Department of Health Services
Audit Guide

A Guide to Performing Audits and Special Investigations for Funding from the Department of Health Services

2014 Revision
(Change to Section 2.3)

2 General requirements

The following general requirements frequently apply to all programs with funding from the Department of Health Services and are essential for proper administration of those programs. These requirements must be tested as part of all audits involving DHS funding from the department (See *DHS Audit Guide*, Section 1.2). Several sections in this part point to the OMB Circular A-133 Compliance Supplement for the audit procedures, making the referenced sections of the Compliance Supplement applicable whether or not a single audit is being performed.

2.1 Segregation of duties

This section applies to all audits.

Segregation of duties is a factor in the internal control structure of any agency. Lack of adequate segregation of duties is frequently a contributing factor in fraud.

Opportunity is a condition that is frequently present in fraud cases. While proper segregation of duties does not guarantee that fraud will be prevented, it greatly diminishes the opportunity to commit fraud.

The following discussion is intended to provide guidance in developing findings and responses to findings concerning segregation of duties.

Definition of segregation of duties
According to the Committee of Sponsoring Organizations of the Treadway Commission, "Key duties and responsibilities need to be divided or segregated among different people to reduce the risk of error or fraud. This should include separating the responsibilities for authorizing transactions, processing and recording them, reviewing the transactions, and handling any related assets. No one individual should control all key aspects of a transaction or event."

Segregation of duties is the strongest control over the prevention of fraud and innocent errors. With well designed segregation of duties, committing fraud would require collusion of two or more persons making it more difficult.

Poor segregation of duties is easily identified when obtaining an understanding of the internal control system of an organization. The best indicator is a person that is performing incompatible duties or responsibilities, for example, issuing checks and reconciling cash.

All duties can be classified into four broad categories: authorization, custody, recordkeeping, and reconciliation. No one person should have control of two or more of these four categories for any one cycle (i.e. disbursement cycle, revenue cycle, payroll cycle, etc.). The four categories are:

> *Authorization* is the process of reviewing and approving transactions or operations. Examples include: approving payroll records, approving vouchers, etc.
>
> *Custody* is having access to or control over any physical asset such as cash, checks, equipment, supplies, or materials. Examples include: processing payments, collecting cash, etc.
>
> *Recordkeeping* is the process of creating and maintaining records of revenues, expenditures, inventories, and personnel transactions. These may be manual records or records maintained in automated computer systems. Examples include: posting entries to the accounting system, updating and creating vendor or employee master files, etc.
>
> *Reconciliation* is verifying the processing or recording of transactions to ensure that all transactions are valid, properly authorized and properly recorded on a timely basis. This includes following up on any differences or discrepancies identified. Examples include:
> bank reconciliations, reconciliation of control accounts to subsidiary ledgers, reconciliation of claim forms to accounting records, etc.

Agencies should have both preventive and detective controls. *Preventive controls* are designed to discourage or pre-empt errors or irregularities from occurring. *Detective controls* are designed to search for and identify errors after they have occurred. An internal control system that primarily relies on detective controls does not completely mitigate segregation of duties findings.

Developing segregation of duties findings

The *Main Document of the State Single Audit Guidelines*, Section 4.11 discusses the information to include in findings. To help report users understand the particular nature of a segregation of duties finding, the auditor should present the condition and recommendation in terms of the four general categories of duties or responsibilities for segregation of duties—authorization, custody, recordkeeping and reconciliation—and whether existing controls are preventive or detective.

Developing corrective action plans for segregation of duties findings

Agencies need to provide their corrective action plan for each audit finding. A corrective action plan that is limited to stating impracticality of adding additional staff is not sufficient for a segregation of duties finding. The agency should be able to mitigate the risk related to the segregation of duties finding with involvement of program administrators, board members and others associated with the agency.

Therefore, when addressing the segregation of duties findings, management should present specific control activities for mitigating the risks associated with a segregation of duties weakness and identify personnel, by position, who are responsible for these activities. The

organization should disclose control activities which are present that decrease the risks related to the lack of segregation of duties.

2.2 Activities allowed or unallowed

This section applies to all audits. For A-133 audits, this section supplements guidance for Topic A Activities Allowed or Unallowed in the OMB Circular A-133 Compliance Supplement.

The requirements for activities allowed or unallowed are unique to each department program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program. Examples of allowed or unallowed activities include:

> *Services to be provided and the means for delivering them* – The contract specifies what the provider can do with the funding.
>
> *Subcontracting* – Some contracts require that agencies obtain written approval from the funding agency prior to subcontracting department funds and that the agency retains all responsibility for fulfillment of the terms and conditions of its contract with the funding agency. (All subcontracts of department funds are to be listed in the "Schedule of Expenditures of Federal and State Awards.")
>
> *Fiduciary responsibilities for resident funds* – Administrative rules for residential care providers (community-based residential facilities, adult family homes, residential care apartment complexes, nursing homes, and facilities for the developmentally disabled) specify what providers can do when holding resident funds.

Compliance requirement(s)
Department funds can only be used for allowed activities.

Suggested audit procedure(s)

- Apply the guidance for Topic "A. Activities Allowed and Unallowed" in Parts 3 and 6 of OMB Circular A-133 Compliance Supplement (applicable whether or not the audit is a single audit, see introduction to Section 2, above).

- If the provider has fiduciary responsibility for resident funds, (typically community-based residential facilities, adult family homes, residential care apartment complexes, nursing homes, and facilities for the developmentally disabled), determine whether the provider:
  - Had written authorization from the resident or the resident's guardian, agent, or designated representative to hold the resident's funds.
  - Segregated resident funds from the provider's funds.
  - Maintained written records of the resident's funds and provided reports of these funds to residents, guardians, agents, or designated representatives.

2.3 Allowable costs *(Updated reference to federal policy)*

This section applies to all agencies audited under the *DHS Audit Guide,* when

- **payments are made on or limited to an allowable cost basis (for a discussion of reserves and profit, see Sections 2.3.5 and 2.3.6, respectively)**
- **the auditee has a match requirement that is met through other allowable expenditures for the program (Sections 2.5 and 2.6)**
- **audited allowable costs are required to be reported in the audit report**

Section 2.3.1 "Allowable costs, generally" and Section 2.3.2 "Related party transactions" apply to all audits when allowable costs are applicable. Section 2.3.3 "Additional Supplemental Schedule(s) Required by Funding Agency" discusses supplemental schedules that funding agencies may require. Section 2.3.4 "Settlement of DHS Cost Reimbursement Contract" replaces Section 2.3.3 for DHS programs. Section 2.2.5 "Reserve Schedule" applies only to nonprofits paid on a cost reimbursement basis or prospective rate that is settled to an allowable cost basis. Section 2.3.6 "Allowable Profit Schedule" applies only to for-profits paid on a cost reimbursement basis or prospective rate that is settled to an allowable cost basis.

For A-133 audits, this section supplements guidance for Topic B Allowable Costs/Cost Principles in the OMB Circular A-133 Compliance Supplement.

Grant agreements and contracts involving department funds require that agencies comply with the *Allowable Cost Policy Manual (ACPM)*. The *ACPM* incorporates the federal cost principles by reference and includes links to the federal policies. These federal allowable cost policies are in *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* for local governments and nonprofits, and in *Contract Cost Principles and Procedures* for for-profit organizations. Requirements for allowable costs may also be found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program.

2.3.2 Allowable costs, generally

This part applies to all audits when allowable costs are applicable.

Compliance Requirement(s)
All costs charged to department programs must be allowable.

In addition, the Department of Health Services does not approve any agency's cost allocation or indirect cost plan. The department relies on the independent audit to confirm that the plans are in accordance with the *ACPM* and applicable federal cost policy. The cost allocation or indirect cost plans must be tested in the audit if the agency claimed reimbursement from department programs for allocated or indirect costs.

Suggested Audit Procedure(s)

- Apply the guidance for Topic "B. Allowable Costs/Cost Principles" in Parts 3 and 6 of OMB Circular A-133 Compliance Supplement, including costs charged through cost allocation or indirect cost plans (applicable whether or not the audit is a single audit, see introduction at the beginning of Section 2).

- For cost allocation or indirect cost, specifically determine whether:
  - The agency's cost allocation and/or indirect cost plans are in accordance with the *Allowable Cost Policy Manual* and the applicable federal allowable cost policy.
  - The agency followed the plan(s) when charging costs to the funding agency.

If the agency's cost allocation and/or indirect cost plans are not included in the scope of the audit, for example, a program audit that does not include audit of the cost allocation/indirect cost plan, all costs charged to department programs through such unaudited plans must be reported as questioned costs in the Schedule of Findings and Questioned Costs.

See *DHS Audit Guide*, Section 3.11 "Income Maintenance Consortia" for audit procedures related to a county's Agency Management, Support, and Overhead (AMSO).

2.3.2 Related party transactions

This part applies to all audits when allowable costs are applicable.

Compliance requirement(s)
Audits performed in accordance with generally accepted auditing standards include procedures to identify related party transactions so that the required financial statement disclosures can be made. However, related party transactions that involve charges to financial assistance programs require further audit consideration, because some agencies have used related party transactions to circumvent the limitations on excess revenue and profit. Examples of related party transactions include:

- Purchasing care and services from an agency with joint control or ownership.
- Renting a building from the director of the agency.
- Paying for consulting services provided by a member of the board of directors.

All costs that are fully or partially reimbursed with any type of federal or state financial assistance (including costs associated with related party transactions) are reimbursable only if they meet the criteria of allowability (*DHS Audit Guide*, Section 2.3.1). The fact that two parties in a transaction are related does not mean that the cost incurred is inappropriate or unallowable. However, it does mean that the auditor may have to do additional work in order to determine whether the related party transaction involves unallowable costs.

Unallowable costs resulting from related party transactions must be reported as a finding. When related party transactions do not affect department programs or do not include unallowable costs, we suggest stating this in the financial statement disclosure so that it is clear to report users that the related party transaction did not adversely affect department programs.

Suggested audit procedure(s)
Determine whether the related party transactions involved costs that affect department programs. If they did, continue with the following procedures:

- Determine whether the cost incurred as the result of a related party transaction is allowable (Section 2.3.1, above).

- Determine whether the agency followed procurement policies and practices that include maximum open and free competition and price and cost analysis to ensure that costs incurred are reasonable.
- If the related party transaction involves rent, determine whether the costs charged to the department's programs are limited to the actual costs that would have been allowed had title to the property been vested with the provider.

2.3.3 Additional supplemental schedule(s) required by funding agency

The *Main Document of the State Single Audit Guidelines*, Section 4.3 allows funding agencies to require additional supplemental schedules to suit their information needs, and funding agencies may specify the format and content for such schedules. For example, several counties specify formats for supplemental schedules as part other the audit they require of providers receiving funds under contracts for purchase of care and services.

See Section 2.3.4, below, for the supplemental schedule when the auditee receives funding directly from the Department of Health Services.

2.3.4 Settlement of DHS Cost Reimbursement Award

The "Settlement of DHS Cost Reimbursement Award" is required for each award (i.e. contract or grant) when all of the following conditions are met:

- The auditee is a nonprofit, a for-profit, or a local unit of government *other than* a county, tribe, Chapter 51 board, or school district,
- The auditee received payments totaling $100,000 or more directly from the Department of Health Services, and
- The payments were based on reported allowable costs or limited to an allowable cost basis.

Department of Health Services has had a long-standing requirement that audit reports include a "Schedule of Revenue and Allowable Costs by Contract" in audit reports of agencies that have DHS funding, and allowed in the *Main Document to the State Single Audit Guidelines*, Section 4.3. The form of the schedule that is now required is the "Settlement of DHS Cost Reimbursement Award."

See the illustration on the following pages for the format for the schedule and instructions for preparing the schedule. Like other supplemental schedules, the "Settlement of DHS Cost Reimbursement Award" must be covered by an auditor's opinion. In program audits, the settlement schedule will be covered by the auditor's "Opinion on the Financial Statement of a Program in Accordance with the Program Audit" (*Main Document,* Section 4.9), which states the auditor's opinion on whether the schedule is fairly presented in all material respects. For single audits, the settlement schedule will be covered by the auditor's "Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards" (*Main Document,* Section 4.6), which states the auditor's opinion on whether the information in the schedule is "fairly stated, in all material respects, in relation to the basic financial statements taken as a whole."

Illustration 2.3.4 – Settlement of DHS Cost Reimbursement Award

This example uses IRS 990 Functional Expense Categories. If the department has specified expense categories for the award budget or for reporting, use those classifications instead.

<Name or organization>
<Name of grant>
Settlement of DHS Cost Reimbursement Award
For the year ended <date>

DHS identification number	**CARS profile XXXXX**	**CARS profile XXXXX**
Award amount	**$XXX,XXX**	**$XXX,XXX**
Award period	**m/d/y – m/d/y**	**m/d/y – m/d/y**
Period of award within audit period	**m/d/y – m/d/y**	**m/d/y – m/d/y**
A. Expenditures reported to DHS for payment	$ xxx,xxx	$ xxx,xxx
B. Actual allowable cost of award		
Program expenses		
1. Grants and other assistance to governments and organizations in the US	$ xx,xxx	$ xx,xxx
2. Grants and other assistance to individuals in the US	xx,xxx	xx,xxx
3. Grants and other assistance to governments, organizations, and individuals outside the US	xx,xxx	xx,xxx
4. Benefits paid to or for members	xx,xxx	xx,xxx
5. Compensation of current officers, directors, trustees, and key employees	xx,xxx	xx,xxx
6. Compensation not included above, to disqualified persons	xx,xxx	xx,xxx
7. Other salaries and wages	xx,xxx	xx,xxx
8. Pension plan contributions	xx,xxx	xx,xxx
9. Other employee benefits	xx,xxx	xx,xxx
(Continue) .	.....	.....
Total program expenses	$ xx,xxx	$ xx,xxx
Management and general expenses allocated to program		
5. Compensation of current officers, directors, trustees, and key employees, allocated based on _____	xx,xxx	xx,xxx
6. Compensation not included above, to disqualified persons, allocated based on _____	xx,xxx	xx,xxx
7. Other salaries and wages, allocated based on _____	xx,xxx	xx,xxx
8. Pension plan contributions, allocated based on _____	xx,xxx	xx,xxx
9. Other employee benefits, allocated based on _____	xx,xxx	xx,xxx
(Continue)	.....	.....
Total management and general expense allocated to program	$ xx,xxx	$ xx,xxx
C. Less program revenue and other offsets to costs (identify in notes)	(xx,xxx)	(xx,xxx)
D. Total allowable costs before profit (for-profits only)	$ xxx,xxx	$ xxx,xxx
E. Allowable profit (for-profits only, Line 3 on Allowable Profit Schedule)	$ xx,xxx	$ xx,xxx
F. Total allowable costs	$ xxx,xxx	$ xxx,xxx

Illustration 2.3.4 – Settlement of DHS Cost Reimbursement Award, continued

Instructions for preparing the schedule

Prepare a "Settlement of DHS Cost Reimbursement Award" for each award (i.e. contract or grant) when the all of the following conditions are met:

- The auditee is a nonprofit, a for-profit, or a local unit of government *other than* a county, tribe, Chapter 51 board, or school district,
- The auditee received payments totaling $100,000 or more directly from the Department of Health Services, and
- The payments were based on reported allowable costs or limited to an allowable cost basis.

If the award period is not the same as the audit period, present a separate column in the schedule for each of the award periods that overlap the audit period.

***A* – Expenditures reported for payment –** Show the amount of expenditures the agency reported to DHS for payment. This amount must tie out to the invoices or CARS expenditure reports that the agency filed for the months included in the audit period.

B – Actual allowable cost of the award - For presenting the actual allowable cost of the award, all costs must meet the criteria in the *Allowable Cost Policy Manual*.

- Present program expenses and management/general expenses in separate sections. For management/general expenses, indicate the basis for allocating these expenses to the award.
- For the program and the management/general expenses, use the functional expense categories specified in the budget or in the reporting instructions for the award. If the award does not specify functional categories, use the categories from Schedule IX of the IRS 990 "Return of Organization Exempt from Income Tax." **Include only actual allowable costs in the schedule.** All allowable costs are likely to fit into one of the IRS 990's functional expense categories, but the reverse is not true. Some IRS 990 functional expense categories, such as lobbying and fundraising, are not allowable for reimbursement from grants. Other expenses, such as rent and interest, are allowable under certain circumstances. Include only actual allowable costs in the schedule.

C – Less program revenue and other offsets to costs - Deduct program revenue and other offsets to costs and include a note explaining these amounts.

D – Total allowable costs before profit and ***E - Allowable profit*** – Sections D and E only apply to for-profit organizations. Use the amount for "D -Total allowable costs before profit" in the "Settlement of DHS Cost Reimbursement Award" for "Line 1a - Net allowable operating cost" in the "Allowable Cost Schedule" (*DHS Audit Guide*, Section 2.3.6). Use the amount of "Line 3 Allowable profit" in the "Allowable Cost Schedule" for the "E - Allowable profit" in "Settlement of DHS Cost Reimbursement Award."

F – Total allowable costs - Total allowable cost for the award is the program costs plus management and general costs allocated to the program less program revenue and other offsets to costs plus profit, when applicable. If total allowable costs are less than the payment based on reported allowable costs, the auditor must present a finding and questioned cost on the Schedule of Findings and Questioned Costs.

2.3.5 Reserves Supplemental Schedule

This part applies only to nonprofits paid on a cost reimbursement basis or prospective rate that is settled to an allowable cost basis.

Wisconsin Statute 46.036(5m) allows reserves funded by department programs when the agency is a non-profit, nonstock corporation *and* the funding agency purchased care and services for clients on the basis of a unit rate per unit of client service. The statute defines rate-based service as "a service or a group of services, as determined by the department, that is reimbursed through a prospectively set rate and that is distinguishable from other services or groups of services by the purpose for which funds are provided for that service or group of services and by the source of funding for that service or group of services." Examples of ways to distinguish services include services with different rate per unit of service, services provided at different locations, services funded with different funding sources, and services purchased by different purchasers.

The statute limits the amount that can be retained with a two-part test. The first test limits the amount that can be retained in any one year to 5% of the contract amount, that is the amount paid under the terms of the contract. The second test limits accumulated reserves for all years to 10% of the amount paid under the current contract. However, funding agencies may set lower thresholds or prohibit holding their funds in reserves. See below for discussion of handling reserves in excess caps.

Some providers that receive funding from the Department of Health Services also receive funding from the Department of Children and Families. The two departments have similar statutes allowing providers to retain reserves, and the statutes governing reserves for funding from the Department of Children and Families are in Wisconsin Statute 49.34, which exempts certain child welfare providers from limitations on use of surplus revenue. These changes **do not apply** to funding from the Department of Health Services. Auditors should be alert to potential that providers have mistakenly applied the changes for reserves involving funding from the Department of Children and Families to funding from the Department of Health Services.

The "Reserve Schedule" - If the auditee maintains a reserve of funding from department programs, the audit report must include a "Reserve Schedule" for each rate-based service.

For program audits, the "Reserve Schedule" must by covered by the auditor's "Opinion on the Financial Statement of a Program in Accordance with the Program Audit," which states the auditor's opinion on whether the schedule is fairly presented in all material respects. For agency-wide audits, the schedule must be covered by the auditor's "Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards," which states the auditor's opinion on whether the information in the schedule is "fairly stated, in all material respects, in relation to the basic financial statements taken as a whole."

For purposes of this schedule, materiality is in relation to the service, taking into account additional considerations in discussion in the *Main Document of the State Single Audit Guidelines*, Section 4.11.

General agency costs cannot be included in the schedules for the program unless the overall cost pool/distribution basis is included in the scope of the audit.

Excess Reserves – Reserves in excess of either the first or second test need to be returned to the funding agency, including situations where the funding agency ceases contracting with a provider. The department recommends that the auditee contact the purchaser to work out disposition of the excess reserve in accordance with the allowable uses for this funding stated in Wis. Stat. 46.036(5m)(b)2. The auditor should report a finding if an agency diverts or uses excess reserve in a way that is not in accordance with an agreement with the purchaser or the terms of the statute.

Instructions for Preparing the Reserve Schedule **-** See Illustration 2.3.5 for an example of a "Reserve Schedule" and instructions for preparing the schedule. This format is to be used whenever an agency maintains a reserve funded by department programs, unless the funding agency specifies an alternate format.

Illustration 2.3.5 - Reserve Supplemental Schedule

Reserve Supplemental Schedule
Name of Facility
Period covered by the audit

1. Total units of service _____
2. Allowable expenses for rate-based service _____
3. Total revenue for rate-based service _____
4. Excess (deficiency) revenue over expenses (line 3 less line 2) _____
5. Total reserve from all prior periods (not including this period) _____
6. Calculation of reserve and amounts due to purchasers:

Purchaser	Revenue from purchaser (6b)	Purchaser's share of total revenue (6c)	First Test				Second Test					Total amount due to purchaser (6m)
			Purchaser's share of excess revenue (defic.) (6d)	Cap on reserve for first test (6e)	Amount to add to reserve for this period (6f)	Amount due to purchaser from first test (6g)	Purchaser's share of reserve from prior periods (6h)	Purchaser's share of reserve from all periods (6i)	Cap on reserve for second test (6j)	Amount of reserve (6k)	Amount due to purchaser from second test (6l)	

Illustration 2.3.5 - Reserve Supplemental Schedule, continued

Instructions for preparing the schedule

Facility -- Enter the name of the facility. A separate schedule is needed for each rate-based service operated by the agency/facility.

Period Covered by the Audit -- Enter the period covered by the audit.

1. Total Units of Service -- Enter the total units of service provided by the facility for rate-based service during the period.

2. Total Allowable Expenses for Rate-Based Service -- Enter the total allowable expenses for rate-based service.

3. Revenue for Rate Based Service -- Enter the total amount of rate-based revenue received from all sources.

4. Excess (Deficiency) Revenue over Expenses -- Subtract allowable expenses (2d) from revenue for rate based service (3) and enter the difference. This is the amount that may be applied to the reserve, subject to contractual and statutory limits.

5. Total Reserve from All Prior Periods -- Enter the amount of reserve carried forward from all prior periods. Do not include reserve from the period covered by the current audit.

6. Calculation of Reserve and Amounts Due to Purchasers

6a. Purchaser -- List the names of all purchasers that provided rate-based revenue to the facility.

6b. Revenue from Purchaser -- List the amount of rate-based revenue from each purchaser. The total revenue for this column would agree with the amount shown on line 3.

6c. Purchaser's Share of Total Revenue -- Calculate each purchaser's share of the total revenue for rate-based service by dividing revenue from the purchaser in column 6b by total revenue in column 6b. The sum of the shares in this column would equal 1.

The next four columns are for the first test: limiting the amount that may be retained for the current period to 5% of contract revenue (s. 46.036) or the limit imposed by the contract, whichever is lower.

6d. Purchaser's Share of Excess Revenue (Deficiency) -- Calculate each purchaser's share of the excess revenue by multiplying the amount from line 4 by the share of total revenue in column 6c. The total for this column would equal the amount in line 4.

6e. Cap on Reserve for First Test -- Enter the cap on the reserve specified by the contract or 5% of the amount of revenue from the purchaser (column 6b), whichever is lower.

6f. Amount to Add to Reserve for this Period and 6g. Amount Due to Purchaser as a Result of the First Test -- If the purchaser's share of excess revenue (column 6d) exceeds the cap on reserve for the first test (column 6e), enter the amount of the cap in column 6f and enter the amount in excess of the cap (column 6d - column 6e) in column

6g. Otherwise, enter the amount of the purchaser's share of excess revenue (deficiency) in column 6f and $0 in column 6g.

Instructions continue on following page

Illustration 2.3.5 - Reserve Supplemental Schedule, continued

The last five columns are for the second test: limiting the amount that may be retained for all periods to 10% of contract revenue (s. 46.036) or the limit imposed by the contract, whichever is lower.

6h. Purchaser's Share of Reserve from All Prior Periods -- Enter the purchaser's share of reserve from all prior periods. Facilities may use any method agreed to by their purchasing agencies for determining the shares. Two possible ways to determine shares are to use the purchaser's share as determined by prior audit or to use a pro-rata share obtained by multiplying the amount of reserve for all prior periods (line 5) by the purchaser's share of total revenue (column 6c). The total for this column would agree with the amount in line 5.

6i. Purchaser's Share of Reserve from All Periods -- Add the amount to be added to the reserve for this period (column 6f) to the share of the reserve from prior periods (column 6h).

6j. Cap on Reserve for Second Test -- Enter the cap on the reserve specified by the contract or 10% of the amount of revenue from the purchaser (column 6b), whichever is lower.

6k. Amount of Reserve and 6l. Amount due to Purchaser as a Result of the Second Test -- If the purchaser's share of the reserve from all periods (column 6i) exceeds the cap on reserve for the second test (column 6j), enter the amount of the cap in column 6k and enter the amount in excess of the cap (column 6i - column 6j) in column 6l. Otherwise, enter the amount of the purchaser's share of reserve from all periods (column 6k) in column 6k and $0 in column 6l.

6m. Total Amount Due to Purchaser -- Add the amounts due to the purchaser from the first test (column 6g) and the second test (column 6l) to determine the total amount due to the purchaser, if the purchaser chooses to collect it.

2.3.6 Allowable Profit Supplemental Schedule

Part 2.3.5 "Allowable Profit Supplemental Schedule" applies only to for-profits paid on a cost reimbursement basis or prospective rate that is settled to an allowable cost basis.

Wisconsin Statute 46.036(3)(c) indicates that contracts with proprietary agencies may include a percentage add-on for profit according to the rules promulgated by the department. The requirements for profit are in the *Allowable Cost Policy Manual* which indicates that allowable profit is determined by applying a percentage equal to 7 1/2% of net allowable operating costs plus 15% applied to the net equity, the sum of which may not exceed 10% of net allowable operating costs. Net equity is defined as the cost of equipment, cost of buildings, cost of land and cost of fixed equipment less accumulated depreciation and long term liabilities. The average net equity for the year shall be used. When net equity is less than zero, the department practice is to disregard the net equity part of the calculation for allowable profit.

Funding agencies may establish lower limits on allowable profit or prohibit profit for their contracts.

The "Allowable Profit Schedule" - If the auditee is a for profit entity, the audit report must include an "Allowable Profit Schedule," Illustration 2.3.5. For program audits, the "Allowable Profit Supplemental Schedule" must by covered by the auditor's "Opinion on the Financial Statement of a Program in Accordance with the Program Audit," which states the auditor's opinion on whether the schedule is fairly presented in all material respects. For agency-wide audits, the schedule must be covered by the auditor's "Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards," which states the auditor's opinion on whether the information in the schedule is "fairly stated, in all material respects, in relation to the basic financial statements taken as a whole."

Profit should be calculated at the function or program level when agencies operate multiple functions or programs.

For purposes of this schedule, materiality is in relation to the program, taking into account additional considerations in discussion in *Main Document of the State Single Audit Guidelines*, Section 4.11.

General agency costs cannot be included in the schedules for the program unless the overall cost pool/distribution basis is included in the scope of the audit.

Excess profit – Profit in excess of the allowable limit must be returned to the funding agency. The auditee should consult with the funding agency on treatment of excess profit. Funding agencies decide how to handle excess profit, and they make this decision based on the terms of the contract and requirements of the funding source. Their options include returning the funds outright and recovering through a rate adjustment.

Illustration 2.3.5 - Allowable Profit Supplemental Schedule

ABC Facility
XYZ Parent Corporation
Allowable Profit Supplemental Schedule
For the year ended XXX

1	Base calculation			
1a	Net allowable operating cost	$ -	⇦ **(See note below)**	
	x 7 1/2%	$ -		
	Note -- deduct unallowable costs (such as costs above cost of ownership in related party rent) and cost offsets (such as commodities)			
1b	Adder for average net equity (disregard this step if equity is less than zero)	Beginning of Period		End of Period
	Cost of equipment	$ -		$ -
	Cost of building	$ -		$ -
	Cost of land	$ -		$ -
	Cost of fixed equipment	$ -		$ -
	Less accumulated depreciation	$ -		$ -
	Less long term liabilities	$ -		$ -
	Net equity	$ -		$ -
	Average net equity	$ -		
	x 15%	$ -		
1c	Total base calculation	$ -		
	(Sum of amounts calculated in steps 1a and 1b)			
2	Cap on allowable profit:			
	Net allowable operating cost	$ -		
	x 10%	$ -		
3	Allowable profit	$ -		
	(Lesser of amounts calculated in steps 1c and 2)			

Adapted from allowable profit calculator in the Allowable Cost Policy Manual.

Note – For agencies that are required to include the "Settlement of DHS Cost Reimbursement Award" (*DHS Audit Guide*, Section 2.3.4) in their audit reports, use the amount for "D -Total allowable costs before profit" in the "Settlement of DHS Cost Reimbursement Award" for "Line 1a - Net allowable operating cost" in the "Allowable Cost Schedule" (*DHS Audit Guide*, Section 2.3.6). Use the amount of "Line 3 Allowable profit" in the "Allowable Cost Schedule" for the "E - Allowable profit" in "Settlement of DHS Cost Reimbursement Award."

2.4 Eligibility

This section applies to all audits of agencies that determine eligibility. For A-133 audits, this section supplements guidance for Topic E Eligibility in the OMB Circular A-133 Compliance Supplement.

The requirements for eligibility are unique to each department program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program.

Compliance requirement(s)
Only eligible individuals can participate in the program. Amounts or services provided to or on behalf of clients must be in accordance with program requirements.

Suggested audit procedure(s)
Apply the guidance for Topic "E. Eligibility" in Parts 3 and 6 of OMB Circular A-133 Compliance Supplement (applicable whether or not the audit is a single audit, see introduction to *DHS Audit Guide*, Section 2, above).

2.5 Matching, level of effort, and earmarking

This section applies to all audits of agencies that have funding with a matching, level of effort, or earmarking requirement. For A-133 audits, this section supplements guidance for Topic G Matching, Level of Effort, Earmarking in the OMB Circular A-133 Compliance Supplement.

The auditor must test matching, level of effort, or earmarking if these requirements are a condition of the agency's funding. The requirements for matching, level of effort, and earmarking are unique to each program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program. Matching, level of effort and earmarking are defined as follows:

> *Matching* or cost sharing includes requirements to provide contributions of a specified amount or percentage to match program awards. Matching may be in the form of allowable costs incurred or in-kind contributions (including third-party in-kind contributions).
>
> *Level of effort* includes requirements for (a) a specified level of service to be provided from period to period, (b) a specified level of expenditures from other sources for specified activities to be maintained from period to period, and (c) program funds to supplement and not supplant non-program funding of services.
>
> *Earmarking* includes requirements that specify the minimum and/or maximum amount or percentage of the program's funding that must/may be used for specified activities, including funds provided to *subrecipients. Earmarking may also be specified in relation to the types of participants covered.*

Compliance requirement(s)
The provider must provide at least the minimum amount or percentage of contributions or matching funds.

Suggested audit procedure(s)
Apply the guidance for Topic "G. Matching, Level of Effort, Earmarking" in Parts 3 and 6 of OMB Circular A-133 Compliance Supplement (applicable whether or not the audit is a single audit, see introduction to Section 2, above).

2.6 Reporting

Sections 2.6.1 and 2.6.2 of this section apply to all audits. Sections 2.6.3 and 2.6.4 apply to counties, and the two nonprofits administering Children's Long Term Support Waiver (CLTS, *DHS Audit Guide*, Section 3.18).

For A-133 audits, Section 2.6 supplements guidance for Topic L Reporting in the OMB Circular A-133 Compliance Supplement.

Reporting requirements are unique to each program and are found in the laws, regulations, the contract provisions and/or grant agreements pertaining to the program. Under the *DHS Audit Guide*, the compliance testing for reporting must be performed as a basic procedure whether or not the auditee has major programs from the department. In addition, this section provides guidance on applying the federal guidance on audit reporting for federal programs passed through the Department of Health Services.

Problems with reporting can result in over or under payment for the program. In addition, some reporting problems signal the potential for a significant disallowance or even violation of laws governing use of program funds. When auditors find problems with reporting, they should expand testing to determine the extent of the problem. Auditors should also contact the funding agency for assistance in understanding the ramifications of the problem and for advice on how the agency can take corrective action.

2.6.1 Reporting, generally

This section applies to all audits.

Apply the guidance for Topic "L. Reporting" in Parts 3 and 6 of OMB Circular A-133 Compliance Supplement (applicable whether or not the audit is a single audit, see introduction to *DHS Audit Guide*, Section 2, above). OMB describes reporting as being in three categories:

Financial reporting -- Most Federal granting agencies require reporting of costs or activities as the basis for making payments to providers.

Performance and program reporting -- Many granting agencies require performance or program reporting. These reports generally contain the following information:

1. A comparison of actual accomplishments with the goals and objectives established for the period.
2. Reasons why established goals were not met, if appropriate.
3. Other pertinent information including, when appropriate, analysis and explanation of cost overruns or high unit costs.

Special reporting – Granting agencies may require other reports to meet their information needs.

Examples of financial reporting mechanisms include invoices and Community Aids Reporting System (*DHS Audit Guide*, Section 2.6.2) and Human Services Reporting System (*DHS Audit Guide*, Section 2.6.3 and 2.6.4). An example of performance reporting is the reporting requirements for the objective based program cluster Public Health Program Cluster (*DHS Audit Guide*, Section 3.13).

2.6.2 Reporting allowable costs for reimbursement through invoices and Community Aids Reporting System (CARS)

This section applies to all audits, and it supplements Section 2.6.1. for agencies that are reimbursed for allowable costs reported through invoices or through the Community Aids Reporting System (CARS).

Compliance requirement(s)

Expenses and revenues reported to the department through Community Aids Reporting System (CARS) or through invoices must be complete, accurate, and supported by the agency's records. All expenses must meet the criteria for allowability in the *Allowable Cost Policy Manual*, which incorporates the federal cost principles that apply to local governments. Third party revenues such as collections from private insurers, client cost share, and payments for medical assistance card services must be credited to the respective programs (waiver programs require additional explanation for third party revenues - see Sections 2.6.3 and 2.6.4, below).

CARS prepayments must be earned or returned. Some agencies that are new to reporting costs to the Department of Health Services for payment through CARS are surprised to owe money back to the department at the end of the contract. Here's what happens: Because there is a several month lag between when an agency incurs costs and when CARS pays those costs, CARS makes up to three "prepayments" at the beginning of the grant to help with cash flow. Then CARS switches to making payments based on reported costs, and toward the end of the grant, CARS takes back the prepayments by deducting them from payments based on reported costs. Some agencies have stopped reporting costs once their prepayments plus payments on reported costs equal their contract amount, not realizing that they need to report all costs in order to earn the full contract amount.

Pre-payments can result in situations where an agency has received more funding than it has incurred in allowable costs, especially early in the contract or in situations where the bulk of the contract activity is later in the contract.

Suggested audit procedure(s)

- Determine whether the agency is reporting allowable costs and third party revenues on CARS and invoices. (This procedure may be performed in conjunction with major program testing for programs from this department.)
- Determine whether the agency is performing control activities for ensuring accurate reporting, such as timely and accurate reconciliations between what it records in its records and what it reports to the department through CARS or invoices.

- Confirm that the agency has reconciled final reported costs to their accounting records and that those amounts are supported by the audited financial statements.
- At the end of the contract, CARS payments that are made to and retained by the agency in excess of allowable costs net of third party revenues must be reported to the Department of Health Services as a questioned cost.

2.6.3 Reporting through the Human Services Reporting System (HSRS)

Section 2.6.3 (and 2.6.4) applies to counties and Chapter 51 boards. It supplements Section 2.6.1 for agencies that report long-term care costs to the department through Human Services Reporting System (HSRS). HSRS is the system of record for Medicaid payment for the waiver programs, and agencies report detailed information on waiver services on this system. As HSRS does not have the capacity to generate payments, agencies also report summary information on CARS, which is a payment system. The department adjusts the amount on CARS to agree with the waiver service costs that the county reported on HSRS.

Compliance requirement(s)

Expenses and revenues reported to the department through HSRS must be complete, accurate, and supported by the agency's records. All expenses must meet the criteria for allowability in the *Allowable Cost Policy Manual*, which incorporates the federal cost principles that apply to local governments. In addition, all costs must meet the criteria for allowability for the particular service category, 1) the service was approved for the client through the Individual Service Plan, and 2) the cost of the service does not include non-service components, such as personal allowance. Third party revenues such as collections from private insurers, client cost share, and payments for medical assistance card services must be credited to the respective programs (waiver programs require additional explanation for third party revenues - see Section 2.6.4, below).

Suggested audit procedure(s)

- Determine whether the agency is reporting allowable costs and third party revenues on HSRS. (This procedure may be performed in conjunction with major program testing for programs from this Department.)
- Determine whether the agency is performing control activities for ensuring accurate reporting, such as timely and accurate reconciliations between what it records in its accounting records and what it reports to the department through HSRS.
- Confirm that the agency has reconciled final reported costs to their accounting records and that those amounts are supported by the audited financial statements. Costs reported in excess of those supported by the audited financial statements must be reported as a questioned cost .

2.6.4 Additional considerations for reporting for Medicaid waiver programs

Section 2.6.4 (and 2.6.3) applies to counties, and the two nonprofits administering Children's Long Term Support Waiver (CLTS, Section 3.18). This section and Illustration 2.6.4 supplement Sections 2.6.1, 2.6.2, and 2.6.3 for agencies that report costs for Medical Assistance waiver programs to the department through CARS and HSRS

The Medical Assistance waiver programs are established with Federal approval in accordance with Sections 1115 or 1915 of Title XIX of the Social Security Act. These programs include Community Integration Program I (*DHS Audit Guide*, Section 3.2) and Community Integration Program II/ Community Options Program Waiver (*DHS Audit Guide*, Section 3.5). They provide flexibility for the State of Wisconsin and its counties in providing community based care to citizens who might otherwise require services in a nursing home or other institution. Because of the flexibility allowed under the Medical Assistance waiver programs, the Federal granting agency imposes more stringent and extensive financial and programmatic reporting requirements.

Throughout the year, the county reports Medical Assistance waiver programs on HSRS, along with other service detail that supports the federal funds used for the waiver. Since HSRS is not a payment system, the county also reports costs on the respective CARS waiver profile. Except for the Children's Long Term Support waiver program as it operated prior to transition in 2011 to Third Party Administrator, there is no link at this point between the costs reported on HSRS and those reported on CARS other than the county's records supporting what it reported on those systems.

As noted above, all costs reported on CARS and HSRS must be complete, accurate, and supported by the agency's records. All expenses must meet the criteria for allowability in the *Allowable Cost Policy Manual*, which incorporates the federal cost principles that apply to local governments. In addition, all costs must be meet the criteria for allowability for the particular service category, 1) the service was approved for the client through the Individual Service Plan and, 2) the cost of the service does not include non-service components, such as personal allowance or room and board.

The costs reported on HSRS and on the CARS profiles for the waiver programs must be net of applicable credits for third party revenues. These revenues include collections from private insurers and payments for medical assistance card services, which must be credited to the respective programs. It is not appropriate to report the cost of these services to the waiver programs and later credit those programs for collections: even with subsequent adjustment, such a practice constitutes duplicate billing for Medicaid. (Client cost share is reported on HSRS as SPC 095.01, which HSRS handles as a negative number.)

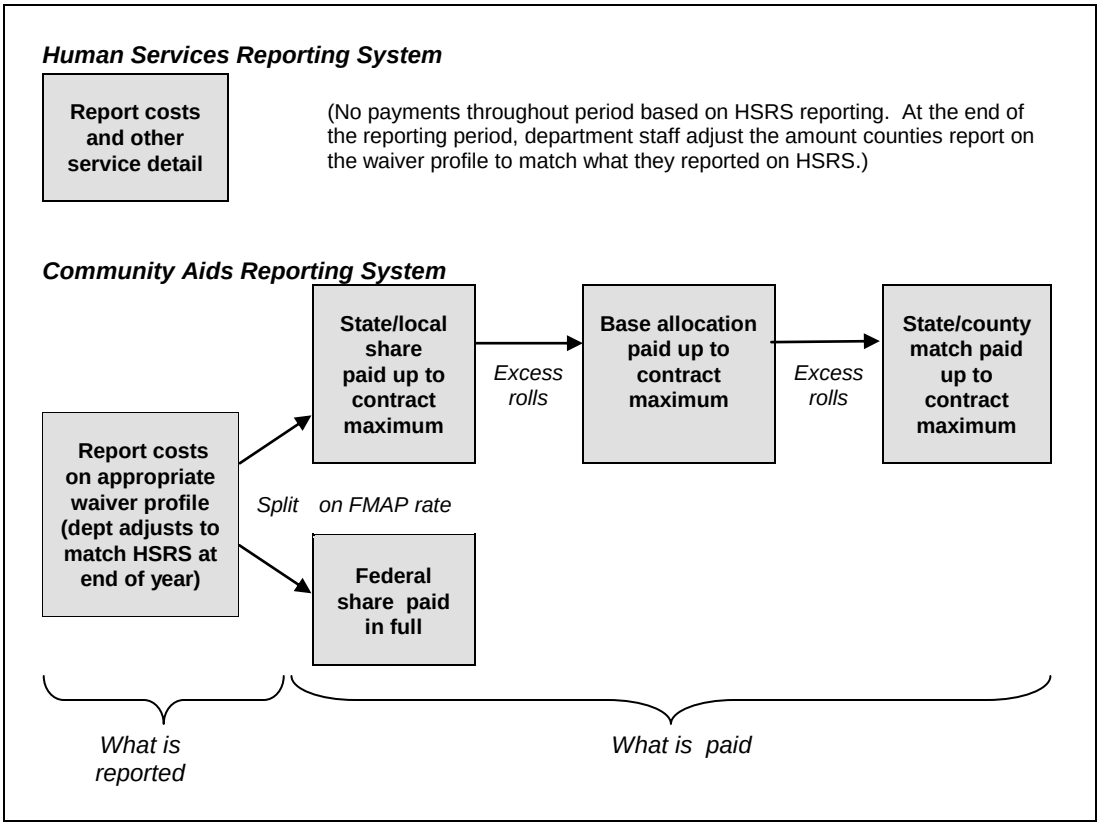
However, in some cases there is uncertainty as to what the county will collect under the medical assistance card billing, making it difficult to determine the net amount that could be reported to the waiver program. Counties may report the cost of services that are billed to medical assistance card services and the subsequent revenues for the Base County Allocation. This avoids the possibility of duplicate billing for Medicaid, while ensuring completeness of reporting.

Costs that the county reported on the Home and Community-Based Services waiver profiles are split between profiles for the state share and the federal share based on the Federal Medical Assistance Participation (FMAP) rate that is in effect for that period (see Illustration 2.6.4, below). CARS makes monthly payments for the state share up to the contract maximum, and it rolls any excess to the Base County Allocation. CARS pays the Base County Allocation up to its

contract maximum, and it rolls the excess to the state/county match profile. Counties commonly have significant amounts ultimately roll to the state/county match.

Costs allocated to the federal share profiles are reimbursed to the reporting county in full. The department draws federal funds to cover reimbursement of waiver costs. At reconciliation for closing out the contract year, the department's program managers adjust the costs recorded and paid based on CARS waiver profile to match the more detailed cost information on HSRS, the system of record. Payments are adjusted based on this year-end reconciliation and any contract amendments.

Illustration 2.6.4 - HSRS and CARS - What is reported and what is paid



2.7 Information technology (IT) security provision in state/county contract

This section applies to audits of counties and Chapter 51 boards.

Compliance requirement(s)
Federal regulations 45 CFR Part 95 require agencies administering federal financial assistance

programs to establish a plan, policy, and procedures to address information technology (IT) security. The Department of Health Services included the following IT security requirements in the State/County Contract:

(1) The County shall keep all State owned data processing equipment that is located in the County in a secure place and compensate the Department for any theft, damage, or other loss of the equipment if the Department's prescribed security precautions have not been met.
(2) The County shall designate an employee as County Security Officer to be responsible for ensuring compliance with security precautions for state-owned computer equipment, data confidentially, and user access.
(3) …
(4) The County shall comply with the provisions contained in HIPAA and 45 C.F.R. § 95.621 and any other applicable federal or state laws or requirements for maintaining security and privacy for protected health information, personally identifiable information and any other confidential information.

Federal security regulations 45 CFR Part 164 implementing the Health Insurance Portability and Accountability Act (HIPAA) require DHS to enter into business associate agreements with counties that are administering the Home and Community Based Waiver programs on behalf of DHS. The agreements require counties to implement certain security safeguards.

1. **Safeguarding and maintenance of Protected Health Information (HIPAA Business Associate Agreement Addendum)**
   a. The County will develop, implement, maintain, and use:
      (i) appropriate administrative, technical, and physical safeguards to prevent improper use or disclosure of Protected Health Information (PHI), in any form or media; and
      (ii) appropriate administrative, technical, and physical security measures to preserve the confidentiality, integrity and availability of stored electronically maintained or transmitted PHI.

   b. The County will document and keep these safeguards and security measures current and available for inspection by the Department or its agents, upon request. Security measures employed by the County must comply with HIPAA security requirements.

2. **Use or disclosure of Protected Health Information by subcontractors and agents of the county (HIPAA Business Associate Agreement Addendum)**
   The County agrees to require any agent, including subcontractors, to whom the County provides PHI to comply with the same restrictions and conditions applicable to the County with respect to PHI. This provision does not apply to the use or disclosure of PHI by subcontractors that provide health care treatment to individuals or to other persons or organizations that have entered into an Organized Health Care Arrangement (OHCA) as provided for under the provisions of HIPAA. (See *DHS Audit Guide,* Section 2.8 for other compliance requirements for subcontracts.)

Suggested audit procedure(s)
Determine whether the county has procedures and controls to provide reasonable assurance of achieving the following objectives and whether the county actually did achieve these objectives:

- Only authorized personnel have access (i.e. view, add, change, or delete) to department systems and to confidential information entered into or extracted from these systems.
- Access is removed or changed on a timely basis when a person leaves employment or changes job duties.
- Department-owned equipment is protected from loss due to damage or theft.
- The agency has a contingency plan to ensure continuation of essential IT services in event of a disaster.

- The county periodically assesses the effectiveness of its IT security plan in meeting the requirements in the *Security Manual* and the requirements under HIPAA, and the county identifies and implements improvements to the plan.
- The county has required subcontractors to whom protected health information is provided to comply with the same restrictions to which the county is held in the HIPAA Business Associate Agreement Addendum. (See *DHS Audit Guide*, Section 2.8 for other audit procedures for subcontracts.)

2.8 Procurement and suspension and debarment

Section 2.8.1 applies to all agencies, while Section 2.8.2 applies only to counties, 51 boards and tribes.

Section 2.8 supplements guidance for Topic I "Procurement and Suspension and Debarment" and Topic M "Subrecipient Monitoring" in the OMB Circular A-133 Compliance Supplement in situations where the agency needs to have an A-133 audit.

2.8.1 Procurement and suspension and debarment, generally

This part applies to all agencies

Procurement requirements of this section apply to all agencies when:

- payments are made on or limited to an allowable cost basis, including limits on reserves and profit (*DHS Audit Guide*, Section 2.3),
- the auditee has a match requirement that is met through other allowable expenditures for the program (*DHS Audit Guide*, Section 2.5), or
- audited allowable costs are required to be reported in the audit report

Grant agreements and contracts involving department funds require that agencies comply with the *Allowable Cost Policy Manual (ACPM)*. The *ACPM* discusses several aspects of acceptable procurement practices, including written standard of conduct, open and free competition, and minimum procedural requirements. The ACPM also directs agencies to detailed guidance on procurement and subcontracting in OMB Circular A-102/Common Rule and OMB Circular A-110 by reference.

Many grant agreements and contracts involving funding from DHS prohibit contracting or granting funds to parties that have been suspended or debarred or whose principals are suspended or debarred.

Credit cards and purchasing cards are particularly vulnerable to fraudulent, abusive, and inappropriate transactions, warranting attention when assessing risks for an agency's purchasing function. The Association of Government Accountants has a best practices guide for purchase cards that can be a useful resource for agencies.

Compliance Requirement
Agencies must follow acceptable procurement practices.

Suggested Audit Procedures

- Apply the guidance for Topic "I. Procurement and Suspension and Debarment" in Parts 3 and 6 of OMB Circular A-133 Compliance Supplement.

2.8.2 Purchase of Care and Services

This section applies to counties, 51 boards and tribes.

In addition to compliance requirements on procurement in general that are discussed in *DHS Audit Guide*, Section 2.8.1, Wisconsin Statute 46.036 establishes the standards for purchases of care and services made by a county social services department, a county department of public welfare, or a board established under s. 46.23, 51.42 or 51.437. Per s. 20.002(13) these standards are also applicable to Indian Tribes. Additional purchase of service (subcontracting) requirements are contained in the *Financial Management Manual*, the federal Common Rule and OMB Circular A-133 . See *DHS Audit Guide*, Section 2.7 for compliance requirements and audit procedures under the Health Insurance Portability and Accountability Act (HIPAA) related to subcontracting.

Procurement of care and services

Compliance requirement(s)
Counties must follow acceptable procurement standards when purchasing care and services using funds from the Department of Health Services.

Suggested audit procedure(s)
Determine whether the county:

- procured the care and services through a process that is consistent with applicable procurement policies and procedures.
- has a conflict of interest policy regarding the selection, award, or administration of the contract.
- has contracts on file for purchase of services, where applicable, or a waiver from the Department of Health Services.
- monitors contract compliance, including collecting financial, performance, program, and special reports; reviewing them in a timely manner; and taking action when problems were noted.
- ensures that payments for care and services do not exceed the amount specified in the contract.

License and certification of providers

Compliance requirement(s)
Services that are paid using funding from DHS must meet standards for quality. One of the ways that a funding agency ensures that the services they purchase from providers meet the standards for quality is to confirm that the providers hold the appropriate license or certification for the type of service being purchased.

- *License or certification requirements for providers for residential care* – Providers of residential care services must hold the appropriate license or certification. Examples of residential care providers typically paid with funding from DHS include:

  Adult Family Home
  Community Based Residential Facility
  Residential Care Apartment Complex (RCAC facilities may be "certified" or "registered." Facilities must be "certified" to serve publicly funded tenants, and facilities that are "registered" may serve only private pay tenants.)

- *Certification requirements for providers for alcohol and other drug abuse or mental health services* – Providers for alcohol and other drug abuse or mental health services may need to be certified prior to receiving payments under Chapter 51 of Wisconsin Statutes, third party reimbursement (e.g. health maintenance organizations (HMO's)), or the Medicaid program. HMO's may require certification based on their guidelines.

  Alcohol and Other Drug Abuse

DHS 75.04	Prevention Service
DHS 75.05	Emergency Outpatient Service
DHS 75.06	Medically Managed Inpatient Detoxification Service
DHS 75.07	Medically Monitored Residential Detoxification Service
DHS 75.08	Ambulatory Detoxification Service
DHS 75.09	Residential Intoxication Monitoring Service
DHS 75.10	Medically Managed Inpatient Service
DHS 75.11	Medically Monitored Treatment Service
DHS 75.12	AODA Day Treatment
DHS 75.13	Outpatient Treatment
DHS 75.14	Transitional Residential
DHS 75.15	Narcotic Treatment Service For Opiate Addiction
DHS 75.16	Intervention Service

  Mental Health

DHS 34	Emergency Mental Health Services
DHS 35	Outpatient Mental Health Clinics
DHS 36	Comprehensive Community Services
DHS 40	Mental Health Day Treatment Services for Children
DHS 61.71	Inpatient
DHS 61.75	Day Services
DHS 61.79	Children and Adolescent Inpatient
DHS 63	Community Support Programs

Suggested audit procedure(s)
For a sample of providers of residential care and of alcohol and other drug abuse or mental health services, determine whether the county has confirmed that the providers have the appropriate license(s) or certification(s) for the nature of the services purchased from these providers.

Audits of providers

Compliance requirement(s)
Wisconsin Statute 46.036(4)(c) requires providers that receive more than $25,000 in funds from the Department of Health Services or from a county to have an audit that meets department standards, unless the audit is waived by the department. The statute allows the department to

waive audits on a case-by-case basis. In addition, Wis. Stat. 66.0143 authorizes local governments to file requests for waivers of statutory mandates with the Department of Revenue. Several counties have used this provision to receive waivers increasing the $25,000 threshold in Wis. Stat. 46.036 for requiring providers to have audits to $75,000 or, in a few instances, $100,000. These waivers are effective for four years, and the department may renew the waivers for additional four-year periods. A current list of counties that have these waivers, the thresholds for their waivers, and the dates the waivers expire is on the department's website at http://www.dhs.wisconsin.gov/grants/Audit/auditdept/index.HTM.

The department's standards for audits are in *State Single Audit Guidelines* and the *DHS Audit Guide*, which is an appendix to the SSAG. Provider audit reports are typically due to the funding agency six months from the end of the provider's fiscal period, and the funding agency should review and resolve the provider audit reports within six months of receipt of the reports.

Because of the timing of audit fieldwork, auditors are likely to encounter situations where the deadlines for when audit reports are due to the county and for when the county must review and resolve the audit reports have not yet passed as of the end of fieldwork. In these cases, there is no finding of noncompliance, and county auditors must follow-up on the status of the provider audits in the subsequent county audit. Guidance on presenting audit findings involving provider audit reports is included at the end of this section.

Suggested audit procedure(s)
Determine whether the agency:

- documented its decision process for deciding whether to require an audit.
- performed alternate monitoring, if it planned to rely on alternate monitoring in order to waive the audit or require a lesser-scoped audit than the risk would have otherwise indicated.
- gave the provider information on the nature of funding (federal, state, local, mixture) so the provider could have the appropriate type of audit.
- received the provider audit reports or has a waiver on file from the Department of Health Services.
- reviewed the provider audit reports to ensure they contain all applicable report elements required by the contract and by the type of audit that was performed.
- resolved audit findings within six months of receipt of the audit.

Guidance on reporting purchase of service findings in the Schedule of Findings and Questioned Costs
For provider audit reports which have not been received as of the end of fieldwork:

- if the deadline for receiving the provider audit report has not passed, there is no finding of noncompliance. (The auditor follows up in the subsequent county audit.)
- if the deadline for receiving the provider audit report has passed, report a finding in the Schedule of Findings and Questioned Costs.

For provider audit reports which have been received, but not yet reviewed and resolved as of the end of fieldwork:

- if the deadline for reviewing and resolving the provider audit report has not passed, there is no finding of noncompliance. (The auditor follows up in the subsequent county audit.)
- if the deadline for reviewing and resolving the provider audit report has passed, report a finding in the Schedule of Findings and Questioned Costs.

At a minimum, the finding must include:

- the name of the provider,
- the payments made applicable to the contract period,
- the Community Aids Reporting System (CARS) line number on which the related expenditures were reported the Department of Health Services, and
- the program title and identification number.

2.9 Client rights and client funds

This section applies to audits of counties and 51 boards.

Wisconsin Statute 51.61 and Administrative Code DHS 94, Patient Rights, define the legal requirements for client rights and client funds for clients with a mental illness, a developmental disability, alcohol abuse or dependency, or other drug abuse or dependency. The purpose of this section is to ensure that county agencies and boards comply with the requirements for client rights and client funds when county staff provide services to these clients. The program manager notes that audit results have assisted in making substantial improvements in implementation requirements for rights and monitoring of client funds.

Compliance requirement(s)
See s. 51.61, Stats. and DHS 94.

Suggested audit procedure(s)
For a representative sample of case files, determine whether the county has complied with the laws and administrative rules governing client rights and client funds. Counties typically document compliance with these requirements in case files using forms or other notations in the treatment record.

1. Check for an annual invitation to or meeting with the client/guardian to facilitate their participation in the planning of their treatment and care.
2. Check for annual written informed consent, signed by the client/guardian, for treatment.
3. Check for annual written informed consent, signed by the client/guardian, for each medication.
4. Check for documentation of annual re-notification of rights, including the right to file a grievance.
5. When the county acts as representative payee for the client, check for consent for the county to act as the representative payee.

6. When the county handles client funds, check for records on the uses of the client funds and cash disbursements and confirm that clients have access to their personal allowance/petty cash.
7. Check for documentation of client rights training for all staff who work with clients.

Report absence of appropriate case file documentation or training documentation as a finding.

2.10 Illegal Acts and other misconduct

This section applies to all audits.

Federal grant administration policies that apply to all federal grants, and by extension to all DHS funding, require recipients of funding to report to the funding agency issues which will materially impair the ability to meet the objective of the award. The American Recovery and Reinvestment Act and its implementation memoranda provide descriptions of the kinds of issues that must be reported for situations involving recovery act funds. We believe that the Recovery Act guidance is consistent with the intent of the more general grant administration policies, making the Recovery Act guidance useful for any grant situation.

This section supplements the discussion of the auditee's and the auditor's responsibilities in *DHS Audit Guide*, Section 2.1.4 "Prevent and detect fraud" and *DHS Audit Guide*, Section 3.6 "Consideration of fraud in a financial assistance environment" of the *Main Document of the State Single Audit Guidelines*. In this section, we are adding clarification from the Recovery Act guidance on the situations involving illegal acts and other misconduct that the agency must report and the parties that the agency must report those situations to.

Compliance requirement(s)
Agencies receiving the department's funds must promptly report all suspected illegal acts or other misconduct to the funding agency, investigate in accordance with these guidelines and the funding agency's direction, take corrective action for weaknesses that led to the fraud or misconduct, and repay the funding agency for all losses of department funding due to illegal acts or other misconduct.

The term "illegal acts" includes false claims under the False Claims Act; a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity; or similar misconduct. Suspected illegal acts are to be reported in writing by mail to DHS Auditors, 1 West Wilson Street, Room 627, P.O. Box 7850, Madison, WI 53707-7850 or by email to DHSAuditors@Wisconsin.gov. For funding received under the American Recovery and Reinvestment Act, the contractor/grantee must also report evidence of illegal acts to the Inspector General of the federal agency that provided the funds. Inspector General contact information is online at http://www.recovery.gov/?q=content/agency-fraud-hotlines.

The term "other misconduct" includes:

1) gross mismanagement of an agency contract or grant relating to funds received under this agreement;

2) a gross waste of funds received under this agreement;
3) a substantial and specific danger to public health or safety related to the implementation or use of funds received under this agreement;
4) an abuse of authority related to the implementation or use of funds received under this agreement; or
5) a violation of law, rule, or regulation related to an agency contract (including the competition for or negotiation of a contract) or grant, awarded or issued relating to funds received under this agreement.

The contractor/grantee shall promptly report such misconduct involving funding received under this agreement in writing to the contract administrator.

Suggested audit procedure(s)

- Apply the procedures in the *Main Document*, Section 3.6 "Consideration of fraud in a financial assistance environment" and current professional guidance on consideration of fraud in an audit.
- If the auditor becomes aware that the auditee had an incident involving illegal acts, confirm with DHS Auditors that the auditee has reported the incident.
- If the auditor becomes aware that the auditee had an incident involving other misconduct, confirm with the contract administrator that the auditee has reported the incident.