinois Controlled Substances Act and the Illinois Administrative Code have the same Prescription Monitoring Program Advisory Committee (PMPAC) members listed for the PMPAC. In addition, the PMPAC charges outlined by the Act should be completed, as required; ensuring Peer Review Committee (PRC) members with the same profession as the prescribers or dispensers being reviewed are preparing preliminary reports and/or making recommendations, as required by the Act. In addition, PRC meetings should be held quarterly and fulfill annual reporting requirements with the required information, as required by the Illinois Administrative Code. Finally, the lists of at-risk prescribers should not be cleared and should be followed up on; and establishing an LTC Advisory Committee as required by the Illinois Administrative Code. This committee should be composed of healthcare professionals associated with the care of geriatric populations and include university partners performing research and longitudinal outcome evaluations.

Current status: Implemented

To follow up on this recommendation, auditors reviewed the Illinois Administrative Code updated effective **September 8, 2023**, and found the PMPAC members listed are the same as those in the Act. Auditors reviewed the Peer Review Committee at-risk dispenser and prescriber review and recommendation process. The Peer Review Committee members were reviewing at-risk prescribers and making recommendations. The Department was also maintaining the lists of at-risk providers identified and following up with the prescribers. Finally, the Illinois Administrative Code was updated effective **July 7, 2023**, and all references to the LTC Advisory Committee were removed.

Therefore, the recommendation was partially implemented as of **June 30, 2023**, with the anticipated completion as of **September 8, 2023**. Although the recommendation was only partially implemented at the end of the compliance examination period (as of June 30, 2023), the recommendation was **implemented** shortly after the compliance examination period ended (on July 7, 2023, and September 8, 2023). Therefore, the status of this recommendation was noted as **implemented** for the purposes of this review and does not need to be followed up on during the next compliance examination period.

Management Audit

Firearm Owner's Identification Card and Concealed Carry License Programs

Legislative Audit Commission Resolution Number 155 directed the Auditor General to conduct a management audit of the Illinois State Police's administration of the Firearm Owners Identification Card Act (430 ILCS 65) and the Firearm Concealed Carry Act (430 ILCS 66). The audit was released in **September 2021** and contained six recommendations. Of the six recommendations, **four are not yet fully implemented**.

Exhibit 22
FIREARM OWNER'S IDENTIFICATION CARD AND CONCEALED CARRY LICENSE PROGRAMS – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	FOID and CCL Application Processes	State Police		X	
2	Application Processing Timeliness	State Police			X
3	Revoked FOID Cards and Concealed Carry Licenses	State Police		X	
4	FOID Card Enforcement Details	State Police	X		
5	Appeals	State Police		X	
6	Administrative Rules Update to Match Process	State Police	X		

Source: Summary of OAG follow-up.

As part of the compliance examination of the Illinois State Police for the period ending June 30, 2022, auditors followed up on the status of the six recommendations. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2022	6	2	3	1

Recommendation 1: FOID and CCL Application Processes

The Illinois State Police should seek to reduce manual verifications and checks of applicant information, reduce multiple and overlapping checks, and seek legislative remedies, if necessary, in order to increase the efficiency of the FOID and CCL application processes.

Current status: Partially Implemented

The September 2021 audit found that the FOID and CCL application processes were labor intensive with some steps being completed multiple times for the same application. The Department has not made any changes to the FOID application process, the CCL application process, or the CCL renewal process. In March 2021, the Department began instituting a new streamlined process for FOID renewals. When a FOID renewal is submitted, the renewal is placed on a 72 hour hold. The FOID card holder's criminal history is checked for any Wants/Warrants, Orders of Protection, or Firearm Restraining Orders. If there are no correlation hits, the renewed FOID card is printed and issued. After issuance, the FOID card holder is checked against the same eligibility verification checks as a new FOID applicant. If there is a hit on the renewal application, the renewal goes to "normal" FOID renewal processing workflow. Any hits during the eligibility verification will require the analyst to review the hits and make the determination as to their validity and whether there is a resulting prohibitor. Those applications with hits go to a 60 day bucket. Analysts can review applications in that bucket. In the event that they are not reviewed prior to the 60th business day, they will be subsequently reviewed in the post approval validation work inbox.

The Department took two legislative steps to sync FOID and CCL dates. Effective December 21, 2021, the Department amended the Illinois Administrative Code to allow FOID card holders who are approved for a new or renewed CCL to have their FOID Card automatically renewed for 10 years from the date of approval of the CCL. (20 Ill. Adm. Code 1230.30(b)(4)) Public Act 102-0237, effective January 1, 2022, also made some changes to the FOID renewal process. If a FOID card expires during the term of a licensee's concealed carry license, the FOID card and the CCL remain valid and the licensee does not have to renew his or her FOID card during the duration of the CCL. Unless the Department has reason to believe a licensee is no longer eligible for the FOID card, the Department may automatically renew the licensee's FOID card and send a renewed FOID card to the licensee.

Recommendation 2: Application Processing Timeliness

The Illinois State Police should ensure that all FOID and CCL applications are approved or denied within the required statutory timeframes.

Current status: Not Implemented

The September 2021 audit found that during Calendar Year 2019, 73.1 percent of FOID new applications and 72.7 percent of FOID renewal applications were processed within the statutorily required timeframes. Additionally, 43.4 percent of CCL new applications and 51.5 percent of CCL renewal applications were processed within the statutorily required timeframes. During Fiscal Year 2022, the Department was not processing applications within the required timeframes. Specifically:

- FOID new applications: 65.8 percent were processed timely, 32.3 percent were not timely, and 2.0 percent a timeliness determination could not be made;
- FOID renewal applications: 96.7 percent were processed timely, 3.0 percent were not timely, and 0.4 percent a timeliness determination could not be made;
- CCL new applications: 66.5 percent were processed timely, 23.9 percent were not timely, and 9.6 percent a timeliness determination could not be made; and
- CCL renewal applications: 45.4 percent were processed timely, 37.0 percent were not timely, and 17.6 percent a timeliness determination could not be made.

Recommendation 3: Revoked FOID Cards and Concealed Carry Licenses

The Illinois State Police should: ensure that Sheriffs are notified of revocations as is required by the Firearm Owners Identification Card Act; and continue to work with local law enforcement agencies to ensure revoked FOID cards and Concealed Carry Licenses are returned to the Department in accordance with the Firearm Owners Identification Card Act and the Firearm Concealed Carry Act.

Current status: Partially Implemented

The September 2021 audit found that the majority of FOID cards and CCLs are not returned to the Department as required by law. Additionally, auditors found that for three cases, the Department could not provide documentation that the county Sheriff was notified as required by law.

The Department provided documentation of the efforts to work with local law enforcement. The Department provided a list of 18 seminars presented on FOID/CCL during Fiscal Years 2021 and 2022. These seminars included new chiefs' orientation, the Grundy County Chiefs of Police Association, State Police cadet classes, and presentations to seven State Police investigative zones. The Department also provided a list of law enforcement agencies that had accessed the

law enforcement portal during Fiscal Year 2022 that showed that over 400 different law enforcement agencies utilized the portal. These included police and sheriff departments, state's attorneys, and college or university police departments. Additionally, the Department's Standard Operating Procedures for Revoked FOID and Firearm Seizure discuss how Department personnel should collaborate with other law enforcement agencies. Effective July 11, 2021, the Law Enforcement Agencies Data System (LEADS) generates the FOID and CCL status when an individual's identifiers are queried. Auditors tested 10 revoked FOID cards for the proper law enforcement notifications and found that 8 of 10 (80%) had the proper notifications. For two cases the Department could not provide documentation that the county Sheriff was notified as required by law.

Recommendation 4: FOID Card Enforcement Details

The Illinois State Police should consider including enforcement details in its procedures to ensure consistency among zones.

Current status: Implemented

The September 2021 audit found that while the Department was conducting FOID revocation enforcement details, there were not procedures related to the enforcement details, and that led to inconsistency between the investigative zones. The Department's Standard Operating Procedures for Revoked FOID and Firearm Seizure went into effect on February 1, 2021. These procedures specified the responsibilities of State Police personnel, and outlined the steps that should be taken during revoked FOID card investigations and seizures. The procedures addressed some of the inconsistencies found during the initial audit. Additionally, as of June 30, 2022, the Department has a Statewide Gun Coordinator, a Statewide Gun Liaison Officer Coordinator, and each of the eight zones has a primary Gun Liaison Officer. The Department's Gun Liaison Officer program is comprised of three full-time personnel that oversee the eight full-time zone Gun Liaison Officers.

Recommendation 5: Appeals

The Illinois State Police should: establish a case management system for tracking appeals; and update its administrative rules to reflect the current appeals process.

Current status: Partially Implemented

The September 2021 audit found that the Department did not have a case management system in place to track appeals and could not provide information for the audit period in order to determine, for certain types of FOID appeals cases, if appeals were being adjudicated in a timely manner. Also, in 2020 the Department changed the process for filing an appeal but the administrative rules had not been amended to reflect the current process. As of June 30, 2022, the Department had completed the procurement process for an appeals case management system, but had not implemented the system. However, in the interim, the Department had transitioned to a new database for tracking appeals.

The Department noted in its response to the September 2021 audit that this database is not a case management system, but it does allow the office to categorize appeals and better track numbers for reporting purposes. The Department was able to provide appeals data, which showed that 5,158 appeals were filed during Fiscal Year 2022. The Department has amended the FOID and CCL administrative rules, effective December 21, 2021, to reflect the new appeals process.

Recommendation 6: Administrative Rules Update to Match Process

The Illinois State Police should update its administrative rules to reflect the current process for determining issuance date and expiration date.

Current status: Implemented

The September 2021 audit found that the Department's process for designating a FOID card issuance date is not in accordance with its administrative rules. The expiration date is calculated based on the date the card was issued, however, the Department's administrative rules define the date of issuance as the first day of the month in which the FOID card application was received. The administrative rules (20 Ill. Adm. Code 1230.30) were updated effective December 21, 2021, to state that the date of issuance is the date the FOID Card becomes active within the Department's online system.

Performance Audit

State's Response to the COVID-19 Outbreak at the LaSalle Veterans' Home

House Resolution Number 62 (from the 102nd General Assembly) directed the Auditor General to conduct a performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home. The audit was released in **May 2022** and contained three recommendations directed to both the Illinois Department of Public Health (IDPH) and the Illinois Department of Veterans' Affairs (IDVA). The single recommendation directed to IDPH was implemented. For the two recommendations directed to IDVA, the initial follow up has not been conducted; it will be conducted as part of the FY24 IDVA compliance examination.

Exhibit 23
STATE'S RESPONSE TO THE COVID-19 OUTBREAK AT THE LASALLE VETERANS' HOME – STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Rec. No.	Recommendation Description	Agency	Current Status		
			Implemented	Partially Implemented	Not Implemented
1	COVID-19 Testing	IDVA		to be determined	
2	COVID-19 Monitoring and Policies	IDPH	X		
3	Veterans' Affairs Management	IDVA		to be determined	

Source: Summary of OAG follow-up.

As part of the compliance examination of IDPH for the period ending June 30, 2023, auditors followed up on the status of the single recommendation directed to IDPH. This was the 1st time that follow-up had been conducted. The chart below shows the progression of recommendations implemented.

Follow-up	Total Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
As of June 30, 2023 – IDPH	1	1	0	0
As of June 30, 2024 – IDVA	2		to be determined	

Recommendation 1: COVID-19 Testing

The Illinois Department of Veterans' Affairs should ensure each of its Veterans' Homes have policies and procedures in place that mandate timely testing of its residents and employees during COVID-19 outbreaks, and should ensure that residents and employees are tested according to the policy.

IDVA Current status: To be determined

Recommendation 2: COVID-19 Monitoring and Policies

The Illinois Department of Public Health should: clearly define its role in relation to monitoring COVID-19 outbreaks at Illinois Veterans' Homes; and develop policies and procedures that clearly identify criteria which mandate IDPH intervention at Veterans' Homes during an outbreak of COVID-19.

IDPH Current status: Implemented

The Illinois Department of Public Health's mission statement is to protect the health and wellness of the people of Illinois through the prevention, health promotion, regulation, and the control of disease and injury. The Department of Public Health Act (20 ILCS 2305/2(a)) states that IDPH has general supervision of the interests of the health and lives of the people of the State. The statute also grants IDPH the "supreme authority" in matters of quarantine and isolation, and may declare and enforce quarantine and isolation when none exists, and may modify or relax quarantine and isolation when it has been established. Therefore, it was the responsibility of IDPH to provide guidance and monitoring to protect the residents at the LaSalle Veterans' Home.

IDPH did not act on the significant outbreak at the LaSalle Veterans' Home during the first week of November, even though it was the largest outbreak in any of the State's congregate care facilities. Although IDPH officials were informed of the increasing positive cases almost on a daily basis, there was no action taken. The number of cases increased rapidly from 4 on November 1st to 53 on November 5th. By November 9th, there had been no effort by IDPH to reach out to the Home to provide assistance, solutions, or to determine the cause of the large outbreak, even though there were now 64 residents and 67 staff positive with COVID-19.

It also appeared that the IDVA Chief of Staff kept IDPH officials apprised of the increasing severity of the outbreak, requested assistance, inquired about additional rapid tests, and inquired about getting antibody treatments for LaSalle Veterans' Home residents. From the documents reviewed, management at IDPH did not offer any advice or assistance as to how to slow the spread at the Home, offer to provide additional rapid COVID-19 tests, and were unsure of the availability of the antibody treatments for long-term care settings prior to being requested by the IDVA Chief of Staff, even though the State had been allocated 6,380 vials of monoclonal antibodies, which could have been used to treat positive residents.

As part of the current follow up, IDPH officials noted it was in the process of filling the new fulltime infectious disease physician position, as well as multiple infection prevention and control staff positions. It was noted there will be six full time infection prevention and control staff and one full time infection prevention and control MD supervisor by July 17, 2023. Ultimately, nine infection prevention and control staff will be hired, consistent with the IDPH public health regions. Each IDVA home continues to have a designated IDPH infection prevention and control staff member for COVID-19 response purposes, along with the State Medical Officer. IDPH also established a Medical Services Division that has recruited eight dedicated full time regional infection preventionists to support the efforts of local health departments and long term care facilities in their outbreak response, including on-site assessments. IDPH officials noted that the Division of Medical Services also functions as a clinical advisory team to provide clinical consultations (e.g. the physician advisors have provided input on COVID-19 treatment options and access for veterans at our VA homes this past year) as well as to facilitate efforts between agencies and develop policy related to any future pandemic responses. In addition, this Division also monitors vaccine rates, hospitalizations and testing data from long term care facilities across the states and works with the Office of Health Care Regulation as well as the Regional Health Officers to provide targeted interventions based on these data.

According to IDPH officials, IDPH infection prevention practitioners and medical staff initially held weekly COVID-19 meetings and consultations with IDVA leadership and the administrative and clinical staff from the five IDVA facilities. With the substantial decline in COVID-19 cases and outbreaks in Illinois, IDPH infection prevention practitioners and medical staff are now holding bi-weekly COVID-19 meetings and consultations (more often if needed), with IDVA infection prevention staff from the five IDVA facilities. Written protocols have been developed whereby each COVID-19 case at an IDVA home is evaluated by the facility's administration and clinical staff, and documented in writing. IDVA will promptly notify the IDPH infection prevention team if an outbreak is occurring. On-site visits are conducted by IDPH infection prevention practitioners in response to evidence that transmission of COVID-19 is occurring within IDVA homes. The IDPH infection prevention team continues to monitor cases through daily (M-F) summary updates from IDVA and weekly test result summaries from the IDPH laboratories. These multiple notification pathways allow IDPH to respond and follow up timely when an IDVA home has cases, to determine what mitigations are being implemented or needed.

IDPH officials indicated the two agencies (IDVA and IDPH) are working together very well to investigate and respond to COVID-19 cases occurring in IDVA facilities, and the IDVA Homes are attentive to all IDPH COVID-19 long-term care guidance. IDPH continues to work in tandem with its sister state agencies through authoring joint guidance and communicating through biweekly meetings and strategy sessions (more often if needed) as it relates to IDVA facilities and other congregate settings across Illinois.

Per IDPH officials, Effective April 1, 2022, IDPH amended the Illinois administrative rules to require LTCs to have an infection prevention program along with a required infection preventionist to serve on staff for facilities the size of IDVA homes. The rules also mandate written policies and procedures for the appropriate use of personal protective equipment and other precautions grounded in CDC guidance and protocols.

Recommendation 3: Veterans' Affairs Management

The Illinois Department of Veterans' Affairs should ensure that: the IDVA Director works with the Department of Public Health and the Governor's office during COVID-19 outbreaks to advocate for the health, safety, and welfare of the veterans who reside in the Homes under IDVA's care; and the Senior Home Administrator position is filled and the duties of the position include monitoring and providing guidance to the Veterans' Homes during COVID-19 outbreaks.

IDVA Current status: To be determined

Appendix A
Scope and Methodology

The Performance Audit Division of the Office of the Auditor General conducts performance audits, making recommendations to improve program performance and operations. After the performance audits are released, the Office conducts follow-up audit work to determine whether the recommendations have been implemented. The initial audit follow-up is conducted by performance audit staff from our Office and consists of audit procedures specific to each audit and each recommendation. Subsequent follow-up work is conducted either by staff from our Office or our Special Assistant Auditors.

The results of the follow-up work are presented as part of the Illinois Office of the Auditor General compliance examinations for each applicable agency. Compliance examinations are conducted in even numbered years for some agencies and odd numbered years for other agencies. Therefore, the most recent follow-up work for this report was conducted as of June 30, 2022, or June 30, 2023.

This report compiles information from the past compliance examinations. The scope of this report includes all past performance audits where follow-up work has been conducted but not all recommendations have been fully implemented. Each section of the report contains an exhibit showing the status of the audit recommendations. The sections also contain the results of the most recent follow-up work that was conducted which can also be found in the agency's compliance examination.

This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

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LPU Order 00000 • July 2025 • 15 copies