# Summary of Significant Audit Findings for Local Mental Health Authorities for Fiscal Year 2018

As Required By

Texas Health and Safety Code

Section 534.068 (f)

Health and Human Services

Commission

December 2019

TEXAS
Health and Human Services

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# Executive Summary

The *Summary of Significant Audit Findings for Local Mental Health Authorities for Fiscal Year 2018* is submitted in compliance with Texas Health and Safety Code, Section 534.068(f).

Local Mental Health Authorities and Local Behavioral Health Authorities (LMHAs/LBHAs) expending $750,000 or more in federal and state awards must have a single audit conducted in accordance with *2 Code of Federal Regulations (CFR) 200 Uniform Administrative Requirements, Cost Principles and Audit Requirements* or the *Uniform Grant Management Standards (UGMS)*.

Single Audits are submitted to the Health and Human Services Commission (HHSC) Procurement and Contracting Services (PCS) Single Audit Unit (SAU). The SAU submits agency finding letters to HHSC PCS Contract Oversight and Support when findings are noted in each Single Audit Report. HHSC is responsible for resolution of these issues and reporting to the Governor, Legislative Budget Board, and Legislative Audit Committee.

This report summarizes the independent auditor's findings of 39 LMHAs and their responses for fiscal year 2018.

# 1. Introduction

Section 534.068(f) requires HHSC to submit a report annually to the Governor, Legislative Budget Board, and Legislative Audit Committee. The report must include a summary of the significant findings identified during a review of fiscal audit activities. Audits are conducted and submitted to HHSC in compliance with Texas Health and Safety Code, Section 534.068(a).

# 2. Background

This report summarizes findings from the review of independent financial and compliance audits, in accordance with *2 CFR 200 Uniform Administrative Requirements, Cost Principles and Audit Requirements* or the UGMS.

Also noted are fiscal year 2017 findings, questioned costs, and corrective plans. In addition, follow up on prior year findings and any relevant comments, as outlined in the auditor's management letter, are included. All findings, comments, and corrective actions are reproduced verbatim from the independent audit reports and are not modified by HHSC.

# 3. Summary of Significant Findings

## 3.1 Abilene Regional MHMR dba Betty Hardwick Center

**City:** Abilene

**Counties Served:** Callahan, Jones, Shackelford, Stephens, and Taylor

**Type of Report on Financial Statement:** Unmodified[1]

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-A – Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. In conjunction with the completion of our audit, we were requested to draft the financial statements and accompanying notes to those financial statements. Additionally, we proposed several audit adjustments to the Center's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

[1] An unmodified or unqualified opinion states that the financial statements present a fair and accurate picture of the company and comply with generally accepted accounting principles.

*Cause:* The Center does not prepare and has not developed an internal control system to provide for the preparation of the financial statements and related disclosures in accordance with generally accepted accounting principles.

*Effect:* Although this circumstance is not unusual for an organization of your size, the preparation of financial statements and adjusting journal entries as a part of the audit engagement may result in financial statements and related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by Center personnel. The need for the audit adjustments indicates that the Center's interim financial information may not be materially correct, which may affect management decisions made during the course of the year.

*Recommendation:* The Center should continue to evaluate and improve the controls over financial reporting and implement changes as necessary to ensure accurate and timely financial reports can be completed.

*Management's Response:* Management agrees with the noted finding and believes they have made progress in improving controls and will continue to make progress.

**Follow-up on Prior Year Findings:**

Finding 2017-A:

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary*: Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that might not would have been identified as a result of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements.

*Status:* Ongoing. Due to cost considerations, we will continue to have Eide Bailly LLP prepare our draft financial statements and accompanying notes to the financial statements.

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Finding 2018-A

*Corrective Action Plan:* It is not cost effective to have an internal control system designed to provide for the preparation of the financial statements and accompanying notes. We requested that our auditors, Eide Bailly LLP, prepared the financial statements and the accompanying notes to the financial statements as a part of their annual audit. We have designated a member of management to review the drafted financial statements and accompanying notes, and we have reviewed with and agree with the material adjustments proposed during the audit.

*Anticipated Completion Date:* Ongoing

## 3.2 Anderson-Cherokee Community Enrichment Services dba ACCESS

**City:** Jacksonville

**Counties Served:** Anderson and Cherokee

**Type of Report on Financial Statement:** Unqualified

**Type of Report on Compliance:** Unqualified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.3 Andrews Center

**City:** Tyler

**Counties Served:** Henderson, Rains, Smith, Van Zandt, and Wood

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-001 – Material Weakness Related to Internal Controls over Financial Reporting

*Criteria:* Management is responsible for maintaining adequate internal controls over financial reporting.

*Condition:* During FY 2018, in response to a FY 2017 audit finding, the Center implemented new general ledger software along with new billing software. As a part of the implementation, the software vendors provided training to the Center staff. During our audit procedures, we noted that the accounting staff is still obtaining the knowledge necessary to manage the new general ledger system and produce reports that will assist in the financial reporting process. Areas of difficulty include accounts receivable; the transfer of data between the general ledger and billing software; accounts payable; bank reconciliations; capital assets and debt. These conditions pose a significant risk to internal controls over financial reporting and contributed to a number of adjusting entries at year-end.

*Cause:* Based on our observation and comments from the Center staff, the staff needs additional training on the use of the general ledger software. The software was implemented toward the end of the fiscal year, so lack of experience with the software also contributed to this condition.

*Effect:* The Center has difficulty producing internal financial statements that are free of significant adjustments.

*Recommendation:* We recommend that management implement procedures to update staff training on the use of the new general ledger software. This additional

training may be available from the software vendor or as an alternative, other Centers who utilize the same software may be able to provide assistance.

*Management's Response:* The Center implemented the financial software on August 1, 2018. The training for our bank reconciliations and fixed assets were scheduled to be after the go live date. It was anticipated that there would be a learning curve for employees as we spoke with another community center that had begun using the software on Sep. 1, 2017 and indicated that it took approximately six months to get familiar with it. In addition, we had staff turnover in key areas of accounts payable, billing, payroll, and the Director of Revenue Cycle Management. The Center also begin using new electronic health record/billing software in FY 2018 on Sep. 1, 2017. As part of that software, there was a general ledger extract to retrieve billing and cash information to go into our new financial software, but it was not functional, which contributed to some of our bank reconciliation issues. We are contracting with an outside programmer to fix this issue. As a result of staff turnover, we did have the electronic health record vendor come on-site on Dec. 18, 19, and 20 to retrain our billing staff for billing and our accounting staff on its reporting capabilities to resolve our reconciliation issues. We are also preparing a gap analysis to determine what additional training is needed from our general ledger software vendor.

Finding 2018-002 – Material Weakness Related to Internal Controls over Financial Reporting

*Criteria:* Management is responsible for maintaining adequate internal controls over financial reporting.

*Condition:* During our audit procedures we noted the Center has a process to reconcile bank accounts on a periodic basis. During our review of reconciliations performed during the year, we noted the bank reconciliations reflected differences with the Center's general ledger trial balance. Sometimes these differences were significant. Generally, these differences were caused by payments received in the SmartCare billing software that were not transferred over to the general ledger accounting system. During the year, entries were not made to the accounting system to reconcile the bank reconciliation and the general ledger trial balance. At year-end it was necessary for Center staff to identify and make journal entries to agree the respective bank reconciliations to the general ledger trial balance.

*Cause:* The Center has no formal procedures in place to make journal entries to adjust the trial balance to agree to the monthly bank reconciliation.

*Effect:* Failure to make entries in the accounting records to agree bank reconciliations to the trial balance does not provide assurance that financial statements can be prepared in accordance with GAAP. Significant year-end entries were required to adjust the financials to reflect ending reconciled balances for bank accounts.

*Recommendation:* Following the efforts of the accounting staff, the year-end trial balance was adjusted to reflect reconciled bank balances. We recommend that any necessary entries be made in a timely manner on a monthly basis.

*Management's Response:* Due to the new general ledger software, it took the accounting staff longer to close the fiscal year than normal which contributed to these issues. Our old software did not have the capability of doing bank reconciliations, so they were done in QuickBooks. The new financial software has a module specifically for bank reconciliations that we are training on now. Once the staff is fully trained, then monthly entries will be made as necessary to reconcile the bank accounts to the general ledger on a monthly basis. Additionally, as mentioned above the accounting staff received training on the electronic health record software in December 2018 to retrieve reports to manually pull information until the general ledger extract is completed.

Item 2018-003: Procurement Standards – Uniform Guidance

*Criteria:* Management is responsible for adopting policies and procedures that comply with the Procurement Standards of the Uniform Guidance. The procurement standards prescribed by the Uniform Guidance require written standards of conduct covering conflicts of interest for all employees involved in procurement. The policy must provide for disciplinary actions for violations.

*Condition:* The Center utilizes procurement cards for certain small purchases. Employees sign a procurement card agreement when a procurement card is assigned to them. The agreement we reviewed did not specifically address conflicts of interest.

*Cause:* The procurement standards prescribed by the Uniform Guidance were effective for the first time in FY 2018. As a result, compliance with this requirement is new to community centers.

*Effect:* The Center is not in full compliance with the procurement standards specified by the Uniform Guidance.

*Recommendation:* We recommend the Center incorporate language prescribed by the Uniform Guidance related to conflicts of interest in the procurement card agreement.

*Management's Response:* The procurement card agreement will be updated with the required language and the agreements will be re-issued for signatures by Feb. 28, 2019. Additionally, the business code of conduct which includes conflicts of interest will be revised to include the required language. All Center employees will be required to sign the Business Code of Conduct electronically through our human resource software by March 1,2019.

Item 2018-004 – Formal Policies and Procedures for Monitoring Subrecipients

*Criteria:* Management is responsible for implementing policies and procedures for monitoring sub-recipients of grant awards. Management is also responsible for having an effective method of responding to prior year findings.

*Condition:* Effective September 25, 2018, The Board adopted a policy for identifying and monitoring sub-recipients of grant awards. This policy was adopted in response to a FY 2017 audit finding and related recommendation. In our review of the status of prior year findings we noted that management's response in the FY 2017 audit indicated the policy would be adopted by the end of the second quarter of FY 2018. Due to the effective date of the Board policy, the Center's response to the prior year finding was not implemented until FY 2019.

*Cause:* Management was implementing new general ledger software and billing systems during 2018. It appears that this compliance issue was overlooked.

*Effect:* The Center is not in full compliance with the Substance Abuse grant contract requirements.

*Management's Response:* As a result of the FY 2017 audit, the CFO began monitoring the sub-recipient contract in September 2017. A draft of the Sub-Recipient Contractors Monitoring Policy was done in May 2018 but was inadvertently not given to the Board of Trustees for approval until September 2018. The Center is in full compliance with the Substance Abuse grant contract requirements in FY 2019.

**Follow-up on Prior Year Findings:**

Finding 2017-001 – Material Weakness Related to Internal Controls over Financial Reporting

*Status:* Partially Corrected

*Reason for Findings Recurrence:* See Corrective action plan for current year finding 2018-001 for the reason for the recurrence of the finding.

*Corrective Action Taken to Date:* See Corrective action plan for current year finding 2018-001 for the corrective action taken to date.

*Remaining Corrective Actions:* See Corrective action plan for current finding 2018-001 for the remaining action to be taken.

Item 2017-002 – Material Weakness Related to Internal Controls over Financial Reporting

*Status:* Corrected

Item 2017-003 – Material Weakness Related to Internal Controls over Financial Reporting

*Status:* Corrected

Finding 2017-004 – Formal Policies and Procedures for Monitoring Sub-recipients

*Status:* Partially Corrected

*Reason for Findings Recurrence:* See Corrective action plan for current year finding 2018-004 for the reason for the recurrence of the finding.

*Corrective Action Taken to Date:* See Corrective action plan for current year finding 2018-004 for the corrective action taken to date.

*Remaining Corrective Actions:* See Corrective action plan for current finding 2018-004 for the remaining action to be taken.

**Independent Auditor's Management Letter:**

Current year comments:

Recommended Days of Operation

During 2018, overall fund equity in the general fund decreased by $450,395. At the end of the year, *overall* general fund balance was $1,176,531 and *unassigned* general fund balance was $1,081,102. These two amounts represent 5.1% and 4.7%, respectively of the 2018 total expenditures in the general fund. These percentages translate into 19 and 17 “days of operation” available in general fund balance at the end of the year. We did note that the Center reduced debt significantly in 2018.

We recommend that community centers maintain 60 “days of operation” in general fund balance. In addition, fund balance will be an important tool for community centers as they begin to operate in more of a managed care environment and experience the swings in cash flows that occur as a result of 1115 waiver programs.

We recommend that the Center budget and plan to achieve surpluses in order to build fund balance to the recommended level.

**Corrective Action Plan:**

Item 2018-001 – Material Weakness Related to Internal Controls over Financial Reporting

*Corrective Action Plan:* The Center implemented the financial software on August 1, 2018. The training for our bank reconciliations and fixed assets were scheduled to be after the go live date. It was anticipated that there would be a learning curve for employees as we spoke with another community center that had begun using the software on Sep. 1, 2017 and indicated that it took approximately six months to get familiar with it. In addition, we had staff turnover in key areas of accounts payable, billing, payroll, and the Director of Revenue Cycle Management. The Center also begin using new electronic health record/billing software in FY 2018 on Sep. 1, 2017. As part of that software, there was a general ledger extract to retrieve billing and cash information to go into our new financial software, but it was not functional, which contributed to some of our bank reconciliation issues. We are contracting with an outside programmer to fix this issue. As a result of staff turnover, we did have the electronic health record vendor come on-site on Dec. 18, 19, and 20 to retrain our billing staff for billing and our accounting staff on its reporting capabilities to resolve our reconciliation issues. We are also preparing a

gap analysis to determine what additional training is needed from our general ledger software vendor.

Item 2018-002 – Material Weakness Related to Internal Controls over Financial Reporting

*Corrective Action Plan:* Due to the new general ledger software, it took the accounting staff longer to close the fiscal year than normal which contributed to these issues. Our old software did not have the capability of doing bank reconciliations, so they were done in QuickBooks. The new financial software has a module specifically for bank reconciliations that we are training on now. Once the staff is fully trained, then monthly entries will be made as necessary to reconcile the bank accounts to the general ledger on a monthly basis. Additionally, as mentioned above the accounting staff received training on the electronic health record software in December 2018 to retrieve reports to manually pull information until the general ledger extract is completed.

Item 2018-003 – Procurement Standards — Uniform Guidance

Federal/State Programs — All Federal Programs

*Corrective Action Plan:* The procurement card agreement will be updated with the required language and the agreements will be re-issued for signatures by Feb. 28, 2019. Additionally, the business code of conduct which include conflicts of interest will be revised to include the required language. All Center employees will be required to sign the Business Code of Conduct electronically through our human resource software by March 1,2019.

Item 2018-004 – Formal Policies and Procedures for Monitoring Subrecipients

Federal/State Programs - U.S. Department of Health and Human Services passed through the Texas Health and Human Services Commission (HHSC) Block Grants for the Prevention and Treatment of Substance Abuse and Opioid State Targeted Response - CFDA 93.959, 93.788, and state general revenue for substance abuse programs - Grantor Number 2016-048240-002 SMOSR

*Corrective Action Plan:* As a result of the FY 2017 audit, the CFO begin monitoring the sub-recipient contract in September 2017. A draft of the Sub-Recipient Contractors Monitoring Policy was done in May 2018 but was inadvertently not

given to the Board of Trustees for approval until September 2018. The Center is in full compliance with the Substance Abuse grant contract requirements in FY 2019.

## 3.4 Austin-Travis County MHMR dba Austin Travis County Integral Care

**City:** Austin

**Counties Served:** Travis

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.5 Bluebonnet Trails Community Services

**City:** Round Rock

**Counties Served:** Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.6 Border Region Behavioral Health Center

**City:** Laredo

**Counties Served:** Jim Hogg, Starr, Webb, and Zapata

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

Finding 2018-A – Financial Reporting – Repeat Finding

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the preparation of the financial statements and the related financial statement disclosures being audited. In conjunction with the completion of the audit, we were requested to draft the financial statements and the accompanying notes to those financial statements. Additionally, we propose several audit adjustments to the Center's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

*Cause:* The Center does not prepare and has not developed an internal control system for the preparation of the financial statements and the related disclosures in accordance with generally accepted accounting principles.

*Effect:* Although this circumstance is not unusual for an organization of this size, the preparation of financial statements and adjusting journal entries as part of the

audit engagements may result in financial statements and related information included in financial statement disclosure not being available for management purposes as timely as it would if prepared by Center personnel. The need for the audit adjustments indicates that Center interim financial statements may not be materially correct, which may affect management decisions made during the course of the year.

*Recommendation:* Auditing standards require that auditors communicate this deficiency, however the Center prepares budgetary and other financial reports for Board review on a routine basis. It is the responsibility of management and those charged with governance to determine whether to accept the risk associated with this condition because of costs and other considerations.

*Management's Response:* Management agrees with the noted finding.

Finding 2018-2 – Public Funds Investment Act

*Criteria:* Management of the Center is responsible for adherence to and compliance with the Texas Public Funds Investment Act.

*Condition:* The Center does not have an internal control system designed to determine adherence to the Public Funds Investment Act.

*Cause:* The Center has adopted a Public Funds investment policy; however, management has not monitored the policy to determine if it is current with requirements of the Public Funds Investment Act.

*Effect:* The Public Funds Investment Act requires that the Center's Investment policy be formally reviewed by the Board of Directors at least annually; the Act requires all Investment officers attend certification training; the Act requires acknowledgement of investment policy by external investment brokers; etc.

*Recommendation:* Obtain the most recent issue of the Texas Public Funds Investment Act. Review the Center's Investment Policy to determine that it is in compliance with the act. Develop internal controls over the Investment Policy to determine that all time tables, certifications, renewals, disclosures, etc. are met and documented.

*Management's Response:* Management agrees with the noted finding.

Finding 2018-3 – Procurement – Repeat Findings

*Criteria:* 2 CRF 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards, also referred to as Uniform Guidance, requires nonfederal entities that expend federal funds to adopt procurement policies that are in compliance with the Uniform Guidance. Entities that have not adopted these policies yet may elect to defer implementation of the procurement policy requirement as long as the decision to elect to defer implementation is documented.

*Condition:* The Center has not updated its procurement policy to be in compliance with the Uniform Guidance. The Center appears to have elected to defer implementation of the procurement policy requirements, but this decision to defer implementation has not be documented. Thus, the Center does not have a control process to ensure compliance with the procurement compliance requirement of the Uniform Guidance.

*Cause:* The Center was not aware of the requirement to update their procurement policy to be in compliance with the Uniform Guidance.

*Effect:* Not adopting the procurement requirements of the Uniform Guidance could result in questioned costs since the costs would not be allowable unless certain written policies were adopted.

*Recommendation:* We recommend that the Center adopt a procurement policy in accordance with the Uniform Guidance.

*Management's Response:* Management agrees with the noted finding.

**Follow-up on Prior Year Findings:**

2017-A – Repeat finding in current fiscal year.

2017-001 – Repeat finding in current fiscal year.

**Independent Auditor's Management Letter:** Management letter not provided

**Corrective Action Plan:**

2018-1 – Financial Reporting

While this is a repeat finding, there is new staff in the Finance Department that will work with the accounting software in order to implement the necessary internal controls necessary to report accurate and timely reports. Management was involved in the preparation of the financial statements and notes to the financial statements but agrees that audit adjustments were necessary.

2018-2 – Public Funds Investment Act

There is new management in the accounting department, and the Chief Financial Officer is in the process of obtaining public funds investment training to avoid this finding in the future.

2018-3 – Procurement

The Chief Financial Officer is in the process of drafting a new procurement policy that adheres to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements. In addition, training will be provided to all staff in the new procurement policy.

## 3.7 Burke Center

**City:** Lufkin

**Counties Served:** Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.8 Camino Real Community Services

**City:** Lytle

**Counties Served:** Atascosa, Dimmit, Frio, La Salle, Karnes, Maverick, McMullen, Wilson, and Zavala

**Type of Report on Financial Statement:** Unqualified

**Type of Report on Compliance:** Unqualified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.9 Center for Health Care Services

**City:** San Antonio

**Counties Served:** Bexar

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:**

Finding 2015-001 – Procurement

2015, 2016, and 2017 Type of Finding: Noncompliance Reported in Accordance with *Government Auditing Standards*

2018 Type of Finding: Internal Control Matter

*Criteria:* State law requires that purchases and/or contracts for goods and (certain) services, in excess of $150,000, to be procured via competitive procurement procedures (Uniform Grant Management Standards); and, that the procurement decisions for professional and consulting services, to be based on the vendor's demonstrated competence, knowledge, and qualifications; and, on the reasonableness of the proposed fee for the service (Texas Government Code 2254.027). The Center's local procurement policy requires a competitive bid or proposal solicitation process for the purchase of goods and services that are expected to exceed $25,000, except for professional services, which should be based on the vendor's demonstrated competence and qualifications for the type of services to be performed, and fair and reasonable prices.

*2015 Finding:* The Center considered 4 vendors to be exempt from competitive bidding since they were procured to provide professional services; and, in another instance a vendor was paid with no indication of competitive procurement. Additionally, in 5 instances, documentation was not available to demonstrate that the Center verified that the vendors were not suspended or debarred.

*2016 Status:* Our testing of procurement for 10 vendors denoted 2 instances where vendors were paid in excess of $300,000 and $140,000 for cleaning services and professional services, respectively, with no indication of competitive procurement or Board approval.

In addition to the above 2 vendors, Board approval was also not obtained for an agreement with a nonprofit organization for Outreach, Screening, Assessment, and Referral services provided.

*2017 Status:* Our testing of procurement for 10 vendors in the current year, denoted an instance where a vendor was paid in excess of $100,000 for language translation services, with no indication that competitive procurement was performed. In addition, in 2014 the Center entered into an indefinite term contract for crisis and respite residential services. Indefinite term contracts are generally not used by the Center since they evaluate contracts on a periodic basis to ensure they will continue to receive the best services at the best competitive prices.

*2018 Status:* Our follow-up in the current year indicated 2 instances of noncompliance that are reported in a separate letter to management.

**Independent Auditor's Management Letter:** Management letter not provide.

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.10 Central Texas MHMR Center dba Center for Life Resources

**City:** Brownwood

**Counties Served:** Brown, Coleman, Comanche, Eastland, McCulloch, Mills, and San Saba

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-A – Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. In conjunction with the completion of our audit, we were requested to draft the financial statements and accompanying notes to those financial statements. We also noted a lack of review of account reconciliations throughout the year that could lead to inaccurate monthly financial statements.

*Cause:* The Center does not prepare and has not developed an internal control system to provide for the preparation of the financial statements and related disclosures in accordance with generally accepted accounting principles. The Center also does not have policies in place to ensure review of all reconciliations.

*Effect:* Although this circumstance is not unusual for an organization of your size, the preparation of financial statements may result in financial statements and

related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by Center personnel. Further lack of account reconciliation review could lead to inaccurate financials.

*Recommendation:* The Center should continue to evaluate and improve the controls over financial reporting and implement changes as necessary to ensure accurate and timely financial reports can be completed and account reconciliations and schedules are reviewed and approved.

*Management's Response:* Management agrees with the noted finding. Refer to the Corrective Action Plan.

Finding 2018-001 – Medical Assistance Program, CFDA 93.778 Texas Health and Human Services Commission: General Revenue – Mental Health Audit; General Revenue – Intellectual and Developmental Disabilities

*Criteria:* Federal and state programs require adequate review of information prepared for and submitted to outside parties.

*Condition:* The Center does not have an internal control system designed to provide sufficient and adequate review and approval of documentation, reports and information submitted to outside parties.

*Cause:* The Center has not developed an internal control system to provide for the adequate review of information submitted to outside parties due to turnover in the current year of key management and accounting personnel.

*Effect:* Although this circumstance is not unusual for an organization of your size, the lack of review could result in error in proper reporting, grants being charged incorrectly and the possibility of management override of internal controls.

*Recommendation:* We recommend the Center implement a system of proper review and approval by appropriate personnel of all documentation and information prepared for and submitted to outside parties to mitigate the risk of improper reporting, overcharging of grants and management override.

*Management's Response:* Management agrees with the finding. Refer to Corrective Action Plan.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Finding 2018-A

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. The also noted a lack of review of account reconciliations throughout the year and, therefore, could have resulted in a material misstatement of our financial statements.

Corrective Action Plan: Our Business Office has experienced turnover during the year. A new CFO was hired in October and the Business Analyst I position was filled in December. We now have a team in place diligently working to improve the process of checks and balances. Also, we have recently posted a new position of Comptroller. This new addition to our team will further assist in the segregation of duties and contribute to the checks and balances processes. We believe we have made significant, substantive progress.

*Anticipated Completion Date:* Ongoing

Significant Deficiency in Internal Control Over Compliance

Finding 2018-001

*State Agency Name:* U.S. Department of Health and Human Services
*Program Name:* General Revenue – Mental Health Adult
General Revenue – Intellectual and Developmental Disabilities

*Federal Agency Name:* Medical Assistance Program
CFDA #93.778

*Finding Summary:* Eide Bailly LLP noted that the Center did not have adequate internal controls over proper review and approval of documentation, reports and information submitted to outside parties.

*Corrective Action Plan:* We now have a process in place for review and approval of all documentation reports and information submitted to outside parties.

*Anticipated Completion Date:* January 2019

## 3.11 Central Counties Center for MHMR Services

**City:** Temple

**Counties Served:** Bell, Coryell, Hamilton, Lampasas, and Milam

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:**

Current year comments (repeat from prior year):

Accrued Revenues

Generally accepted accounting principles (GAAP) for the General Fund require that revenues be recognized on the modified accrual basis. Presently the Center's accounting policy is to record revenues on the cash basis throughout eleven months of the year and then accrue revenues at the end of the fiscal year in order to convert to the modified accrual basis of accounting. This policy understates revenues throughout the course of the year, and in tum, revenues in the last month of the year are overstated in order to convert from the cash basis to the accrual basis. The cash method does not provide financial information during the year that reasonably reflects the operating results of the Center. Accordingly, management and the Board do not have the best financial information available for decision-making. In most cases, reasonable estimates of accrued revenues can be developed based on the number of services provided by service type: normal collection percentages of billed revenues by service type, and other knowledge of amounts that have been billed for certain services. Reasonable estimates can be made using these and similar methods in order to provide financial information on a monthly basis that is more reliable for decision-making. Reasonable estimates made at the end of each month can be reversed following the month-end close allowing cash collections of revenues to continue to be recorded in a manner consistent with the present cash method. The use of reasonable estimated revenue accruals at the end of each month would provide more accurate financial information, and yet would

not require the same level of detail utilized by Center accounting staff at year-end. We recommend that the Center implement procedures that will record revenues on a monthly basis using GAAP methods.

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.12 Central Plains Center

**City:** Plainview

**Counties Served:** Bailey, Briscoe, Castro, Floyd, Hale, Lamb, Motley, Parmer, and Swisher

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-A – Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. In conjunction with the completion of our audit, we were requested to draft the financial statements and accompanying notes to those financial statements. Additionally, we proposed several audit adjustments to the Center's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

*Cause:* The Center does not prepare and has not developed an internal control system to provide for the preparation of, the financial statements and related disclosures in accordance with generally accepted accounting principles.

*Effect:* Although this circumstance is not unusual for an organization of your size, the preparation of financial statements and adjusting journal entries as a part of the audit engagement may result in financial statements and related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by Center personnel. The need for the audit adjustments indicates that the Center's interim financial information may not be materially correct, which may affect management decisions made during the course of the year.

*Recommendation:* The Center should evaluate and improve the controls over financial reporting and implement changes as necessary to ensure accurate and timely financial reports can be completed.

*Management's Response:* Management agrees with the note finding.

Finding 2018-B – Reconciliations of Investments, Prepaid Expenses, Accounts Receivable, Accounts Payable, and Long- Term Obligations

*Criteria:* Investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations should be reconciled at the end of the fiscal year. In addition, someone other than the preparer of the reconciliation should review the reconciliation and document their approval.

*Condition:* The Center does not have a process for the preparation of reconciliations of investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations and/or does not have a process in place for review and approval of these reconciliations by someone other than the preparer. If certain accounts are not reconciled, the financial statements could result in a material misstatement.

*Cause:* Investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations are not reconciled at year end.

*Effect:* The lack of reconciliations of investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations increases the risk of material misstatement in the financial statements for these areas, either due to error or fraud.

*Recommendation:* The Center should design and implement a reconciliation process for investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations, including review of these reconciliations by someone other than the preparer.

*Management's Response:* Management agrees with the note finding.

Finding 2018-C – Review and Approval of Journal Entries

*Criteria:* Journal entries should be reviewed and approved prior to posting.

*Condition:* The Center does not have an internal control process for the review and approval of journal entries. The oversight provided by an effective review and approval process is important to the Center as a result of the limited segregation of duties that exists due to the size of the accounting staff.

*Cause:* Journal entries are not reviewed and approved prior to posting.

*Effect:* The lack of a review and approval process for recorded journal entries increases the risk of material misstatement in the financial statements, either due to error or fraud.

*Recommendation:* An employee other than the employee preparing the journal entries should review and approve the journal entries before posting.

*Management's Response:* Management agrees with the note finding.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management Letter not provided

**Corrective Action Plan:**

Finding 2018-A

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that would not have been identified because of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements.

*Corrective Action Plan:* It is not cost effective to have an internal control system designed to provide for the preparation of the financial statements and accompanying notes. We requested that our auditors, Eide Bailly LLP, prepare the financial statements and the accompanying notes to the financial statements as a part of their annual audit. We have designated a member of management to review the draft financial statements and accompanying notes, and we have reviewed and agree with the material adjustments proposed during the audit.
*Anticipated Completion Date:* Ongoing

Finding 2018-B

*Finding Summary:* The Center does not have a process for the preparation of reconciliations of investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations and/or does not have a process in place for review and approval of these reconciliations by someone other than the preparer.

*Corrective Action Plan:* The Center will design and implement a reconciliation process for investments, prepaid expenses, accounts receivable, accounts payable and long-term obligations, including review of these reconciliations by someone other than the preparer.

*Anticipated Completion Date:* August 2019

*Finding 2018-C*

*Finding Summary:* The Center does not have an internal control process for the review and approval of journal entries.

*Corrective Action Plan:* The Center will ensure that a member of management other than the employee preparing the journal entries will review and approve the journal entries before posting.

*Anticipated Completion Date:* August 2019

## 3.13 Coastal Plains Community Center

**City:** Portland

**Counties Served:** Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, and San Patricio

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-001 – Significant Deficiency Relating to Controls over Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation of financial statements that are fairly presented in accordance with U.S. generally accepted accounting principles (GAAP).

*Condition:* During our audit procedures we identified adjusting entries to accounts payable that were significant to the financial statements of the Center which were required to present the financial statements in accordance with U.S. generally accepted accounting principles.

*Cause:* This was a result of turnover in accounts payable staff during the fiscal year.

*Effect:* Significant audit adjustments identified at year-end limit the Center's ability to produce financial information necessary to present financial statements in accordance with U.S. generally accepted accounting principles.

*Recommendation:* It is the responsibility of management to assure that financial statements are prepared in accordance with U.S. generally accepted accounting principles. We recommend that management implement procedures to review accounts payable on a periodic basis and record adjustments as necessary to reflect accounts payable in accordance with generally accepted accounting principles.

*Management's Response:* The General Ledger Accountant will review monthly accounts payable transactions and balance sheet accounts to ensure charges are posted in the proper period in accordance with generally accepted accounting principles.

Finding 2018-002 – Identification of Expenditures of Federal Awards

*Criteria:* Management is responsible for identifying all federal and state expenditures for the fiscal year so they may be presented in the Schedule of Expenditures of Federal and State Awards.

*Condition:* The Center recorded FEMA Crisis Counseling Immediate Services Program (ISP) revenue netted with program expenditures on the general ledger.

These amounts could have been inadvertently overlooked and omitted from the Schedule of Expenditures of Federal and State Awards.

*Cause:* This was a result of an oversight by the Center staff.

*Effect:* The Center's general ledger did not readily identify the FEMA Crisis Counseling Immediate Services Program (ISP) federal award as required by the Uniform Guidance.

*Recommendation:* The Center's general ledger should be maintained so that federal awards are readily identifiable.

*Management's Response:* The Center has noted this finding and will ensure all future federal awards are readily identifiable on the general ledger.

Finding 2018-003 – Internal Controls over Program Intake and Eligibility

*Criteria:* The Center's grant contract with the Texas Health and Human Services Commission to provide Adult Mental Health services requires the Center to establish and maintain a current financial assessment and treatment plan for consumers as part of the intake and eligibility process.

*Condition:* Documentation of proof of income necessary for appropriate financial assessment is not always obtained for consumers in order to assure appropriate fee assessment. In addition, current treatment plans are not always maintained for consumers receiving services at the Center.

*Cause:* The Center's intake and eligibility process for documentation of proof of income and financial assessment and maintenance of a current treatment plan has not been effectively implemented. Based on our discussion with management it appears turnover in staff responsible for this area was a contributing factor.

*Effect:* All consumer files do not maintain proper documentation of proof of income and financial assessment and current treatment plans in accordance with the terms of the HHSC grant contract.

*Recommendation:* The Center should establish procedures to assure documentation of proof of income necessary for financial assessment is maintained for all consumers. This information should be utilized for proper fee assessment. The

Center should establish procedures to assure a current treatment plan is maintained for all consumers.

*Management's Response:* The Chief Financial Officer will stress this requirement to both Mental Health and IDD program directors, and with the Quality Management Director. Emphasis on training staff will be emphasized.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Item 2018-001 – Significant Deficiency Relating to Controls over Financial Reporting

*Corrective Action Plan:* The General Ledger Accountant will review monthly accounts payable transactions and balance sheet accounts to ensure charges are posted in the proper period in accordance with generally accepted accounting principles.

*Estimated completion date:* The Chief Financial Officer has already implemented training and procedures for the General Ledger Accountant and will monitor progress throughout the year.

Item 2018-002 – Identification of Expenditures of Federal Awards

*Corrective Action Plan:* The Center has noted this finding and will ensure all future federal awards are readily identifiable on the general ledger.

*Estimated completion date:* Notes have been added to 2018 FEMA work papers stipulating how future awards are to be treated.

Item 2018-003: Internal Controls over Program Intake and Eligibility

State Program - The Texas Health and Human Services Commission (HHSC) General Revenue – Adult Mental Health Grantor Number 537-17-0127-00013

*Corrective action plan:* The Chief Financial Officer will stress this requirement to both Mental Health and IDD program directors, and with the Quality Management Director. Emphasis on training staff will be emphasized.

*Estimated completion date:* March 1, 2019

## 3.14 Collin County MHMR Center dba LifePath Systems

**City:** McKinney

**Counties Served:** Collin

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Item 2018-001 – Material Weakness Related to Internal Controls over Financial Reporting – Accrued Payroll Liabilities

*Criteria:* LifePath is responsible for maintaining proper internal controls over accrued payroll liabilities.

*Condition:* LifePath's internal control system allowed the Center to understate accrued payroll liabilities by approximately $295,000 at year-end.

*Cause:* This was due to an error in the calculation of the accrued payroll liabilities at year-end. LifePath's internal controls over review of accrued payroll liabilities were not effective to conduct a proper review of the calculation at year-end.

*Effect:* LifePath's accrued payroll liabilities required audit adjustments at year-end in order to fairly state the liabilities in accordance with generally accepted accounting principles.

*Recommendation:* LifePath should implement procedures to properly review the accrued payroll liabilities calculation to assure it is fairly stated in accordance with generally accepted accounting principles.

*Management's Response:* An error occurred at year-end when the accountant used an incorrect payroll file in the monthly accrual calculations. This error was not caught during the supervisor's review and approval of the journal entries. LifePath

fiscal team members involved in the month-end process received training on the computation of the monthly accrued payroll liabilities on Feb 28, 2018. Management agrees with the recommendation and will re-train staff so that these liabilities are properly reviewed prior to posting of the entry to the general ledger.

Item 2018-002 – Material Weakness Related to Internal Controls over Financial Reporting – Accounting for the Internal Service Fund

*Criteria:* LifePath is responsible for maintaining proper internal controls over financial reporting.

*Condition:* LifePath's internal service fund revenues and expenses are not properly coded on the general ledger during the fiscal year.

*Cause:* LifePath's general ledger for the internal service fund was not set up to properly account for revenues and expenses. At year-end the general ledger was modified to set up accounts to reflect revenues and expenses of the internal service fund.

Effect: LifePath's internal service fund required audit adjustments at year-end in order to properly reflect current year revenues and expenses.

*Recommendation:* LifePath should implement procedures to assure all internal service fund revenues and expenses are coded appropriately in the general ledger to reflect accurate financial reporting during the year.

*Management's Response:* Management agrees to make the suggested change in the mehto0d in which internal service fund revenues and expenses are recorded in the general ledger throughout the year and will work to incorporate these procedures and processes into the new fiscal accounting system currently being implemented.

Item 2018-003 – Internal Controls over Procurement Cards

*Criteria:* LifePath is responsible for maintaining proper internal controls over procurement card expenditures.

*Condition:* LifePath's internal control system allowed the Center to understate procurement card expenditures by approximately $156,000 at year-end.

*Cause:* This was due to the accounting department not receiving timely supporting documentation for multiple procurement card purchases from responsible parties in order to properly code these expenditures and post them to the general ledger.

*Effect:* LifePath's procurement card transactions required audit adjustments at year-end in order to record these expenditures in the general ledger.

*Recommendation:* LifePath should implement procedures to assure all supporting documentation for procurement card transactions is submitted to the accounting department in a timely manner and that all procurement car expenditures are posted to the general ledger to reflect accurate financial reporting.

*Management's Response:* Management agrees with this recommendation and has already implemented additional monthly reminder notifications to cardholders regarding submission deadlines. Additionally, a separate procurement card procedure with specific reporting requirements has been drafted (along with supporting forms/documents. This procedure is currently in the process of being reviewed for subsequent adoption and inclusion in the LifePath System's Policy and Procedure manual.

Item 2018-004 – Compliance with Grant Contract Reporting

*Criteria:* The Texas Health and Human Services Commission contract for Early Childhood Intervention (ECI) services requires quarterly financial reports that are due within one month after the end of each quarter.

*Condition:* The quarterly report for the period ending November 30, 2017 was filed on August 13, 2018 which was after the required due date. The quarterly report for the period ending May 31, 2018 was filed on July 18, 2018 which was after the required due date. All of the remaining reports were filed timely.

*Cause:* The first quarter report was not filed timely due to the Center not having the final executed ECI contract by the due date of the report. The third quarter report was not filed timely due to the Billing Manager being out on personal leave due to unforeseen circumstances.

*Effect:* The reports for the first and third quarters were filed after the due date.

*Recommendation:* LifePath should implement procedures to assure HHSC ECI reports are filed in a timely manner in accordance with the contract.

*Management's Response:* Management agrees with this recommendation. Additional staff members will be trained in report preparation so as to provide alternative coverage should the primary preparer be unable to do so.

Item 2018-005 – Compliance with Policies and Procedures under the Uniform Guidance

*Criteria:* The Uniform Guidance requires written conflict of interest policies. No employee or agent of the Center may participate in the selection, award, or administration of a contract funded by federal grant dollars if he or she has an actual or apparent conflict of interest. The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the Center.

*Condition:* The Center maintains a code of ethics policy. This policy does specifically address conflicts of interest for individuals involved in purchasing goods and services for the Center or disciplinary actions for violations of such policy.

*Cause:* This was a result of oversight by management of the Center.

*Effect:* The Center is not in compliance with the Uniform Guidance requirements.

*Recommendation:* LifePath should implement a conflict of interest policy that is in compliance with the Uniform Guidance.

*Management's Response:* Management agrees with this recommendation to expand the current code of ethics policy to include addressing the conflict of interest for individuals involved in purchasing goods and services for the Center and the disciplinary actions for any violations of the policy in accordance with the Uniform Guidance requirements.

**Follow-up on Prior Year Findings:**

2017-001 – Material Weakness Related to Internal Controls over Financial Reporting

*Status:* Fully corrected.

2017-002 – Material Weakness Related to Internal Controls over Financial Reporting

*Status:* Fully corrected.

*2017-003: Material Weakness Related to Internal Controls over Financial Reporting*

*Status:* Fully corrected.

2017-004 – Significant Deficiency Related to Internal Controls over Financial Reporting

*Status:* Fully corrected.

2017-005 – Compliance with ECI Reporting

*Status:* Fully corrected.

Item 2017-006 – Formal Policies and Procedures for Monitoring Subrecipients

*Status:* Fully corrected.

**Independent Auditor's Management Letter:**

Current year comments:

Accounts Receivable Detail

During our audit procedures we noted the Center maintains primarily all of accounts receivable in one account on the general ledger. We recommend the Center breakout accounts receivable on the general ledger in further detail by source in order to make the reconciliation of accounts receivable an easier process for Center staff.

Internal Service Fund

The internal service fund was established by the Center to accumulate funds internally among the Center's various functions in order to acquire capital assets as well as replace existing capital assets. Due to the Center budget constraints in the past it has been unable to appropriately fund the internal service fund to provide for future capital asset activity. Over time this has resulted in a significant advance in the amount of $2,791,941 at August 31, 2018 from the internal service fund to the general fund. This advance shown on the balance sheet makes the financial statements difficult for users to interpret. Since the Center is now financially able we recommend that management fund the internal service fund to provide a more clear and understandable presentation to users of the financial statements.

Follow-up on prior year comments:

There were no prior year comments.

**Corrective Action Plan:**

Item 2018-001: Material Weakness Related to Internal Controls over Financial Reporting-Accrued Payroll Liabilities

*Corrective Action Plan:* An error occurred at year-end when the accountant used an incorrect payroll file in the monthly accrual calculations. This error was not caught during the supervisor's review and approval of the journal entries. LifePath fiscal team members involved in this month-end process received training on the computation of the monthly accrued payroll liabilities on February 2, 2018. Management agrees with the recommendation and will re-train staff so that these liabilities are properly stated each month and the accuracy of the liabilities are properly reviewed prior to posting of the entry to the general ledger.

Item 2018-002: Material Weakness Related to Controls Over Financial Reporting-Accounting for the Internal Service Fund

*Corrective Action Plan:* Management agrees to make the suggested change in the method in which internal service fund revenues and expenses are recorded in the general ledger throughout the year and will work to incorporate these procedures and processes into the new fiscal accounting system currently being implemented.

Item 2018-003: Internal Controls over Procurement Cards

*Corrective Action Plan:* Management agrees with this recommendation and has already implemented additional monthly reminder notifications to cardholders regarding submission deadlines. Additionally, a separate procurement card procedure with specific reporting requirements has been drafted (along with supporting forms/documents). This procedure is currently in the process of being reviewed for subsequent adoption and inclusion in the LifePath System's Policy and Procedure manual.

Item 2018-004: Compliance with Grant Contract Reporting

*Corrective Action Plan:* Management agrees with this recommendation. Additional staff members will be trained in report preparation so as to provide alternative coverage should the primary preparer be unable to do so.

Item 2018-005: Compliance with Policies and Procedures under the Uniform Guidance

*Corrective Action Plan:* Management agrees with the recommendation to expand the current code of ethics policy to include addressing the conflict of interest for individuals involved in purchasing goods and services for the Center and the disciplinary actions for any violations of the policy in accordance with the Uniform Guidance requirements.

## 3.15 Denton County MHMR

**City:** Denton

**Counties Served:** Denton

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.16 El Paso MHMR dba Emergence Health Network

**City:** El Paso

**Counties Served:** El Paso

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management letter not provided

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.17 Gulf Bend Center

**City:** Victoria

**Counties Served:** Calhoun, DeWitt, Goliad, Jackson, Lavaca, Refugio, and Victoria

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.18 Gulf Coast Center

**City:** Galveston

**Counties Served:** Brazoria, and Galveston

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management Letter not provided

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.19 Harris Center for Mental Health and IDD

**City:** Houston

**Counties Served:** Harris

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management Letter not provided

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.20 Heart of Texas Region MHMR

**City:** Waco

**Counties Served:** Bosque, Falls, Freestone, Hill, Limestone, and McLennan

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management Letter not provided

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.21 Helen Farabee Centers

**City:** Wichita Falls

**Counties Served:** Archer, Baylor, Childress, Clay, Cottle, Dickens, Foard, Hardeman, Haskell, Jack, King, Knox, Montague, Stonewall, Throckmorton, Wichita, Wilbarger, Wise, and Young

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Item 2018-001 – Internal Controls over Maintenance of Current Recovery Plans

*Criteria:* The Center's contract with the Texas Health and Human Services Commission (HHSC) to provide mental health services requires the Center to maintain current recovery plans for consumers in mental health programs.

*Condition:* Documentation of a current recovery plan is not always maintained for consumers receiving services at the Center.

*Cause:* The Center's controls over this area were disrupted by the implementation of a new client record system in 2018. The implementation of the new system led to delays in updating recovery plans.

*Effect:* All consumer files did not contain current recovery plans in accordance with the terms of the HHSC mental health contract.

*Recommendation:* In July of 2018, management recognized this issue and initiated a plan of correction so that consumer recovery plans would be brought up to date. This plan of correction was on-going at the time of our audit field work. We encourage management to continue with this plan of correction.

*Management's Response:* The monitoring of the Recovery Plans has been underway, and improvement has been noted on a monthly basis. As part of our internal quality management practices, medical records are pulled on a monthly basis and the element of Recovery Planning is being closed audited. A follow up process to each audit completed is known as a Quality Management Action Plan or QMAP which requires the Case Manager and Supervisory staff to discuss the findings of the audit tool; agree to corrective actions taken and encourages refresher training to ensure ongoing competency of the staff member.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Item 2018-001 – Internal Controls over Maintenance of Current Recovery Plans

*Corrective action plan:* The monitoring of the Recovery Plans has been underway and improvement has been noted on a monthly basis. As part of our internal quality management practices, medical records are pulled on a monthly basis and the element of Recovery Planning is being closed audited. A follow up process to each audit completed is known as a Quality Management Action Plan or QMAP which requires the Case Manager and Supervisory staff to discuss the findings of the audit tool; agree to corrective actions taken and encourages refresher training to ensure ongoing competency of the staff member.

*Estimated completion date:* Currently, we have a corrective action plan is place based on our July HHSC Mental Health audit. The required training of all Case Manager staff to a newly designed person-centered recovery plan has been completed by December 31, 2018 as requested.

Ongoing monitoring of our charts are underway monthly and a goal of 90% compliance with the Recovery Plan elements are expected by August 31, 2019.

## 3.22 Hill Country Community MHMR Center dba Hill Country Mental Health and Developmental Disabilities Centers

**City:** Kerrville

**Counties Served:** Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, and Val Verde

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-A – Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. In conjunction with the completion of our audit, we were requested to draft the financial statements and accompanying notes to those financial statements. Additionally, we proposed several audit adjustments to the Center's recorded account balances, which if not recorded, would have resulted in a material misstatement of the Center's financial statements.

*Cause:* The Center does not prepare and has not developed an internal control system to provide for the preparation of the financial statements and related disclosures in accordance with generally accepted accounting principles.

*Effect:* Although this circumstance is not unusual for an organization of your size, the preparation of financial statements and adjusting journal entries as a part of the audit engagement may result in financial statements and related information

included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by Center personnel. The need for the audit adjustments indicates that the Center's interim financial information is not materially correct, which may affect management decisions made during the course of the year.

*Recommendation:* Auditing standards require that auditors communicate this deficiency; however, the Center prepares budgetary and other financial reports for Board review on a routine basis, similar to most governmental entities. It is the responsibility of management and those charged with governance to determine whether to accept the risk associated with this condition because of cost or other considerations.

*Management's Response:* Management agrees with the noted finding. Management weighed the costs and benefits of preparing its own financial statements, including proposing the adjusting journal entries that would be necessary, and found it beneficial to outsource this service to the independent auditor.

Finding 2018-B – Significant Deficiency

*Criteria:* Management of the Center is responsible for the implementation and maintenance of internal controls over payroll processes.

*Condition:* Salary and on call pay paid to one salaried employee tested and recorded in the general ledger does not agree with budgetary action request and position action request form in the employee's payroll file. Further, for four employees tested, their pay was allocated to various cost centers in the general ledger based on their budgeted allocation and not based on their actual time spent in the cost centers per timesheets approved by their supervisor.

*Cause:* Employee timesheets are properly approved by the employee's supervisor. However, the timesheets are summarized in an Excel spreadsheet through a manual process, which is then used to enter pay into the general ledger. The Center does not review the spreadsheet used to enter time into Abila, resulting in a process prone to errors.

*Effect:* While none of these errors were material to the financial statements, without adequate controls there is a potential that errors could occur that could have a significant impact on the financial statements.

*Recommendation:* We recommend the Center explore a more automated process of supervisor approval of timesheets and posting of time to cost centers through their new financial software and attempt to eliminate the manual process of summarizing payroll into a master spreadsheet.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

Finding 2018-001 –Significant Deficiency in Internal Controls over Compliance and Noncompliance

*Criteria:* Federal and state cost principles require that charges for payroll for employees that worked in more than one grant be supported by time and effort records (i.e., timesheets) for the actual time spent in these areas and not based on a budgeted formula.

*Condition:* Salary and on call pay paid to one salaried employee tested and recorded in the general ledger does not agree with budgetary action request and position action request form in the employee's payroll file. Further, for four employees tested, their pay was allocated to various cost centers in the general ledger based on their budgeted allocation and not based on their actual time spent in the cost centers per timesheets approved by their supervisor.

*Cause:* Employee timesheets are properly approved by the employee's supervisor. However, the timesheets are summarized in an Excel spreadsheet through a manual process, which is then used to enter pay into the general ledger. The Center does not review the spreadsheet used to enter time into Abila, resulting in a process prone to errors.

*Effect:* A portion of payroll charges to cost centers is based on a budgeted allocation and not based on actual time spent in the cost centers.

*Recommendation:* We recommend the Center explore a more automated process of supervisor approval of timesheets and posting of time to cost centers through their new financial software and attempt to eliminate the manual process of summarizing payroll into a master spreadsheet.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

**Follow-up on Prior Year Findings:**

Finding 2017-A

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that might not would have been identified as a result of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements.

*Status:* Ongoing. Due to cost considerations, we will continue to have Eide Bailly LLP prepare our draft financial statements and accompanying notes to the financial statements.

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

*Finding 2018-A*

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that would not have been identified because of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements.

*Corrective Action Plan:* It is not cost effective to have an internal control system designed to provide for the preparation of the financial statements and accompanying notes. We requested that our auditors, Eide Bailly LLP, prepared the financial statements and the accompanying notes to the financial statements as a part of their annual audit. We have designated a member of management to review the drafted financial statements and accompanying notes, and we have reviewed with and agree with the material adjustments proposed during the audit.

*Anticipated Completion Date:* Ongoing

Finding 2018-B

*Finding Summary:* Eide Bailly LLP noted that the Center did not have adequate internal controls over the payroll review process.

*Corrective Action Plan:* Background: Since 2011 the timekeeping system implemented with the Anasazi personnel program had two different timesheets per employee. The first timesheet (Employee Timesheet) was prepared by the employee and signed by the supervisor. The supervisor would give the signed Employee Timesheet to the timekeeper. The timekeeper would then prepare a second timesheet (Timekeeper Timesheet) in Excel which would calculate a Summary Page creating a Batch File. Embedded calculations were in the Timekeeper Timesheet which would calculate employee overtime, compensatory time and on-call pay. These calculations would be recorded in the Timekeeper Timesheet and Summary Page. The Timekeeper Timesheet and Summary Page were not signed by the Supervisor or Employee.

The Batch file created would be sent to HR for a third data entry from only the Summary Page which included the embedded calculation in the Summary Page for overtime, compensatory time, and on-call pay.

This process created more opportunity for data entry errors given the employee's time was re-entered twice and embedded calculations were taken directly from the Summary Page rather than the signed Employee Timesheet. This process is labor intensive and left little time for quality control. The process relied upon after-payroll timesheet corrections.

In April 2018, a new payroll/timekeeping system (Abila/Microix) was implemented due to Anasazi software no longer being supported by the software company. However, the timekeeping functions of Microix did not function as Anasazi software. The Microix timekeeping system allows for employees to enter time electronically, but due to software system programming issues the rollout to employees of the Microix timekeeping system has been delayed. This required the Anasazi/Excel timesheet system continue to be used.

*Corrective Action:*

We have been and are working to get a separate test database to test additional payroll programming that is needed for the proper calculation of payroll based upon current FSLA rules and HCMHDDC policies. Additionally, this will allow testing for direct employee input into Microix timekeeping system. This will eliminate double

entry of the employee's time and allow for time entry to be approved directly in the Microix timekeeping system by the supervisor. Software programming will be tested to ensure accuracy for the Phase II implementation.

Beginning January 1, 2019, all signed employee timesheets will be scanned to the HR office for quality control.

Phase II of the Abila/Microix implementation will allow for Timekeepers in each location to enter the employee's time from their signed timesheet directly into the Microix timekeeping system. This will eliminate the Excel Timekeeper Timesheet and Summary Page as well as HR's data entry of the employee's time. This will increase efficiency and eliminate more opportunity for data entry errors, accurately reflect time entered by the employee in their cost center(s), as well as allow HR to quality control timekeeper entries against the signed employee timesheet. Implementation by calendar year 2nd quarter 2019 to include updated timekeeping policy and procedure.

Phase III of the Abila/Microix implementation will allow employees to enter time directly into the Microix timekeeping system and supervisors will approve all time entries electronically. This will further increase efficiencies by eliminating the need for timekeepers and allow employees to view their pay data directly online. Phase III will eliminate the need for paper timesheets and duplicate entries. Implementation by calendar year 4th quarter 2019 to include updated timekeeping policy and procedure.

*Anticipated Completion Date:* January 2019

Significant Deficiency in Internal Control Over Compliance

Finding 2018-001

*Finding Summary:* Eide Bailly LLP noted that the Center did not have adequate internal controls over payroll.

*Corrective Action Plan:* Background: Since 2011 the timekeeping system implemented with the Anasazi personnel program had two different timesheets per employee. The first timesheet (Employee Timesheet) was prepared by the employee and signed by the supervisor. The supervisor would give the signed Employee Timesheet to the timekeeper. The timekeeper would then prepare a second timesheet (Timekeeper Timesheet) in Excel which would calculate a

Summary Page creating a Batch File. Embedded calculations were in the Timekeeper Timesheet which would calculate employee overtime, compensatory time and on-call pay. These calculations would be recorded in the Timekeeper Timesheet and Summary Page. The Timekeeper Timesheet and Summary Page were not signed by the Supervisor or Employee.

The Batch file created would be sent to HR for a third data entry from only the Summary Page which included the embedded calculation in the Summary Page for overtime, compensatory time, and on-call pay.

This process created more opportunity for data entry errors given the employee's time was re-entered twice and embedded calculations were taken directly from the Summary Page rather than the signed Employee Timesheet. This process is labor intensive and left little time for quality control. The process relied upon after-payroll timesheet corrections.

In April 2018, a new payroll/timekeeping system (Abila/Microix) was implemented due to Anasazi software no longer being supported by the software company. However, the timekeeping functions of Microix did not function as Anasazi software. The Microix timekeeping system allows for employees to enter time electronically, but due to software system programming issues the rollout to employees of the Microix timekeeping system has been delayed. This required the Anasazi/Excel timesheet system continue to be used.

*Corrective Action:*

We have been and are working to get a separate test database to test additional payroll programming that is needed for the proper calculation of payroll based upon current FSLA rules and HCMHDDC policies. Additionally, this will allow testing for direct employee input into Microix timekeeping system. This will eliminate double entry of the employee's time and allow for time entry to be approved directly in the Microix timekeeping system by the supervisor. Software programming will be tested to ensure accuracy for the Phase II implementation.

Beginning January 1, 2019, all signed employee timesheets will be scanned to the HR office for quality control.

Phase II of the Abila/Microix implementation will allow for Timekeepers in each location to enter the employee's time from their signed timesheet directly into the Microix timekeeping system. This will eliminate the Excel Timekeeper Timesheet

and Summary Page as well as HR's data entry of the employee's time. This will increase efficiency and eliminate more opportunity for data entry errors, accurately reflect time entered by the employee in their cost center(s), as well as allow HR to quality control timekeeper entries against the signed employee timesheet. Implementation by calendar year 2nd quarter 2019 to include updated timekeeping policy and procedure.

Phase III of the Abila/Microix implementation will allow employees to enter time directly into the Microix timekeeping system and supervisors will approve all time entries electronically. This will further increase efficiencies by eliminating the need for timekeepers and allow employees to view their pay data directly online. Phase III will eliminate the need for paper timesheets and duplicate entries. Implementation by calendar year 4th quarter 2019 to include updated timekeeping policy and procedure.

*Anticipated Completion Date:* January 2019

## 3.23 Lakes Regional Community Center

**City:** Terrell

**Counties Served:** Camp, Delta, Franklin, Hopkins, Lamar, Morris, and Titus

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management letter not provided

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.24 MHMR Authority of Brazos Valley

**City:** Bryan

**Counties Served:** Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.25 MHMR of Nueces County dba Behavioral Health Center of Nueces County

**City:** Corpus Christi

**Counties Served:** Nueces

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.26 MHMR Services for the Concho Valley

**City:** San Angelo

**Counties Served:** Coke, Concho, Crockett, Irion, Reagan, Sterling, and Tom Green

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:**

Finding 2017-A – Financial Reporting

*Status:* Fully corrected.

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.27 MHMR Services of Texoma dba Texoma Community Center

**City:** Sherman

**Counties Served:** Cooke, Fannin, and Grayson

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Item 2018-001 – Material Weakness Related to Internal Controls over Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. In conjunction with the completion of our audit, we were requested to draft the financial statements and accompanying notes to those financial statements. Additionally, we proposed several audit adjustments to the Center's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

*Cause:* The Center does not prepare and has not developed an internal control system to provide for the preparation of, the financial statements and related disclosures in accordance with generally accepted accounting principles.

*Effect:* Although this circumstance is not unusual for an organization of your size, the preparation of financial statements and adjusting journal entries as a part of the audit engagement may result in financial statements and related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by Center personnel. The need for the audit adjustments indicates that the Center's interim financial information may not be materially correct, which may affect management decisions made during the course of the year. In addition, the Center recorded a prior period adjustment to increase net position and capital assets of governmental activities as of September 1, 2017, by $413,571.

*Recommendation:* The Center should evaluate and improve the controls over financial reporting and implement changes as necessary to ensure accurate and timely financial reports can be completed.

*Management's Response:* Management agrees with the noted finding.

Item 2018-002 – Material Weakness Related to Reconciliations of Various Accounts

*Criteria:* Accounts receivable, interfund balances, health claims incurred but not reported (IBNR), capital assets, unearned revenue and long-term obligations should

be reconciled at the end of the fiscal year. In addition, someone other than the preparer of the reconciliation should review the reconciliation and document their approval.

*Condition:* The Center does not have a process for the preparation of reconciliations of accounts receivable, interfund balances, IBNR, capital assets, unearned revenue and long-term obligations and/or does not have a process in place for review and approval of these reconciliations by someone other than the preparer. If certain accounts are not reconciled, the financial statements could result in a material misstatement.

*Cause:* Accounts receivable, interfund balances, IBNR, capital assets, unearned revenue and long-term obligations are not reconciled and/or reviewed by someone other than the preparer at year end.

*Effect:* The lack of reconciliations of accounts receivable, interfund balances, IBNR, capital assets, unearned revenue and long-term obligations increases the risk of material misstatement in the financial statements for these areas, either due to error or fraud.

*Recommendation:* The Center should design and implement a reconciliation process for accounts receivable, interfund balances, IBNR, capital assets, unearned revenue and long-term obligations, including review of these reconciliations by someone other than the preparer.

*Management's Response:* Management agrees with the noted finding.

**Follow-up on Prior Year Findings:**

Finding 2017-001

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* The Center does not have appropriate procedures in place to perform a detailed review of unearned program revenue to assure that the liability account is reconciled and reflects the appropriate balance in accordance with generally accepted accounting principles.

*Status:* Not resolved. This finding is repeated in current year Finding 2018-001.

Finding 2017-002

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* The Center does not have appropriate procedures in place to assure all accounts receivable are recorded at year end for billed grants and services related to the fiscal period and that accounts receivable are reported at their net realizable value in accordance with generally accepted accounting principles.

*Status:* Not resolved. This finding is repeated in current year Finding 2018-002. See also Finding 2018-001 regarding material audit adjustments. A material audit adjustment was recorded to accrue ICF receivables at August 31, 2018.

Finding 2017-003

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* The Center does not have appropriate procedures in place to perform a detailed review of the accrued payroll liabilities estimate to assure it reflects the appropriate balance in accordance with generally accepted accounting principles.

*Status:* Resolved. This finding was not repeated in the current year.

Finding 2017-004

*Initial Fiscal Year Finding Occurred*: 2017

*Finding Summary:* The Center has not conducted a complete physical inventory of all assets in the past two years as required by Uniform Grant Management Standards.

*Status:* Resolved. The Center performed a physical inventory of its capital assets in the current year.

**Independent Auditor's Management Letter:** Management letter not provided

**Corrective Action Plan:**

Finding 2018-001

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that would not have been identified because of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements.

*Corrective Action Plan:* It is not cost effective to have an internal control system designed to provide for the preparation of the financial statements and accompanying notes. We requested that our auditors, Eide Bailly LLP, prepare the financial statements and the accompanying notes to the financial statements as a part of their annual audit. We have designated a member of management to review the draft financial statements and accompanying notes, and we have reviewed and agree with the material adjustments proposed during the audit.

*Anticipated Completion Date:* Ongoing

Finding 2018-002

*Finding Summary:* The Center does not have a process for the preparation of reconciliations of accounts receivable, interfund balances, health claims incurred but not reported (IBNR), capital assets, unearned revenue and long-term obligations and/or does not have a process in place for review and approval of these reconciliations by someone other than the preparer.

*Corrective Action Plan:* The Center will design and implement a reconciliation process for accounts receivable, interfund balances, health claims incurred but not reported (IBNR), capital assets, unearned revenue and long-term obligations, including review of these reconciliations by someone other than the preparer.

*Anticipated Completion Date:* August 31, 2019

## 3.28 MHMR of Tarrant County

**City:** Fort Worth

**Counties Served:** Tarrant

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Item 2018-001 – Compliance with Procurement Requirements under the Uniform Guidance

*Criteria:* The Uniform Guidance requires written standards of conduct covering conflicts of interest and governing the performance of employees engaged in the selection, award and administration of contracts. No employee or agent of the Center may participate in the selection, award, or administration of a contract supported by a federal award if he or she has a real or apparent conflict of interest. The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the Center.

*Condition:* The Center's conflict of interest policy does not presently contain all of the requirements set forth in the Uniform Guidance for employees participating in the procurement process.

*Cause:* The procurement standards associated with the Uniform Guidance first became effective during FY 2018. Center management normally looks to the State of Texas Uniform Grant Management Standards for procurement guidance. Management was not aware of this new federal procurement requirement.

*Effect:* The Center's conflict of interest policy is not in full compliance with the Uniform Guidance requirements.

*Recommendation:* MHMR should review its current written standards related to conflicts of interest and revise as necessary to assure compliance with Uniform Guidance requirements.

*Management's Response:* See corrective action plan.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** Management Letter not provided

**Corrective Action Plan:**

Item 2018-001 – Procurement Standards — Uniform Guidance

*Corrective Action Plan:* MHMR of Tarrant County will begin requiring all employees that are issued a purchasing card and/or given approval rights in the Purchasing System to sign a conflict of interest form that discloses any potential conflicts of interest, if applicable.

*Estimated completion date:* March 1, 2019

## 3.29 North Texas Behavioral Health Authority

**City:** Dallas

**Counties Served:** Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:**

Finding No. 2017-001 – Balance Sheet Account Reconciliations – Material Weakness

*Criteria:* NTBHA is responsible for presenting basic financial statements that are fairly stated in accordance with U.S. generally accepted accounting principles.

*Condition:* The operating bank account, accrued expenses, and due to/due from accounts were not properly reconciled at year end.

*Cause:* NTBHA experienced several issues with the implementation of new accounting software and changes to internal accounting processes, procedures and reporting. These issues resulted in significant delays in proper reconciliations of certain year-end balance sheet accounts.

*Effect:* Management updated these reconciliations resulting in journal entries and delays to the original audit timeline. The effect of the entries decreased assets by $2,557,273, decreased liabilities by $2,419,396, and increased net income by $137,877.

*Recommendation:* We recommend that management follow their policy of reconciling and reviewing detailed accounts to the general ledger in a timely manner.

*Management's Response:* The accounting staff responsible for preparing the 2017 audit, experienced unanticipated delays due to the accounting and recordkeeping of the external CPA. This CPA was responsible for the organization's accounting and financial reporting from September 1, 2016 through December 31, 2016. This CPA did not record the FY 2016 audit adjusting entries in the accounting system for FY 2016. Therefore, current accounting staff had to reconcile the beginning balances to the prior year audit report, trace the transactions to the underlying source documents provided by the external CPA during this timeframe, and assure that they were recorded correctly in the new accounting system.

In addition to these unanticipated accounting delays, staff also experienced significant problems with the accounting and financial reporting software system that had been implemented in January 2017. Upon review of the system in May 2017, it was determined that the current system was inadequately designed and implemented and would not support NTBHA and its growing business. A second accounting system had to be designed, implemented, and all transactions had to be recorded and entered into the correct accounts and accounting periods in the new system. Due to these circumstances, balance sheet reconciliations were unable to be prepared prior to the commencement of the 2017 audit.

The Finance Department has implemented a monthly reconciliation process and review of all balance sheet accounts and has ensured these reconciliations are completed monthly. These internal control processes reasonably ensure all reconciliations are complete as of year-end.

In addition, the CFO has hired additional qualified accounting personnel to assist with the increased growth. All staff have received training on the new accounting software.

*Current Status:* NTBHA has completed the corrective action plan required as a result of the prior year audit.

**Independent Auditor's Management Letter:** Management Letter not provided

**Corrective Action Plan:** Corrective Action Plan not provided

## 3.30 Pecan Valley Centers for Behavioral and Developmental Healthcare

**City:** Granbury

**Counties Served:** Erath, Hood, Johnson, Palo Pinto, Parker, and Somervell

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding No. 2018-A – Financial Reporting

*Criteria:* Management of the Center is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP). This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Center does not have an internal control system designed to provide for the accurate preparation of the financial statements and related financial statement disclosures being audited. We proposed audit adjustments to the Center's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

*Cause:* The Center has not previously recorded an allowance for insurance receivables as they write off aged receivables each month over 90 days old. We identified approximately $100,000 in receivables written off subsequent to year-end that relate to recorded receivables at August 31, 2018. Further, the Medicaid Administrative Claiming (MAC) receivable had only been accrued through March 2018 services due to the lag time in filing requirements and receiving payment. GAAP requires that the receivable be accrued through year-end; however, revenues not considered available should be reported as deferred inflows of resources in the General Fund.

*Effect:* At August 31, 2018 the MAC receivable and related deferred inflows of resources in the general fund were understated by $225,897. In the government-wide financial statements, beginning net position was understated by $274,351 and 2018 revenues were overstated by $48,454. Accordingly, the Center recorded a prior period adjustment to increase net position of governmental activities as of September 1, 2017, by $274,351. The general fund and government-wide financial statements also understated the allowance for insurance receivables by $70,000 at August 31,2017. Accordingly, the Center recorded a prior period adjustment to decrease net position of governmental activities and fund balance of the general fund as of September 1,2017, by $70,000.

*Recommendation:* The Center should record receivables in accordance with GAAP. This includes recording an allowable for receivables not expected to be collected. This also includes adjusting receivables such as MAC for services provided through fiscal year end within the parameters of the modified accrual basis in the governmental fund statements.

Management's Response: Management agrees with the noted finding.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Finding 2018-A

*Condition:* The Center does not have an internal control system designed to provide for the accurate preparation of the financial statements and related financial statement disclosures being audited. Eide Bailly LLP proposed audit adjustments to the Center's recorded account balances, which if not detected by their auditing procedures, could have resulted in a material misstatement of the Center's financial statements.

*Cause:* The Center has not previously recorded an allowance for insurance receivables as they write off aged receivables each month over 90 days old. The auditor identified approximately $100,000 in receivables written off subsequent to yearend that relate to recorded receivables at August 31, 2018. Further, the Medicaid Administrative Claiming (MAC) receivable had only been accrued through March 2018 services due to the lag time in filing requirements and receiving

payment. GAAP requires that the receivable be accrued through yearend; however, revenues not considered available should be reported as deferred inflows of resources in the General Fund.

*Corrective Action Plan:* The Center's Chief Financial Officer has posted to our financial statements the two audit adjustments identified during the audit. Going forward, the Center will record receivables in accordance with GAAP. This includes recording an allowable for receivables not expected to be collected. This also includes adjusting receivables such as MAC for services provided through fiscal year end within the parameters of the modified accrual basis in the governmental fund statements.

*Anticipated Completion Date:* February 1, 2019

## 3.31 Permian Basin Community Centers for MHMR

**City:** Midland

**Counties Served:** Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, and Presidio

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.32 Sabine Valley Regional MHMR Center dba Community Healthcore

**City:** Longview

**Counties Served:** Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk, and Upshur

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.33 Spindletop Center

**City:** Beaumont

**Counties Served:** Chambers, Hardin, Jefferson, and Orange

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-001 – Reporting – Significant Deficiency in Internal Control over Compliance

*Criteria:* Grant agreement requires controls over payroll transactions to ensure the right amount is charged to the grant.

*Condition:* The Center discovered that an employee entered and was paid for 40 hours of overtime during one week rather than 40 hours of regular time.

*Cause:* The Center did not have adequate internal control to ensure review and approve timecard entry.

*Effect:* The Center disbursed funds for incorrect time entry.

*Recommendation:* The Center should implement tighter controls over timecard approval. We recommend the Center review all timecard entries involving overtime to ensure accuracy.

*Management's Response:* Management agrees with the finding. Refer to Corrective Action Plan.

**Follow-up on Prior Year Findings:**

Finding 2017-001

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* The Center discovered that a former employee was purchasing personal items using a company credit card and submitting fictitious and altered receipts. The Center continues to investigate the impact of the theft. All charges to expense were charged to administration costs and were note allocated to grant programs.

*Status:* Resolved – The Center has improved controls over employee credit card purchases including having adequate review and approval. The Center has also implemented other control over vendors and other purchasing policies.

**Independent Auditor's Management Letter:** Management letter not provided

**Corrective Action Plan:**

Finding 2018-001

*Description of Finding:* The Center discovered that an employee entered and was paid for 40 hours of overtime during one week rather than 40 hours of regular time.

*Center Position:* We concur with the finding.

*Corrective Action:* An additional level of timecard approval was implemented to review all timecard entries, focusing on overtime and other entries outside of regular hours.

*Implementation Timeline:* August 2018

*Monitoring to be Performed*: Staff will review all timecard entries prior to payroll processing to ensure time is correctly entered by the submitting employee.

## 3.34 StarCare Specialty Health System dba Lubbock Regional MHMR Center

**City:** Lubbock

**Counties Served:** Cochran, Crosby, Hockley, Lubbock, and Lynn

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-A – Financial Reporting

*Criteria:* Management of the Company is responsible for the preparation and fair presentation of the financial statements in accordance with generally accepted accounting principles (GAAP) as well as timely reconciliations of account balances. This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

*Condition:* The Company does not have an internal control system designed to provide for the preparation of the financial statements and related financial statement disclosures being audited. In conjunction with the completion of our audit, we were requested to draft the financial statements and accompanying notes to those financial statements. Our audit procedures indicated that the Company lacks proper controls over the closing process which includes reconciliations of accounts and appropriate approval of journal entries. Additionally, we proposed

several audit adjustments, including an adjustment to beginning fund balance/net position, to the Company's recorded account balances, which if not detected by our auditing procedures, could have resulted in a material misstatement of the Company's financial statements.

*Cause:* The Company does not prepare and has not developed an internal control system to provide for the preparation of the financial statements and related disclosures in accordance with generally accepted accounting principles in a timely and accurate manner.

*Effect:* The preparation of financial statements and adjusting journal entries as a part of the audit engagement as well as lack of account reconciliations and appropriate approval of journal entries may result in financial statements and related information included in financial statement disclosures not being available or accurate for management purposes as timely and accurate as it would be if the financial statements were prepared by the Company and proper controls were in place around account reconciliations. The need for the audit adjustments indicates that the Company's interim financial information may not be materially correct, which may affect management decisions made during the course of the year.

*Recommendation:* The Company should evaluate and improve the controls over financial reporting and implement changes as necessary to ensure accurate and timely financial reports can be completed. The Company should also implement controls in which accounts are being properly monitored, reconciled, and reviewed on a regular basis.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

Finding 2018-B – System Access

*Criteria:* Management of the Company is responsible for assuring that there are proper system access controls in place. Controls should limit system access and only authorized personnel should have access to the system and they should be able to only perform specific authorized functions.

*Condition:* The Company does not have an internal control system design to limit system access to personnel as certain personnel have full system access and administrative rights to make system changes. The lack of limited access can result in the loss or misstatement of assets and/or resources.

*Cause:* The Company does not have proper controls over system access.

*Effect:* Unlimited system access can lead to personnel having access to all data, including data that might not be considered appropriate. Unlimited system access can also lead to incorrect data being entered by unauthorized personnel or personnel that lack proper experience. This can lead to inaccurate information or inaccurate internal financial reports generated by management used to make decisions that impact the Company's operations. This could also lead to fraudulent transactions or misappropriation of the Center's assets.

*Recommendation:* The Company should implement controls around system access and limit access to individuals to have access only to what is considered appropriate. Access should be reviewed on a regular basis in order to assure that access is still appropriate.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

Finding 2018-001 – Significant Deficiency in Internal Control Over Compliance

*Criteria:* Grant agreement requires that the Company determine, invoice for, and report accurate expenditures that are allowed under the grant agreement.

*Condition:* The Company had a desk review by HHSC that resulted in the Company re-submitting a quarterly report due to the Company reporting a certain amount on a cash basis. The Company was told to restate the quarterly report and re-submit. We did not have any findings in our disbursement testing.

*Cause:* The Company had always reported this particular item on a cash basis as they were not aware of any guidance that stated otherwise.

*Effect:* Quarterly report included inaccurate amounts as the accrual related to claims incurred but not reported (IBNR) was reported on a cash basis rather than accrual basis.

*Recommendation:* The Company should implement controls that include appropriate review for allowed activities as well as allowable costs prior to submitting information.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

Finding 2018-002 – Significant Deficiency in Internal Control Over Compliance

*Criteria:* Grant agreement requires the Company to determine eligibility for service recipients as well as proper billing for services provided.

*Condition:* The Company did not have controls in place to ensure that services were provided to eligible individuals and a review that includes review of billing to the individuals who receives the services. While testing controls over eligibility, we noted one instance in which services were billed to an individual that did not receive services.

*Cause:* The Company does not have proper controls over eligibility and billing.

*Effect:* Services were billed to an individual that did not receive services.

*Recommendation:* The Company should implement proper controls over eligibility including billing for services provided.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

Finding 2018-003 – Significant Deficiency in Internal Control Over Compliance

*Criteria:* Grant agreement requires certain reports to be filed on a quarterly basis in which the Company reports expenditures and revenues for all applicable grants as well as matching requirements.

*Condition:* The Company did not have controls in place to ensure consistent and accurate review of financial reports for grants. Our audit procedures resulted in multiple instances in which reports were not properly reviewed and, in one instance, the report was not properly prepared as it included inaccurate information.

*Cause:* The Company does not have proper controls over reporting.

*Effect:* No formal review of required reports was performed consistently. Fourth quarter Form X, a report required to be filed for the general revenue Inpatient Grant, was selected for testing and it was noted that information was not properly

supported as it was not reported correctly. There was a difference in the amounts reported versus the amounts supported. Report was subsequently amended and resubmitted to the State.

*Recommendation:* The Company should implement proper controls around the reporting process including formal review and approval prior to reports being submitted to the State.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

**Follow-up on Prior Year Findings:**

Finding 2017-A

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that might not would have been identified as a result of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements.

*Status:* Ongoing. Due to cost considerations, we will continue to have Eide Bailly LLP prepare our draft financial statements and accompanying notes to the financial statements.

**Independent Auditor's Management Letter:**

We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, we identified certain deficiencies in internal control over compliance, as described in the accompanying schedule of findings and questioned costs as items 2018-001, 2018-002, and 2018-003 that we consider to be significant deficiencies.

**Corrective Action Plan:**

Finding 2018-A

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit

adjustments, including an adjustment to prior period, that would not have been identified because of our existing controls and, therefore, could have resulted in a material misstatement of our financial statements. Additionally, several account reconciliations and journal entries were not properly reviewed.

*Corrective Action Plan:* StarCare will address the systemic issues as we continue to implement and refine the new accounting system and the new electronic medical record system. Both of these systems have the ability to make the accounting process more efficient and will therefore allow more time for better controls and review. In addition to new system integration, we will create a new senior accountant position to oversee the monthly financial close process. This position will supervise the staff accountants and that team will be solely responsible for accurate and timely financial statements. When this position is filled and trained, the Associate CFO will have adequate time to completely review and update all relevant financial policies and procedures and follow through with compliance and oversight.

*Anticipated Completion Date:* August 31, 2019

Finding 2018-B

*Finding Summary:* During the audit performed by Eide Bailly LLP, it was noted that system access was not limited as individuals with access had unlimited access. Unlimited system access can lead to incorrect data being entered by unauthorized personnel or personnel that lack proper experience. This can also lead to fraudulent transactions or misappropriation of the Company's assets and inaccurate information or inaccurate internal financial reports generated by management used to make decisions that impact the Company's operations.

*Corrective Action Plan:* The CFO and the Associate CFO will work directly with the on-site Management Information System (MIS) staff to complete a full fiscal staff audit on all electronic systems used by the fiscal department staff. In this audit, we will identify current access levels, by employee, for each system in use and determine the minimum access required to complete their function. Consideration will be given by position and the expectations based on actual duties performed. Appropriate levels of access will be granted to certain MIS staff so that the MIS staff will be able to manage access levels going forward. Through the audit process, the MIS staff will limit access, by employee, to each system in use based on the minimum levels determined.

*Anticipated Completion Date:* August 31, 2019

Finding 2018-001

*Finding Summary:* Eide Bailly LLP noted that, as a result of a desk review by HHSC, the Company filed an inaccurate quarterly report. As a result, the Company had to restate their original filing and resubmit.

*Corrective Action Plan:* Management understands that through an HHSC desk review it was discovered that a long-standing standard reporting practice was not in line with cost reporting guidance from HHSC. The cost reporting method has been corrected, thus the restatement, and has been updated going forward.

*Anticipated Completion Date:* December 7, 2018

Finding 2018-002

*Finding Summary:* Eide Bailly LLP performed testing procedures over eligibility and noted lack of proper controls over eligibility as they identified one instance in which services were billed to an individual that did not receive services.

*Corrective Action Plan:* The testing performed was from StarCare's legacy system data. That system was replaced with a more robust electronic system on 09/01/18. The new electronic system allows for better, stricter controls designed to prevent services being assigned individuals that do not qualify or did not receive them. The new system also has more strict controls around employee access and their ability to add services in error. Since the start of the new system, the MIS department has worked closely with supervisors to determine proper levels of access by employee. This will be a continual process as we continue to refine the system.

*Anticipated Completion Date:* August 31, 2019 and ongoing

Finding 2018-003

*Finding Summary:* Eide Bailly LLP identified several instances in which quarterly reports, which are required to be submitted by the Company, were not properly reviewed and approved. Additionally, in one instance, the report submitted was not properly prepared as it included inaccurate information. Report was subsequently amended and resubmitted.

*Corrective Action Plan:* StarCare will address the systemic issues as we continue to implement and refine the new accounting system. This system has the ability to make the accounting process more efficient and will therefore allow more time for better controls and review. In addition to new system integration, we will create a new senior accountant position to provide support to the Associate CFO. Specifically, this position will assist with external reporting. This will allow for proper review and oversight of data leaving our internal system. When this position is filled, and they have been properly trained, the Associate CFO will have adequate time to completely review and update all relevant financial policies and procedures and follow through with compliance and oversight.

*Anticipated Completion Date:* August 31, 2019

## 3.35 Texana Center

**City:** Rosenberg

**Counties Served:** Austin, Colorado, Fort Bend, Matagorda, Waller, and Wharton

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.36 Texas Panhandle Centers Behavioral and Developmental Health

**City:** Amarillo

**Counties Served:** Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Potter, Randall, Roberts, Sherman, and Wheeler

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:**

Finding 2017-A

*Initial Fiscal Year Finding Occurred:* 2017

*Finding Summary:* Eide Bailly LLP prepared our draft financial statements and accompanying notes to the financial statements. They also proposed material audit adjustments that may not have been identified as a result of our existing controls, and therefore, could have resulted in a material misstatement of our financials. Finally, Eide Bailly LLP reported that our year end close process was ineffective due to material adjustments provided to the auditors after fieldwork completion.

*Status:* The Center has implemented controls to improve the close process including controls over the review of financial statements which Eide Bailly prepares. We believe this finding has been resolved and it has not been repeated in the current fiscal year.

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.37 Tri-County Behavioral Healthcare

**City:** Conroe

**Counties Served:** Liberty, Montgomery, and Walker

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:** None

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:**

Current year comments

The Center had no current year comments.

Follow-up on prior year comment

Allowance for Doubtful Accounts

During our review of accounts receivable and the related allowance for doubtful accounts. we noted that the allowance for doubtful accounts was increased by $20,000 to a total of $80,000. This adjustment by management was made after giving consideration to the steady increase in overall receivable balances. We encourage management to continue to evaluate the allowance on a periodic basis. We consider the prior year comment to be resolved in accordance with our recommendation.

**Corrective Action Plan:** No findings/comments requiring corrective action

## 3.38 Tropical Texas Behavioral Health

**City:** Edinburg

**Counties Served:** Cameron, Hidalgo, and Willacy

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-001 – Significant Deficiency in Internal Control Over Compliance

*Criteria:* Grant agreement requires entities to file quarterly reports for the Medical Assistance Program.

*Condition:* We noted that the Center filed the quarterly reports as required; however, upon reviewing the support for the expenditures for the first quarter, it was noted that, while the total expenditures reported were correct, the numbers reported within categories was incorrect for two-line items.

*Cause:* The Center did not have adequate internal controls to review the reports in detail prior to being submitted.

*Effect:* The Reporting requirement for the first quarter was incorrectly reported.

*Recommendation:* While the Center has controls in place to review the reports prior to being filed, we recommend for the Center to implement a detail review by line item by someone independent from report preparation responsibilities.

*Management's Response:* Management agrees with the noted finding. Refer to Corrective Action Plan.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Finding 2018-001

*Finding Summary:* We noted that the Center filed the quarterly reports as required; however, upon reviewing the support for the expenditures for the first quarter, it was noted that, while the total expenditures reported were correct, the numbers reported within categories was incorrect for two-line items.

*Corrective Action Plan:* Management has corrected the quarterly report for the first quarter and has implemented additional review controls over the reports preparation to ensure accuracy.

*Anticipated Completion Date:* Error was noted by Center prior to audit and controls were modified to include a detail review by line item. Eide Bailly tested all subsequent quarters and noted that reports were properly prepared and reviewed.

## 3.39 West Texas Centers

**City:** Big Spring

**Counties Served:** Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum

**Type of Report on Financial Statement:** Unmodified

**Type of Report on Compliance:** Unmodified

**Schedule of Findings and Questioned Costs:**

Finding 2018-001 – Procurement Standards – Uniform Guidance

*Criteria:* Management is responsible for adopting policies and procedures that comply with the Procurement Standards of the Uniform Guidance. The procurement standards prescribed by the Uniform Guidance require written standards of conduct covering conflicts of interest for all employees involved in procurement. The policy must provide for disciplinary actions for violations.

*Condition:* The Center employees sign a code of conduct policy when hired. The agreement we reviewed did not specifically address conflicts of interest and disciplinary actions for violations.

*Cause:* The procurement standards prescribed by the Uniform Guidance were effective for the first time in FY 2018. As a result, compliance with this requirement is new to community centers.

*Effect:* The Center is not in full compliance with the procurement standards specified by the Uniform Guidance.

*Recommendation:* We recommend that the Center develops a conflicts of interest policy which incorporates language prescribed by the Uniform Guidance related to conflicts of interest and that all employees involved in procurement sign the policy.

*Management's Response:* Management agrees with the noted finding. Management will adopt and implement a conflict of interest policy in line with the Procurement Standards of the Uniform Guidance on or before August 31, 2019. The policy will provide for disciplinary actions for violations.

**Follow-up on Prior Year Findings:** None

**Independent Auditor's Management Letter:** No findings/comments

**Corrective Action Plan:**

Item 2018-001 – Procurement Standards - Uniform Guidance

*Corrective Action Plan:* Management agrees with the noted finding. Management will adopt and implement a conflict of interest policy in line with the Procurement Standards of the Uniform Guidance on or before August 31, 2019. The policy will provide for disciplinary actions for violations.

*Estimated completion date:* On or before August 31, 2019

# 4. Conclusion

This report summarizes the independent auditor's findings of 39 LMHAs and their responses.

# List of Acronyms

| Acronym | Full Name |
|---|---|
| CFDA | Catalog of Federal Domestic Assistance |
| CFO | Chief Financial Officer |
| CFR | Code of Federal Regulations |
| CPA | Certified Public Accountant |
| dba | Doing Business As |
| ECI | Early Childhood Intervention |
| GAAP | Generally Accepted Accounting Principles |
| HHSC | Health and Human Services Commission |
| IBNR | Incurred But Not Reported |
| IDD | Intellectual and Developmental Disabilities |
| ISP | Immediate Services Plan |
| LMHA | Local Mental Health Authority |
| MAC | Medicaid Administrative Claiming |
| MHMR | Mental Health and Mental Retardation |
| MIS | Management Information System |

| Acronym | Full Name |
|---|---|
| NTBHA | North Texas Behavioral Health Authority |
| PCS | Procurement and Contracting Services |
| SAU | Single Audit Unit |
| UGMS | Uniform Grant Management Standards |