

Inspector General

United States
Department of Defense



Improving Planning for Military Construction of Army Child Development Centers

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Acronyms and Abbreviations

ASIP	Army Stationing and Installation Plan
CDC	Child Development Center
CYSC	Child Youth Services Center
GCM	Garrison Capability Model
MILCON	Military Construction
OACSIM	Office of the Assistant Chief of Staff for Installation Management
OMB	Office of Management and Budget
USACE	United States Army Corps of Engineers



INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-4704

March 1, 2011

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)/
CHIEF FINANCIAL OFFICER
AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: Improving Planning for Military Construction of Army Child Development Centers (Report No. D-2011-046)

We are providing this report for review and comment. We determined that the Army needed to improve planning for constructing child development centers to ensure the appropriate use of Recovery Act funds. We considered management comments on a draft of this report when preparing the final report.

DoD Directive 7650.3 requires that recommendations be resolved promptly. The comments from the Assistant Chief of Staff for Installation Management were not responsive to Recommendation B. Therefore, we request additional comments by March 31, 2011.

If possible, please send a .pdf file containing your comments to audacm@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-9201 (DSN 664-9201).

A handwritten signature in black ink, reading "Richard B. Jolliffe", is positioned above the typed name.

Richard B. Jolliffe
Assistant Inspector General
Acquisition and Contract Management



Results in Brief: Improving Planning for Military Construction of Army Child Development Centers

What We Did

We evaluated DoD's implementation of plans for the American Recovery and Reinvestment Act of 2009 (Recovery Act). Specifically, we determined that the Army needed to improve planning for constructing child development centers (CDCs) to assure the appropriate use of Recovery Act funds.

What We Found

The Army's overall requirements for Recovery Act-funded CDCs were valid. However, internal controls in the following areas involving planning for the apportionment of child development center resources needed improvement.

The apportionment of 1,633 childcare spaces among the seven selected bases was questionable. Also, the Army's methodology of using the design capacities (fixed numbers based on the constructed buildings), rather than the operational capacities (varies depending on the age group of the children), of planned CDCs to assess its ability to meet projected childcare demand overestimated future Army childcare capacity. The apportionment inequities occurred because Army planners focused mainly on formulating a construction plan for CDCs using earlier approved but unfunded project requests to promote timely expenditure of the \$80 million Recovery Act authorization. Army planners did not emphasize working toward the most equitable distribution of childcare resources. The Army's overestimate of childcare capacity occurred because its assessment tool, the Garrison Capability Model, used design capacity of future CDCs to estimate Army childcare capacity. As a result, the Army's plans for constructing CDCs with Recovery Act funds will underserve childcare

demand at some garrisons while overserving others. Also, the Army's overestimation of future Army childcare capacities could lead to making decisions for future childcare needs based on faulty assumptions.

What We Recommend

We made no recommendation to the Assistant Chief of Staff for Installation Management regarding the apportionment of childcare spaces because the Army took responsive action to notify Congress, through the DoD Comptroller, of its intent to use available Recovery Act funds to construct a CDC at Fort Polk, Louisiana. At the time of our audit, the Army was projecting Fort Polk as the fort that would have the greatest shortfall in childcare capacity in FY 2015.

We recommend that the Assistant Chief of Staff for Installation Management revise its estimating methodology for assessing CDC capacity. Specifically, the Army should apply corrective factor(s) and percentage(s) to reduce CDC design capacities to expected operational capacity ranges when estimating a garrison's future operational capability.

Management Comments and Our Response

The Assistant Chief of Staff for Installation Management disagreed with our findings and recommendation, stating that the recommendation would reduce the number of children served in Army CDCs. Our recommendation would improve CDC assessment accuracy and would thereby better match new CDC construction to actual CDC needs without any reduction in the number of children served. Therefore, we request additional management comments. Please see the recommendations table on page ii.

Recommendations Table

Management	Recommendation Requiring Comment
Assistant Chief of Staff for Installation Management	B

Please provide comments by March 31, 2011.

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Introduction

Objective

Our overall objective was to evaluate how DoD implemented its plans for the Recovery Act, so that we can ensure accountability and transparency of Recovery Act funds. As part of achieving our overall objective, we determined whether the military construction of Army child development centers (CDCs) was adequately planned to ensure the appropriate use of Recovery Act funds. See Appendix A for a discussion of our scope and methodology.

Recovery Act Background

The President signed the Recovery Act into law on February 17, 2009. It is an unprecedented effort to jump-start the economy and create and save jobs.

The purposes of this Act include the following:

- (1) To preserve and create jobs and promote economic recovery.
- (2) To assist those most impacted by the recession.
- (3) To provide investments needed to increase economic efficiency by spurring technological advances in science and health.
- (4) To invest in transportation, environmental protection, and other infrastructure that will provide long-term economic benefits.
- (5) To stabilize State and local government budgets, in order to minimize and avoid reductions in essential services and counterproductive state and local tax increases

... the heads of Federal departments and agencies shall manage and expend the funds made available in this Act so as to achieve the purposes specified ... including commencing expenditures and activities as quickly as possible consistent with prudent management.

See Appendix B for implementing Recovery Act criteria and guidance.

Recovery Act Requirements

The Recovery Act and implementing Office of Management and Budget (OMB) guidance require projects to be monitored and reviewed. We grouped these requirements into the following four phases: (1) planning, (2) funding, (3) execution, and (4) tracking and reporting. The Recovery Act requires that projects be properly planned to ensure the appropriate use of funds. Review of the funding phase is to ensure the funds were distributed in a prompt, fair, and reasonable manner. Review of the project execution phase is to ensure that contracts awarded with Recovery Act funds were used for authorized purposes; and that instances of fraud, waste, error, and abuse were mitigated. Review of the execution phase also ensures that program goals were achieved, including specific program outcomes and improved results on broader economic indicators; that projects funded avoided unnecessary delays and cost overruns; and that contractors or

recipients of funds reported results. Review of the tracking and reporting phase ensures that the recipients’ use of funds was transparent to the public and that benefits of the funds were clearly, accurately, and timely reported.

OMB Recovery Act Guidance

Criteria for planning and implementing the Recovery Act continue to change as OMB issues additional guidance, and DoD and the Components issue their implementation guidance. OMB has issued 10 memoranda and 1 bulletin to address the implementation of the Recovery Act. See Appendix B for Recovery Act criteria and guidance.

DoD Recovery Act Program Plans

Under the Recovery Act, Congress appropriated approximately \$12 billion to DoD for the following programs: Energy Conservation Investment; Facilities Sustainment, Restoration, and Modernization; Homeowners Assistance; Military Construction (MILCON); Near Term Energy-Efficient Technologies; and U.S. Army Corps of Engineers (USACE) Civil Works.

The values of the six Recovery Act programs are shown in the following table.

DoD Agency-Wide and Program-Specific Recovery Act Programs

Program	Amount (in millions)
Energy Conservation Investment	\$120
Facilities Sustainment, Restoration, and Modernization	4,260*
Homeowners Assistance	555
Military Construction	2,185
Near Term Energy-Efficient Technologies	300
U.S. Army Corps of Engineers Civil Works	4,600
Total	\$12,020*

*On August 10, 2010, Public Law 111-226, Title III, “Recessions,” rescinded \$260.5 million of funds from DoD Operations and Maintenance Accounts supporting the Recovery Act. This reduced the DoD Recovery Act FSRM amounts to approximately \$4 billion and total DoD Agency-Wide and Program Specific Recovery Act program funding to approximately \$11.76 billion.

The Recovery Act divides the approximately \$12 billion among 32 DoD and USACE line items of appropriations.

Army’s Planned Construction of Recovery Act-Funded Child Development Centers

The Army’s planned construction of Recovery Act-funded CDCs meets the purposes of the Recovery Act by creating jobs for both construction and long-term operation and management of the CDCs. Through Public Law 111-5, “American Recovery and Reinvestment Act of 2009,” February 17, 2009, specifically title X, “Military

Construction and Veterans Affairs,” the Army received \$80 million in Recovery Act appropriations for the military construction (MILCON) of Army CDCs (preschools). The Army planned to use the Recovery Act funding to construct six CDCs and a child youth services center (CYSC) at seven garrisons to provide 1,633 additional childcare spaces. Estimated costs were:

- Fort Belvoir, Virginia: \$14.6 million (CDC, capacity of 338);
- Fort Hood, Texas: \$12.7 million (CDC, capacity of 338);
- Fort Carson, Colorado: \$12.5 million (CDC, capacity of 232);
- Fort Bragg, North Carolina: \$11.3 million (CDC, capacity of 232);
- Fort Drum, New York: \$10.7 million (CDC, capacity of 126);
- Fort Eustis, Virginia: \$9.6 million (CDC, capacity of 232); and
- Hunter Army Airfield, Georgia: \$8.6 million (CYSC, maximum capacity of 135).

Due to a favorable contract bid environment, the actual construction costs were expected to be less than the appropriations, resulting in additional military construction funds of between \$11.7 million and \$20 million. In addition to building the 7 CDCs with Recovery Act funding, the Army planned to construct 14 additional CDCs and CYSCs at an estimated cost of \$121 million between FYs 2010 and 2015. See Appendix C for criteria on Army MILCON.

Army Policy on Establishing and Operating Child Development Services

Army Regulation 608-10 (Personal Affairs), “Child Development Services,” July 15, 1997, prescribes policy and procedures for establishing and operating Army child development services. Under the regulation, Army child development services include the following:

- CDCs, which are centralized installation facilities used for the child development program.
- Family Childcare, which involves childcare services provided by military family members in individual housing units located on base or in Government-controlled housing off-base.
- Supplemental Programs and Services, which involve alternative childcare programs and services that augment the services provided by the CDCs and family childcare.

Under the general business rules of the Army’s Garrison Capability Model (GCM), the above three sources provide child development services to military, civilian, and contractor personnel. CDCs are normally expected to fulfill from 60 to 80 percent of a garrison’s childcare needs, with family childcare and supplemental programs and services meeting the rest. Per Assistant Chief of Staff for Installation Management memorandum, “Army Standard for Child Development Centers,” March 12, 2008, Army CDCs have three standard sizes, with design capacities of 126, 232, and 338 children.

Review of Internal Controls

DoD Instruction 5010.40, “Managers’ Internal Control Program (MICP) Procedures,” July 29, 2010, requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls. We identified internal control weaknesses in the Army’s planning for construction of CDCs with Recovery Act funds. Specifically, the Army’s planning for the use of Recovery Act funds in constructing CDCs did not include working toward the most equitable distribution of childcare resources. Additionally, the Army’s methodology for estimating the capacity of planned CDCs did not consider the difference between the design and operational capacities of CDCs. The Army’s planned action to fund construction of an additional CDC at a fort having the greatest need for additional capacity documents that the Army is now effectively working towards equitable distribution of childcare resources.

Finding A. Inadequate Planning for the Apportionment of Childcare Spaces

The Army's planning for constructing seven CDCs with Recovery Act funds was not adequate. Specifically, Army projections for FY 2015 show that plans for constructing Recovery Act-funded CDCs at seven bases will result in available CDC childcare capacity varying from 77 percent of projected CDC childcare demand at Fort Bragg, North Carolina, to 102 percent of projected CDC childcare demand at Hunter Army Airfield, Georgia; Fort Hood, Texas; Fort Carson, Colorado; and Fort Eustis, Virginia. This condition occurred because the Army did not focus on needs-based planning, involving constructing larger CDCs at bases with greater projected childcare needs and smaller CDCs at bases with relatively smaller projected needs. Instead, the Army formulated a CDC construction plan using previously approved but unfunded project requests to promote timely expenditure of the \$80 million in Recovery Act authorization for CDCs. As a result, there will be greater variation in the ability of the seven bases to meet requirements for childcare spaces than would have occurred had the Army used needs-based apportionment childcare capacity.

Apportionment of Childcare Spaces Was Questionable

Although the Army's Recovery Act-funded CDC requirements were valid, the apportionment of 1,633 childcare spaces among the 7 selected bases was questionable. To document how the Army could have apportioned childcare capacity to more effectively meet needs, we made a comparison of currently planned versus needs-based apportionment of CDCs to meet FY 2015 CDC childcare space requirements at the seven Army Bases receiving Recovery Act-funded CDCs. For the Army's currently planned apportionment of childcare capacity, the following factors applied:

- The Army used business rules from the Army's GCM for establishing targets at each base for the percent of childcare service requirements to be met through facility-based sources (CDCs and CYSCs). The Army established these targets after considering factors relevant to each base, such as geographic location (isolated, standard, or metropolitan) and the availability of off-post alternatives.
- The Army established planned sizes for Recovery Act-funded CDCs at Forts Hood, Drum, Belvoir, and Eustis and for the CYSC at Hunter Army Airfield by using earlier approved but currently unfunded project requests (DD Forms 1391) originally dated between May 2000 and December 2007. CDC sizes for Forts Bragg and Carson came from subsequent documents (Request for Proposal and Statement of Work, respectively) that updated the CDC sizes from the DD Form 1391. The Army updated these forms between June 2008 and August 2009 to reflect the current costs and (for five of them) the new standard CDC sizes. However, the updates did not include re-evaluating the CDC childcare needs at the bases or comparing their CDC childcare needs with the rest of the Army.

Our comparison showed that using needs-based apportionment at the seven Army bases receiving Recovery Act-funded CDCs would have resulted in more closely meeting each base's CDC childcare space requirements. Specifically, under the Army's current plan, two bases, Fort Bragg at 77 percent and Fort Drum at 84 percent, would meet less than 90 percent of CDC space requirements. Additionally, four bases,

. . . using needs-based apportionment . . . would have resulted in more closely meeting each base's CDC childcare space requirements.

Hunter Army Airfield, Fort Hood, Fort Carson, and Fort Eustis, would meet 102 percent of CDC space requirements. Conversely, using needs-based apportionment to increase the size of the planned CDCs at Fort Bragg and Fort Drum and decrease the size of those planned at Fort Carson and Fort Hood would have resulted in only one base (Fort Bragg) meeting less than 90 percent of the childcare space requirements that the Army targeted to meet with CDCs. Additionally, two bases (Fort Eustis and Hunter Army Airfield), at 102 percent, would slightly exceed the targeted space requirements. Appendix D provides details of our comparison of currently planned versus need-based apportionment of CDC resources to meet CDC childcare space requirements for FY 2015 at the seven Army Bases receiving Recovery Act-funded CDCs.

Army Did Not Focus on Needs-Based Planning to Provide Additional CDC Capacity to Bases with the Greatest Need

The Army did not focus on needs-based planning, involving constructing larger CDCs at bases with greater projected childcare needs and smaller CDCs at bases with relatively smaller projected needs. The U.S. Senate Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, requested the Army to identify projects that it could execute quickly to provide construction stimulus. In response, the Army formulated a CDC construction plan that would result in timely expenditure of the \$80 million in Recovery Act authorization for CDCs. Specifically, the Army identified CDC projects for which they had already developed DD Forms 1391 and had the USACE review the DD Forms 1391 to ensure costs were accurate and that projects could be executed quickly. They did not re-evaluate the CDC childcare needs.

While the Army did identify projects that contributed to meeting childcare requirements and that could be executed timely with reasonable costs, the Army did not emphasize working towards the most equitable distribution of childcare resources. Additionally, the

. . . the Army did not emphasize working towards the most equitable distribution of childcare resources.

Army's actions did not fully meet the intent of Office of Management and Budget memorandum M-09-15, "Updated Implementing Guidance for the American Recovery and Reinvestment Act of 2009," April 3, 2009. The memorandum calls for projects that should deliver long-term benefits such as improving educational quality for beneficiaries such as families, infants, and preschoolers (those served by CDCs). In choosing the projects, the memorandum calls for merit-based

decisionmaking, which in the case of Army CDCs, means that the bases with the greatest shortage of childcare services have the greatest need for and thus the greatest benefit from additional CDC capacity.

Opportunity for Adjusting Apportionment of Childcare Spaces Still Exists

Because the Army had already awarded contracts for all seven of the planned Recovery Act-funded CDCs, there was no longer an opportunity to change the size of the CDCs to adjust the apportionment of childcare spaces. Specifically, Army officials stated that reapportioning these CDCs would lead to delays in project execution and increased costs, including penalties for cancelling projects. However, there was still an opportunity for a needs-based apportionment decision on an additional Recovery Act-funded CDC, due to the lower-than-expected costs from the award of the contracts for the seven CDCs. Specifically, the Army expected that there would be \$11.7 million to \$20 million of additional funds, based on the difference between the \$80 million in appropriations and the amounts of the seven awarded contracts. Office of the Assistant Chief of Staff for Installation Management (OACSIM) personnel estimated that it costs \$8 million to \$10 million to build a CDC with a capacity of 126. On November 12, 2009, we discussed using the additional funds to build a CDC at one of the Army bases projecting significant childcare shortfalls in FY 2015 but that was not receiving a Recovery Act-funded CDC. See Table 1 for a list of these Army bases.

Table 1. Projected Percentage of Childcare Requirements Met in FY 2015 for Army Bases Not Receiving Recovery Act Funds for Building CDCs

Army Bases Not Receiving Recovery Act-Funded CDCs	Percent of Childcare Requirements Met From CDCs and Other Army Childcare
Detroit Arsenal, Michigan	59
Fort Polk, Louisiana	67
Aberdeen Proving Ground, Maryland	70
Fort Knox, Kentucky	74
West Point, New York	77
McAlester Ammunition Plant, Oklahoma	78
Fort Meade, Maryland	79
Presidio of Monterey, California	79

During our audit discussions, OACSIM staff mentioned Detroit Arsenal, Michigan, and Fort Polk, Louisiana, as potential candidates for the additional Recovery Act-funded CDC because their childcare capacities were projected to be only 59 and 67 percent, respectively, of needs in FY 2015. By building a Recovery Act-funded CDC at one of these bases, the Army would better comply with the requirement for merit-based decision making stated in Office of Management and Budget Memorandum M-09-15.

Summary

The Army's planned Recovery Act-funded CDC construction will relatively underserve CDC childcare demand at some garrisons while relatively overserving others. Specifically, our comparison showed that using needs-based apportionment at the seven Army bases receiving Recovery Act-funded CDCs would have resulted in more closely meeting each base's CDC childcare space requirements. While contracting considerations prevent resizing the original seven Recovery Act-funded CDCs, the expected \$11.7 million to \$20 million of additional funds make it possible to use needs-based apportionment when planning the construction of at least one additional CDC.

Management Actions During the Audit

On March 5, 2010, the Army, through the Assistant Chief of Staff for Installation Management and in response to a discussion draft of this report, agreed with a recommendation for using additional funds resulting from the contract awards on the seven Recovery Act-funded CDCs to fund construction of an additional CDC at a base having a greater need for additional capability. On April 29, 2010, the Army, through the DoD Comptroller notified Congress of its intent to fund construction of a CDC at Fort Polk, Louisiana, using the additional military construction funds. At the time of our audit, the Army projected Fort Polk as the fort with the greatest shortfall in childcare capacity in FY 2015. Because the other CDC decisions have already been contracted for, we have not made any recommendations.

Management Comments on the Finding

The Assistant Chief of Staff for Installation Management disagreed with the finding and Appendix D. See Appendix E for a summary of the comments and our response.

Finding B. Army Methodology Overestimated Future Childcare Capacity

The Army's methodology of using design capacities, rather than operational capacities, of planned CDCs to assess its ability to meet projected childcare demand overestimated future Army childcare capacity. The Army's overestimate of childcare capacity occurred because its assessment tool, the GCM, used design rather than operational capacities of future CDCs in estimating childcare capacity. As a result, the Army's overestimation of the capacities of planned CDCs could lead to making decisions for future childcare needs based on faulty assumptions.

Army Model Used Design Capacity for Estimating Future Childcare Capacity

The Army used the GCM to help garrisons assess their ability to meet projected childcare demand caused by future Army population changes. The GCM also tracked the impact of future planned construction of childcare facilities. To calculate childcare demand, the Excel-based GCM used population data from OACSIM's Army Stationing and Installation Plan (ASIP) Common Operating Picture. The ASIP Common Operating Picture is a spreadsheet that provides current and planned official soldier and civilian population data by garrison. Based on expected childcare demand, the GCM:

- calculated a yearly maximum allocation of childcare spaces for each garrison,
- determined the need for facility-based (CDCs and CYSCs) and non-facility-based childcare spaces, and
- assessed each garrison's current and future capabilities for meeting expected childcare demand.

The staff of the Family Morale, Welfare, and Recreation Command, under the OACSIM, provided the briefing, "Garrison Capability Model," March 2009, which described the steps the GCM used to review CDC capacity and differentiated between design capacity and operational capacity. Specifically, the briefing defined design capacity as a fixed number based on the constructed building and stated that operational capacity varies depending on the square footage and staff-to-child ratios dictated by the age group mix of the children. For example, infants require more space and thus lower the CDC's operational capacity. The briefing stated that operational capacity is used for assessing CDC capacity.

Design Capacity Overestimated Childcare Capacity

In examining Child Development Services Planning Charts, generated through the GCM using ASIP Common Operating Picture data as of November 12, 2009, we noted that the charts used design capacity of planned CDCs in estimating total facility-based childcare capacity for the garrisons. However, the "Garrison Capability Model" briefing stated that operational capacity, rather than design capacity, is used for assessing the capacity of current CDCs.

To determine the degree to which CDC design capacity can exceed operational capacity, our audit team surveyed Installation Management Command staffs at the four bases we visited. As shown in the table below, we found that, for the existing large-size CDCs (with child design capacities of 303), the design capacity exceeded operational capacities by 17 to 24 percent.

... for the existing large-size CDCs ... the design capacity exceeded operational capacities by 17 to 24 percent.

Table 2. Comparison of CDC Design Capacity to Operational Capacity
(measured in number of childcare spaces)

Army Base	Design Capacity	Operational Capacity	Overestimate in Using Design Capacity (with percent based on operational capacity)
Fort Hood, Texas	303	258	45 (17 percent)
Fort Belvoir, Virginia	303	257	46 (18 percent)
Fort Drum, New York	303	254	49 (19 percent)
Fort Carson, Colorado	303	248	55 (22 percent)
	303	244	59 (24 percent)

Design capacity is a fixed number based on the constructed building. In contrast, operational capacity varies depending on the age group mix of the children. For example, infants require more space and thus lower the CDC’s operational capacity. Also, total enrollment may exceed capacity by up to 10 percent to compensate for absenteeism. The 303 child design capacity indicates that the Army constructed these CDCs before March 12, 2008, when Assistant Chief of Staff for Installation Management Memorandum, “Army Standard for Child Development Centers,” increased the design capacity of large CDCs to 338 children. Also, there were two CDCs at Fort Carson with 303 child design capacities, so both are shown in the table. For accuracy and consistency, we believe that the expected operational capacity (or range of capacities) for future CDCs would be the more accurate factor for estimating the capacity that the future CDCs would add to garrison’s childcare capabilities.

Army Needs to Revise Methodology for Assessing CDC Childcare Capacity

The overestimate of childcare capacity of planned CDCs occurred because the Army’s assessment tool, the GCM, used the design capacity of future CDCs, rather than the operational capacity, in estimating childcare capacity. Specifically, the Family Morale, Welfare, and Recreation Command briefing, “Garrison Capability Model,” March 2009, provides a description of how the Army uses the GCM to help garrisons assess their

ability to meet projected childcare demand caused by future Army population changes. The briefing outlined a five-step process for making the assessment, and steps 1 and 2 required:

- reviewing the current operational childcare capability, to include existing CDCs, and
- adding in projected childcare capability, to include programmed MILCON of CDCs.

Step 1 included defining CDC operational space capacity, based on square footage and adult-to-child ratios. The briefing specifically stated that CDC operational space capacity is not design capacity. We agree with step 1. However, we do not agree with the

. . . using design capacity of CDCs in projecting childcare capability is less accurate because the actual operational capacity of a CDC will be less than the design capacity.

description the briefing provided for step 2, which included adding in planned military construction of CDCs for projecting childcare capability. Specifically, the briefing showed two examples of adding design capacities, rather than expected operational capacities, of future CDCs to determine future childcare capabilities. As described, step 2 is inconsistent with step 1, which uses operational capacities of CDCs as input for determining childcare capability.

Furthermore, using design capacity of CDCs to project childcare capability is less accurate because the actual operational capacity of a CDC will be less than the design capacity.

Conclusion

The Army's methodology for using design capacities of planned CDCs for assessing its ability to meet projected childcare demand overestimates the future Army childcare capacity. As a result, the Army's overestimation of the capacities of planned CDCs could lead to making decisions for future childcare needs based on faulty assumptions.

Management Comments on the Finding

The Assistant Chief of Staff for Installation Management disagreed with the finding. See Appendix E for a summary of the comments and our response.

Recommendation, Management Comments, and Our Response

B. We recommend that the Assistant Chief of Staff for Installation Management improve child development center assessment accuracy by revising its methodology for assessing projected childcare capacity. Specifically, the Army should apply corrective factor(s) and percentage(s) to reduce child development center design capacities to expected operational capacity ranges when estimating a garrison's future childcare capacity.

Department of the Army Comments

The Assistant Chief of Staff for Installation Management disagreed, stating that the recommendation would reduce the number of children that can be served in CDCs built using Army's standard CDC designs.

Our Response

The comments from the Assistant Chief of Staff for Installation Management are not responsive. His comments do not support the assertion that implementing the recommendation would reduce the number of children served. Our recommendation would improve CDC assessment accuracy by revising the Army's methodology for assessing projected childcare capacity. It would not reduce the number of children that can be served in the CDCs that the Army plans to build. Our recommendation only addresses the need for the Army to adjust its estimation methodology to better project the operational capability ranges of planned Army CDCs. As discussed in the "Design Capacity Overestimated Childcare Capacity" section, factors that reduce the number of children served in an Army CDC include changes in the age group. For example, an increase in the number of infants would require more space and therefore, lower the number of children served. Accordingly, we request that the Assistant Chief of Staff reconsider his position and provide comments on the final report.

Appendix A. Scope and Methodology

We conducted this audit from September 2009 through August 2010 in accordance with generally accepted government auditing standards. Generally accepted government auditing standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our conclusions based on our audit objectives.

Scope

During the audit, we reviewed the Army's planning for the MILCON of seven CDCs, with an expected total cost of \$80 million. The Army planned to build these CDCs at the following installations:

- Fort Bragg, North Carolina;
- Fort Drum, New York;
- Fort Belvoir, Virginia;
- Fort Eustis, Virginia;
- Hunter Army Airfield, Georgia;
- Fort Carson, Colorado; and
- Fort Hood, Texas.

We reviewed planning documents and records dated from December 2000 to April 2010 from the OACSIM and the seven installations. These documents and records included:

- "Military Construction Project Data" sheets (DD Form 1391), which document project requirements and justifications for review and approval within the Army and DoD, and supporting documentation; and
- Child Youth and School Services charts, generated through the GCM showing current and projected (to FY 2015) capacity of and need for childcare services (including CDCs and CYSCs) at individual Army garrisons.

Methodology

We visited and interviewed Army personnel from the OACSIM, including staffs from the Installation Management Command; the Family and Morale, Welfare, and Recreation Command; and the Child, Youth, and School Services Directorate. We also visited and interviewed USACE staff and garrison staff at the following four installations: Fort Drum, New York; Fort Belvoir, Virginia; Fort Hood, Texas; and Fort Carson Colorado.

Before selecting DoD Recovery Act projects for audit, the Quantitative Methods and Analysis Division of the DoD Office of Inspector General analyzed all DoD agency-funded projects, locations, and contracting oversight organizations to assess the risk of waste, fraud, and abuse associated with each. We selected most audit projects and

locations using a modified Delphi technique, which allowed us to quantify the risk based on expert auditor judgment, and other quantitatively developed risk indicators. We used information collected from all projects to update and improve the risk assessment model. We selected 83 projects with the highest risk rankings; auditors chose some additional projects at the selected locations.

We did not use classical statistical sampling techniques that would permit generalizing results to the total population because there were too many potential variables with unknown parameters at the beginning of this analysis. The predictive analytic techniques employed provided a basis for logical coverage not only of Recovery Act dollars being expended, but also of types of projects and types of locations across the Military Services, Defense agencies, State National Guard units, and public works projects managed by USACE.

Use of Computer-Processed Data

We relied on computer-processed data from the OACSIM ASIP Common Operating Picture spreadsheet. The ASIP Common Operating Picture spreadsheet provided population numbers for the GCM, which is the Family and Morale, Welfare, and Recreation Command's tool for estimating Army childcare requirements and capabilities. The GCM provided childcare numbers for the charts from the Child, Youth, and School Services Directorate, which in turn supported our findings. To determine the reliability of the ASIP data, we examined the control procedures the Army had implemented over the collection and compilation of the data. Specifically, we determined that the garrison commanders who submit ASIP data update the data quarterly and certify its accuracy annually. We then obtained the latest annual certifications from the commanders from each of the seven garrisons receiving a Recover Act-funded CDC. No issues regarding data integrity came to our attention in the course of the audit.

Use of Technical Assistance

We used assistance from an engineer in the Technical Assessment Directorate, DoD Office of Inspector General. The engineer assisted the audit team on audit planning and fieldwork, including objectives, methodologies, CDC requirements, and computer-processed data.

Prior Audit Coverage

The Government Accountability Office, the Department of Defense Inspector General, and the Military Departments have issued reports and memoranda discussing DoD projects funded by the Recovery Act. You can access unrestricted reports at <http://www.recovery.gov/accountability>.

As part of the audit coverage of DoD projects funded by the Recovery Act, the Department of Defense Inspector General, and the U.S. Army Audit Agency have issued two memoranda and three reports respectively, which discuss military construction of Army CDCs.

Department of Defense Inspector General

DoD IG Memorandum No. D-2010-RAM-011, “American Recovery and Reinvestment Act Projects—Fort Drum, New York,” June 21, 2010

DoD IG Memorandum No. D-2010-RAM-007, “Child Development Center at Fort Eustis, Virginia—Recovery Act Project 7,” May 28, 2010

U.S. Army Audit Agency

Army Audit Agency Report No. A-2010-0120-ALO, “American Recovery and Reinvestment Act of 2009 - Fort Stewart and Hunter Army Airfield, Georgia,” June 23, 2010

Army Audit Agency Report No. A-2010-0073-ALO, “American Recovery and Reinvestment Act of 2009 - Fort Bragg, North Carolina,” April 5, 2010

Army Audit Agency Report No. A-2010-0070-FFH, “Child Development and Youth Center Space Requirements,” March 16, 2010

Appendix B. Recovery Act Criteria and Guidance

The following list includes the primary Recovery Act criteria documents (notes appear at the end of the list):

- U.S. House of Representatives Conference Committee Report 111-16, “Making Supplemental Appropriations for Job Preservation and Creation, Infrastructure Investment, Energy Efficiency and Science, Assistance to the Unemployed, and State and Local Fiscal Stabilization, for the Fiscal Year Ending September 30, 2009, and for Other Purposes,” February 12, 2009
- Public Law 111-5, “American Recovery and Reinvestment Act of 2009,” February 17, 2009
- OMB Memorandum M-09-10, “Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009,” February 18, 2009
- OMB Bulletin No. 09-02, “Budget Execution of the American Recovery and Reinvestment Act of 2009 Appropriations,” February 25, 2009
- White House Memorandum, “Government Contracting,” March 4, 2009
- White House Memorandum, “Ensuring Responsible Spending of Recovery Act Funds,” March 20, 2009
- OMB Memorandum M-09-15, “Updated Implementing Guidance for the American Recovery and Reinvestment Act of 2009,” April 3, 2009¹
- OMB Memorandum M-09-16, “Interim Guidance Regarding Communications With Registered Lobbyists About Recovery Act Funds,” April 7, 2009
- OMB Memorandum M-09-19, “Guidance on Data Submission under the Federal Funding Accountability and Transparency Act (FFATA),” June 1, 2009
- OMB Memorandum M-09-21, “Implementing Guidance for the Reports on Use of Funds Pursuant to the American Recovery and Reinvestment Act of 2009,” June 22, 2009²
- OMB Memorandum M-09-24, “Updated Guidance Regarding Communications with Registered Lobbyists About Recovery Act Funds,” July 24, 2009
- OMB Memorandum M-09-30, “Improving Recovery Act Recipient Reporting,” September 11, 2009

- OMB Office of Federal Procurement Policy, “Interim Guidance on Reviewing Contractor Reports on the Use of Recovery Act Funds in Accordance with FAR Clause 52.204-11,” September 30, 2009²
- OMB Memorandum M-10-08, “Updated Guidance on the American Recovery and Reinvestment Act – Data Quality, Non-Reporting Recipients, and Reporting of Job Estimates,” December 18, 2009²
- OMB Memorandum M-10-14, “Updated Guidance on the American Recovery and Reinvestment Act,” March 22, 2010²
- White House Memorandum, “Combating Noncompliance with Recovery Act Reporting Requirements,” April 6, 2010²
- OMB Memorandum M-10-17, “Holding Recipients Accountable for Reporting Compliance under the American Recovery and Reinvestment Act,” May 4, 2010

Notes

¹ Document provides Government-wide guidance for carrying out programs and activities enacted in the American Recovery and Reinvestment Act of 2009. The guidance states that the President’s commitment is to ensure that public funds are expended responsibly and in a transparent manner to further job creation, economic recovery, and other purposes of the Recovery Act.

² Document provides Government-wide guidance for carrying out the reporting requirements included in section 1512 of the Recovery Act. The reports will be submitted by recipients beginning in October 2009 and will contain detailed information on the projects and activities funded by the Recovery Act.

Appendix C. Army Military Construction Criteria and Guidance

The following list includes the primary Army criteria documents for MILCON:

- Army Regulation 608-10 (Personal Affairs), “Child Development Services,” July 15, 1997;
- Department of the Army, Assistant Chief of Staff for Installation Management, Memorandum, “Army Standard for Child Development Centers,” March 12, 2008;
- Department of the Army Regulation 415-15 (Construction), “Army Military Construction and Nonappropriated-Funded Construction Program Development and Execution,” June 12, 2006; and
- USACE Technical Instructions 800-01, “Design Criteria,” July 20, 1998.

Appendix D. Currently Planned Apportionment Versus a Needs-Based Apportionment of Recovery Act-Funded CDCs

Seven Army Bases Receiving Recovery Act-Funded CDCs		Currently Planned Recovery Act-Funded CDCs		Needs-Based Apportionment of Recovery Act-Funded CDCs		
(The CYSC is denoted with *)	Percent of the Total Army Childcare to be Met by CDCs	Planned CDC Size	Percent of the Base's CDC Childcare Space Requirements Met With the Added CDC ¹	Needs-Based CDC Size ²	Change From Planned CDC Size	Percent of the Base's CDC Childcare Space Requirements Met With the Added CDC ¹
Fort Bragg, NC	60	232	77	338	↑ increase	80
Fort Drum, NY	70	126	84	232	↑ increase	90
Fort Belvoir, VA	70	338	94	338	same	94
Hunter Army Airfield, GA*	30	135	102	135	same	102
Fort Eustis, VA	80	232	102	232	same	102
Fort Carson, CO	70	232	102	126	↓ decrease	97
Fort Hood, TX	60	338	102	232	↓ decrease	99

¹ “Percent of the Base’s CDC Childcare Space Requirements Met with the Added CDC” is the resulting percentage from including the capacity of the planned CDC (the second main column) or needs-based CDC (the third main column). An example of how we computed this percentage is as follows: At Fort Bragg, CDCs were planned to meet 60 percent of projected childcare demand in FY 2015, which, according to the OACSIM database as of November 2009, would equate to 3,259 spaces (5,431 total demand x 60 percent). We then divided the total CDC spaces planned in FY 2015 (2,511, which includes the 232 spaces from the Recovery Act-funded CDC) by 3,259 to show that 77 percent of the bases’ CDC childcare space requirements would be met with the currently planned CDC.

² We determined the “Needs-Based CDC Size” for the Recovery Act-funded CDCs based on comparative analysis of the seven installations’ CDC capacities and needs projected to FY 2015. Army CDCs come in three standard design capacities of small—for 126 children, medium—for 232 children, and large—for 338 children. Similarly, CYSCs come in three standard design capacities: 90, 135, and 180. In our analysis, we chose the needs-based mix of standard CDC and CYSC sizes that brought the seven installations closest to meeting the 80 to 100 percent range of the projected CDC requirement at each installation, depending on the availability to off-post alternatives. According to Army practice, CDCs are planned to meet 60 to 80 percent of projected total childcare demand at each installation, depending on the geographic location of the installation and the availability of off-post alternatives. Because the Army had a finite amount of funding for building CDCs (\$80 million), in order to increase two CDCs by one size each, we needed to decrease other CDCs by the same amount. The highest percentage of CDC requirements met was 102 percent, which occurs at four installations. Because decreasing the size of an additional CDC has a smaller effect on bases with more childcare capacity, we show decreases to the Recovery Act-funded CDCs at Forts Hood and Carson, whose childcare capacities are far larger than those of Hunter Army Airfield and Fort Eustis.

Appendix E. Summary of Army Comments and Our Response

Army Comments on the Report

The Assistant Chief of Staff for Installation Management disagreed with Findings A and B, Recommendation B, and Appendix D. He stated that the Army's CDC construction program, including the Recovery Act-funded CDCs, as planned, will have a positive impact on the Army. Additionally, the Assistant Chief of Staff made the following suggestions.

- The final report should include all of the Army's comments (the memorandum and five enclosures) because Enclosure 1 provides comments and support to justify his disagreement with the findings and recommendation, and Enclosures 2 through 5 clarify the Army's position that the planning process for constructing CDCs was adequate.
- The DoD Office of Inspector General should initiate mediation regarding the report's findings with the Assistant Chief of Staff for Installation Management under the purview of the Army Deputy Auditor General, Forces and Financial Audits, or the Principal Under Secretary of Defense for Personnel Readiness.

Our Response

We agree that the Army's CDC construction program, as planned, would have a positive impact on the Army. In the Results in Brief and Finding A, we acknowledge that the Army's overall requirements for Recovery Act-funded CDCs were valid. However, there is potential for improvement in planning the apportionment of CDC resources.

Furthermore, we have included all of the Assistant Chief of Staff's comments, including his detailed comments in Enclosure 1, "Detailed ACSIM/IMCOM/FMWRC Comments," and Enclosure 5, "Garrison Capability Model (GCM)," which provides a flowchart of the Army's GCM. We did not include Enclosures 2, 3, and 4 for the following reasons.

- Enclosure 2, "SAC-M Stimulus Package Request (#81110906)," did not convey any information not already included in Finding A. For example, Finding A states that the U.S. Senate Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, requested the Army to identify projects that it could execute quickly to provide construction stimulus.

- Enclosure 3, “MCA Project Listing for BES 3.4.2010,” (7 pages) lists more than 300 Army projects, including 6 of the 7 Recovery Act-funded CDCs. Likewise, the enclosure did not convey any information not already included in Finding A regarding the Army’s use of approved DD Forms 1391 for Recovery Act-funded CDC projects.
- Enclosure 4, Army Regulation 420-1 supports an Assistant Chief of Staff for Installation Management comment that USACE reviewed the DD Forms 1391 for the CDC projects to ensure that costs were accurate and that the projects could be executed in a timely manner. We agree that the Army had USACE review the DD Forms 1391 to ensure that costs were accurate and that projects could be executed quickly and so stated in the report section “Army Did Not Focus on Needs-Based Planning to Provide Additional CDC Capacity to Bases with the Greatest Need.”

In reference to the Army’s suggestion to initiate mediation action under the purview of the Army Deputy Auditor General, Forces and Financial Audits, or the Principal Under Secretary of Defense, Personnel Readiness; DoD Directive 7650.3 states that the Inspector General, Department of Defense oversees and coordinates follow-up programs on behalf of the Deputy Secretary of Defense. The Directive further states that the heads of DoD Components work with the DoD Inspector General to resolve disagreements and that outstanding issues will be decided by the Deputy Secretary of Defense.

Army Comments on Finding A

General Comments on Finding A

The Assistant Chief of Staff for Installation Management stated that our draft report failed to acknowledge that:

- childcare spaces in re-locatable facilities were only a stop gap measure,
- significant penalties would have been incurred to cancel existing construction contracts or change the Recovery Act-funded CDC project designs,
- delays in CDC openings would impact childcare for more than 1,000 children, and
- additional options (other than CDCs) for childcare are available at garrisons.

Additionally, the Assistant Chief of Staff stated that Finding A had no recommendation, yet the report states that the Army’s methodology needed improvement.

Our Response

The Assistant Chief of Staff’s assertion that childcare spaces in re-locatable facilities were only a “stop gap” measure is inconsistent with his comments regarding plans for

re-locatable facilities. Specifically, his comments regarding Fort Drum note that Fort Drum is to retain a “temporary re-locatable facility (providing 100 childcare spaces),” which was to close by FY 2014.

We disagree that the report does not acknowledge penalties that would result from canceling existing construction contracts or changing the Recovery Act-funded CDC project designs. Specifically, the “Opportunity for Adjusting Apportionment of Childcare Spaces Still Exists” section states that, because the Army had already awarded contracts for all seven of the planned Recovery Act-funded CDCs, there was no longer an opportunity to change the size of the CDCs to adjust the apportionment of childcare spaces. Our report states that reapportioning these CDCs would lead to contract penalties for canceling projects. Additionally, because we are not recommending canceling existing contracts or project designs, there will be no resulting delays in CDC openings.

In addition, we address additional options (other than CDCs) for childcare available at garrisons in the “Army Policy on Establishing and Operating Child Development Services” section. The section contains a list of additional options for childcare (other than CDCs), as defined in Army Regulation 608-10 (Personal Affairs), “Child Development Services,” July 15, 1997.

Furthermore, we did not include a recommendation in Finding A because the Army had taken action to meet the intent of a recommendation in a discussion draft of the report. The recommendation was for the Assistant Chief of Staff for Installation Management to use the bid savings resulting from contract awards on the seven Recovery Act-funded CDCs to fund construction of an additional CDC at the base having the greatest need for additional childcare capability. In his March 5, 2010, response to our discussion draft, the Assistant Chief of Staff agreed with this recommendation. As discussed in the “Management Actions During the Audit” section, in April 2010, the Army announced plans to fund construction of a CDC at Fort Polk, Louisiana, using the additional military construction funds. At the time of our audit, the Army projected Fort Polk as the fort with the greatest projected shortfall in childcare capacity in FY 2015.

Comments on Needs-Based Planning to Provide Additional CDC Capacity to Bases With the Greatest Need

The Assistant Chief of Staff stated that he disagreed that the Army did not emphasize working towards the most equitable distribution of childcare resources and instead focused mainly on formulating a CDC construction plan that would result in timely expenditure of the \$80 million in Recovery Act funding for CDCs. The Assistant Chief of Staff further stated that the Army appropriately complied with guidance from the U. S. Senate Committee on Appropriations to provide a list of projects that the Army could execute quickly to provide economic stimulus.

Our Response

We agree that the Army responded to the guidance from the U.S. Senate Committee on Appropriations with a list of projects, including the seven Recovery Act-funded CDCs, which it could execute quickly to provide construction stimulus. However, as stated in

the report, the Army's actions did not fully meet the intent of OMB Memorandum M-09-15. Specifically, OMB Memorandum M-09-15 requires merit-based decisionmaking in choosing projects, which we believe means that the Army bases with the greatest shortage of childcare services have the greatest need for, and would derive the greatest benefit from, additional CDC capacity.

We clarified our discussion in the final report to better clarify that the Army formulated its CDC construction plan in response to guidance that the Army received from the U.S. Senate Committee on Appropriations in executing the CDC projects. In a November 8, 2009, e-mail, "Congressional – SAC-M Stimulus Package Request (#81110906)," the Army Congressional Affairs Installation Management team requested staff recommendations for projects that the Army could execute "quickly."

Comments on the Opportunity for Adjusting the Apportionment of Childcare Spaces Still Exists

The Assistant Chief of Staff stated that the Army made an extraordinary effort to meet its soldier and family readiness requirements with the following results.

- Army-identified Recovery Act projects were already in the Future Years Defense Plan (FYs 2011-2013) and were validated as requirements that would contribute to meeting the Army's childcare demand end strength of 87,479 childcare spaces.
- The FY 2010 Budget Estimate Submission for all Army military construction projects shows that the Army's Recovery Act childcare projects, with the exception of the Fort Belvoir CDC, were previously identified as requirements. The Assistant Chief of Staff stated that the Army added the Fort Belvoir CDC to the previously identified requirements because it was projected to be a potential FY 2009 congressional addition.
- USACE reviewed the DD Forms 1391 to ensure that costs were accurate and that projects could be executed in a timely manner in compliance with Army Regulation 420-1.

Our Response

We agree that the Army made an effort to meet soldier and family readiness requirements and that the Recovery Act-funded CDC projects were identified, validated, and reviewed. Specifically, in the "Apportionment of Childcare Spaces was Questionable" section, we state that the Army had already approved DD Forms 1391 for the CDCs and the CYSC at the seven bases receiving Recovery Act funding for constructing these facilities. We also state that the Army was using Recovery Act funding to meet valid CDC requirements. As previously noted, we stated that USACE reviewed the DD Forms 1391 to ensure that costs were accurate and that the projects could be executed quickly.

Comments on Appendix D, Currently Planned Apportionment Versus a Needs-Based Apportionment of Recovery Act-Funded CDCs

General Comments on Appendix D

The Assistant Chief of Staff stated that our comparison of the Army's planned apportionment versus needs-based apportionment of CDCs was flawed because we did not consider Army garrison responses. The Assistant Chief of Staff noted that Office of the Deputy Assistant Chief of Staff for Installation Management personnel had informed us of the problems with our analysis in a November 2009 meeting.

Our Response

The comparison of the Army's actual CDC selection versus a needs-based apportionment of CDCs shows that using a needs-based apportionment would have resulted in more closely meeting base CDC childcare space requirements. However, as our report acknowledges, the Army had already awarded contracts for all seven of the planned Recovery Act-funded CDCs, so there was no longer an opportunity to change the size of the CDCs to adjust the apportionment of childcare spaces. To reapportion these CDCs would have lead to delays in project execution and increased costs, including penalties for canceling contracts for the CDC projects already in implementation. See our responses below regarding Fort Bragg, Fort Carson, Fort Drum, and Fort Hood for detailed examples of how needs-based CDC apportionment provides better distribution of childcare capability throughout the Army.

Comments on Fort Bragg Portion of Appendix D

The Assistant Chief of Staff stated that our needs-based apportionment conclusion to increase the Fort Bragg CDC size from a 232-child to a 338-child capacity CDC is not viable because the identified construction site could not accommodate a larger capacity CDC and because re-competing the contract would cause additional expense and delay. He also noted that, although the Army's GCM continues to project a childcare need at Fort Bragg, the base has not requested additional capacity beyond the facilities projected to open through FY 2012. He further noted that the Army will review Fort Bragg childcare demand again after the new facility is open and that Fort Bragg will continue to meet any interim childcare needs through on-base homes or off-base programs.

Our Response

We recognize that it is no longer viable to change the size of the Recovery Act-funded CDC. However, if the Army staff had used needs-based CDC apportionment, they could have considered alternate construction sites that would have accommodated a larger CDC facility. Also, the Army staff could have sized the Fort Bragg Recovery Act-funded CDC to better distribute childcare capability.

Fort Bragg had a projected CDC childcare requirement of 3,259 spaces in FY 2015, 2,279 of which were projected as available. The Army was planning to use Recovery Act

funding to build a medium-sized CDC to gain 232 spaces. However, the medium-sized CDC would not enable Fort Bragg to have an acceptable (at least 80 percent of the requirement) number of childcare spaces. By increasing the childcare spaces to 338, Fort Bragg would have an acceptable childcare space range. Table E-1 shows how the needs-based-apportioned CDC would have better met childcare needs.

Table E-1. Comparison of Currently Planned Apportionment Versus Needs-Based Apportionment of Recovery Act-Funded CDC Resources at Fort Bragg, North Carolina
(measured in number of CDC childcare spaces)

Fort Bragg, North Carolina	Spaces Required	Spaces Available	Percent Filled
November 2009 Capacity	3,259	2,279	70
Adding Planned Recovery Act-Funded 232-child capacity CDC		2,511	77
Adding Needs-Based 338-child capacity CDC		2,617	80

Comments on the Fort Carson Portion of Appendix D

The Assistant Chief of Staff stated that our needs-based apportionment conclusion to decrease the CDC size from a 232-child to a 126-child capacity CDC was not viable because the planned CDC will replace three temporary re-locatable facilities (now providing 249 childcare spaces) that will be closed when the 232-child capacity CDC is operational.

Our Response

We recognize that it is no longer viable to change the size of the Recovery Act-funded CDC. However, Army staff could have sized the Fort Carson CDC to better distribute childcare capability had they used needs-based CDC apportionment in planning the CDC construction.

Fort Carson had a projected CDC childcare requirement for 2,085 spaces, 1,895 of which were available. The Army was planning to build a medium-sized CDC with Recovery Act funding to gain 232 spaces. Data from the Army’s Family Morale, Welfare, and Recreation Command had already taken into account the reduction of 249 childcare spaces from temporary re-locatable Fort Carson facilities. By decreasing Fort Carson childcare spaces to a needs-based level of 126, the base would remain at an acceptable childcare capacity. Table E-2 shows how needs-based apportioned CDC would have better met childcare needs.

Table E-2. Comparison of Currently Planned Apportionment Versus Needs-Based Apportionment of Recovery Act-Funded CDC Resources at Fort Carson, Colorado

(measured in number of CDC childcare spaces)

Fort Carson, Colorado	Spaces Required	Spaces Available	Percent Filled
November 2009 Capacity	2,085	1,895	91
Adding Planned Recovery Act-Funded 232-child capacity CDC		2,127	102
Adding Needs-Based 126-child capacity CDC		2,021	97

Comments on the Fort Drum Portion of Appendix D

The Assistant Chief of Staff stated that that our needs-based apportionment conclusion to increase the CDC size from a 126-child to a 232-child capacity CDC is not viable because Fort Drum would retain a temporary re-locatable facility (providing 100 childcare spaces), which was originally planned to close by FY 2014. He also stated that Fort Drum staff had determined that the 126-child capacity CDC would meet the base’s needs.

Our Response

We recognize that it is no longer viable to change the size of the Recovery Act-funded CDC. However, Army staff could have sized the Fort Drum CDC to better distribute childcare capability had they used needs-based apportionment in CDC planning.

Fort Drum had a CDC childcare need for 1,612 spaces, 1,221 of which were available. The Army was planning to build a small CDC with Recovery Act funding to gain 126 spaces. Data from the Army’s Family Morale, Welfare, and Recreation Command already took into account the retention of the 100 childcare spaces from the temporary re-locatable facilities. With the addition of the small Recovery Act-funded CDC, Fort Drum would have an acceptable number of childcare spaces. By increasing the childcare spaces to 232, Fort Drum will better fill this need. Table E-3 shows how the needs-based apportioned CDC would have better met Fort Drum childcare needs.

Table E-3. Comparison of Currently Planned Apportionment Versus Needs-Based Apportionment of Recovery Act-Funded CDC Resources at Fort Drum, New York
(measured in number of CDC childcare spaces)

Fort Drum, New York	Spaces Required	Spaces Available	Percent Filled
November 2009 Capacity	1,612	1,221	76
Adding Planned Recovery Act-Funded 126-child capacity CDC		1,347	84
Adding Needs-Based 232-child capacity CDC		1,453	90

Comments on the Fort Hood Portion of Appendix D

The Assistant Chief of Staff stated that that our needs-based apportionment conclusion to decrease the CDC size from a 338-child to a 232-child capacity CDC is not viable because the 338 capacity CDC is required to meet the garrison childcare demand and would augment and eventually replace a 100-childcare space re-locatable facility.

Our Response

We recognize that it is no longer viable to change the size of the Recovery Act-funded CDC. However, the Army staff could have sized the Fort Hood CDC to better distribute childcare capability had they used a needs-based CDC apportionment planning approach.

Fort Hood had a CDC childcare need for 2,876 spaces, 2,602 of which were available. The Army was planning to build a large CDC with Recovery Act funding to gain 338 spaces. Data from the Army’s Family Morale, Welfare, and Recreation Command already took into account the reduction of 82 childcare spaces from the temporary re-locatable facilities once the Recovery Act CDC is operational. By decreasing the childcare spaces to 232 through needs-based apportionment, Fort Hood would still remain at acceptable childcare capability. Table E-4 shows how the needs-based apportionment approach would have better met childcare needs at Fort Hood.

Table E-4. Comparison of Currently Planned Apportionment Versus Needs-Based Apportionment of Recovery Act-Funded CDC Resources at Fort Drum, New York
(measured in number of CDC childcare spaces)

Fort Hood, Texas	Spaces Required	Spaces Available	Percent Filled
November 2009 Capacity	2,876	2,602	90
Adding Planned Recovery Act-Funded 338-child capacity CDC		2,940	102
Adding Needs-Based 232-child capacity CDC		2,834	99

Army Comments on Finding B

General Comments on Finding B

The Assistant Chief of Staff stated that our conclusion that the Army overestimated planned CDC capacity was based on a misunderstanding of the Army’s assessment tool, the GCM, which projects CDC operational capability for 2008 and out-year CDC construction projects. He further stated that a GCM chart included in the Army comments provided a graphic depiction of the process the Army uses to assess gaps and identify the projected childcare demand caused by future Army population changes.

Our Response

We did not misunderstand the Army’s GCM assessment tool. The chart noted in the Army’s comments was an excerpt from a Family Morale, Welfare, and Recreation Command briefing, “Garrison Capability Model,” March 2009, which we discuss in the “Army Needs to Revise Methodology for Assessing CDC Childcare Capacity” section of this report. The briefing outlined a five-step process for assessing the Army’s ability to meet projected childcare demands. Steps 1 and 2 required:

- reviewing the current operational childcare capability, to include existing CDCs, and
- adding projected childcare capability, to include programmed MILCON of CDCs.

Step 1 included defining CDC operational space capacity, based on square footage and adult-to-child ratios. For Step 1, the briefing specifically stated that CDC operational space capacity is not design capacity. However, we note in the report that Step 2 is inconsistent with Step 1, which uses operational capacities of CDCs as input for determining childcare capability. The Family Morale, Welfare, and Recreation

Command briefing highlights the inconsistency in Step 2 by including two examples that use design capacities, rather than expected operational capacities, of planned CDCs to determine future childcare capabilities. Using design capacities of CDCs to project childcare capability is less accurate because the actual operational capacity of a CDC will be less than the design capacity.

Comments on Design Capacity Overestimated Childcare Capacity

The Assistant Chief of Staff stated that the new Army standard CDC designs, approved in 2008, have childcare space capability ranges built into the designs, while the Army's older 303 standard design CDCs, which we toured while at the four installations we visited, had a defined capacity. He noted that using the new capability range design gives the Army needed flexibility to adjust to the changing childcare needs and avoids costly retrofitting of classrooms as the child population fluctuates due to deployment-related baby booms, changes in adult-to-child supervision ratios, Army transformation, and troop movements. Further, the Assistant Chief of Staff stated that the capability ranges in the new standard design address our concerns about the Army's planning process. Lastly, the Assistant Chief of Staff noted that the Army's inventory of CDC facilities includes many older, nonstandard facilities built before 2008 that have since been renovated and do not have the flexibility that the new Army CDC standard designs provide. He stated that these renovation efforts have changed the original design space capacity in these CDCs to give them their current operational capability to meet the needs of the increasing numbers of infants and toddlers.

Our Response

As noted in Finding B, the Army's new standard design for CDCs serving children under 6 years of age is in the Assistant Chief of Staff for Installation Management Memorandum, "Army Standard for Child Development Centers," March 12, 2008. However, the memorandum does not clearly define the capacity range for CDCs designed for children under 6 years of age. The memorandum only states that facility capacity "... could vary depending on installation requirements" and that "Activity rooms allow for flexibility in programming and use." In contrast, the Army clearly defines capability range in the Assistant Chief of Staff for Installation Management Memorandum, "Army Standard for Child Development Centers," October 19, 2004, which defines capability ranges of CDCs designed for children from 6 through 10 years of age. Specifically, the 2004 memorandum defines facility childcare capacities as follows for four designs:

- 60-75 (wing addition to existing CDC)
- 105-135
- 150-180
- 195-225

We agree with the Assistant Chief of Staff's statement that Army renovation efforts have changed the original design space capacity in existing CDCs to their current operational

capability to meet the needs of increasing numbers of infants and toddlers. We consider the Assistant Chief of Staff's statement concerning the renovation of the older CDCs as consistent with our recommendation for using expected operational capability when estimating a garrison's future childcare capacity.

Department of the Army Comments



DEPARTMENT OF THE ARMY
ASSISTANT CHIEF OF STAFF FOR INSTALLATION MANAGEMENT
600 ARMY PENTAGON
WASHINGTON, DC 20310-0600

DAIM-ZA

NOV 22 2010

MEMORANDUM FOR Inspector General, Office of the Secretary of Defense, 4000
Defense Pentagon, Washington DC 20310-4000

SUBJECT: Draft Report, Project No. D2009-D000AE-0268.000, *Improvement Needed
in the Planning for Military Construction of Army Child Development Centers*

1. The Assistant Chief of Staff for Installation Management (ACSIM) non-concurs with Findings A and B and Recommendation B in the DoDIG Draft Report, Project No. D2009-D000AE-0268.000, *Improvement Needed in the Planning for Military Construction of Army Child Development Centers*, dated November 2010.
2. Detailed program comments and extensive supporting data/documents that justify the non-concurrence can be found at Enclosure 1. Enclosures 2 through 5 are included to help clarify the Army position that the planning process for construction of child development centers was adequate and all factors in determining requirements were properly considered. These command comments should be included in full in the final DoDIG Report.
3. The details in this command response and supporting documents are intended to provide the DoDIG inspectors with sufficient information to accommodate agreement on the essential report findings and recommendations. If agreement cannot be reached, request the DoDIG initiate mediation action under the purview of the Army Deputy Auditor General, Forces and Financial Audits, or the Principal Under Secretary of Defense, Personnel Readiness.
4. The CDC construction program constitutes an essential line of effort supporting Soldiers and Families, as expressed in the Army Family Covenant, and American Recovery and Reinvestment Act (ARRA) funded Child Development Centers, as programmed, will have a positive impact on our Army.

DAIM-ZA

SUBJECT: Draft Report, Project No. D2009-D000AE-0268.000, Improvement Needed
in the Planning for Military Construction of Army Child Development Centers



- 5 Encls
- 1. Detailed Comments
- 2. Congressional SAC-M Request
- 3. FY10 Budget Estimate Submission
- 4. AR 420-1 (Excerpt)
- 5. Garrison Capability Model Process Chart

A handwritten signature in black ink, appearing to read "Rick Lynch".

RICK LYNCH
Lieutenant General, GS
Assistant Chief of Staff
for Installation Management

CF:
PUSD, PR
SAAG-FFH
ASA (FM&C)
DACSIM
ACSIM, OD
ACSIM, IS
ACSIM, RD
DCG/CoS IMCOM
CG, FMWRC

[REDACTED]

Enclosure 1: Detailed ACSIM/IMCOM/FMWRC Comments in Response to DoDIG Report

1. All command comments and supporting documentation should be included in the final report (and, if necessary, provided in full to appropriate authority for mediation or adjudication).

2. Although the Draft Report states that the Army's total Child Development Center (CDC) requirements were valid, *Finding A* takes issue with the apportionment of child care spaces at the seven American Recovery and Reinvestment Act (ARRA) funded installations (Carson, Drum, Stewart/Hunter Army Airfield, Bragg, Hood, Eustis, and Belvoir).

a. Report states...*"the Army had not emphasized working towards the most equitable distribution of child care resources. Instead the Army focused mainly on formulating a CDC construction plan that would result in timely expenditure of the \$80M in Recovery Act authorization for CDCs."*

b. Army followed guidance from SAC-MILCON to provide a list of validated projects that could be quickly executed to provide economic stimulus.

c. This contradiction indicates the DoDIG Team misunderstands the methodology used for the planning and selection of identified ARRA child care projects. The Report incorrectly asserts that the Army's construction planning was formulated to spend \$80M rather than meet valid demand.

3. The Army appropriately responded to SAC MILCON based on the stated requirements for CDC projects to be included in a stimulus package (Encl 2).

4. ACSIM, Installation Management Command (IMCOM), and Family & MWR Command (FMWRC) have taken extraordinary efforts to meet the Army's Soldier and Family readiness requirements. Because of outstanding prior planning:

a. The Army Projects identified for ARRA were already in the Future Years Defense Plan (FY11-FY13), validated as requirements, and identified as contributing toward the Army's child care demand end strength of 87,479 child care spaces. (Encl 3)

b. The FY10 Budget Estimate Submission (BES) for all Military Construction Projects (TAB B) shows that, with the exception of the Fort Belvoir CDC, the Army's ARRA child care projects were previously identified as requirements. The Fort Belvoir CDC was included because it was projected to be a potential FY09 Congressional add. This information was provided to the DoDIG team on 6 March 2010.

c. United States Army Corps of Engineers (USACE) reviewed the DD 1391's to ensure costs were accurate and that projects could be executed in a timely manner per AR 420-1, Army Facilities Management. (Encl 4)

Sentence added to "Army Did Not Focus on Needs-Based Planning to Provide Additional CDC Capacity to Bases with the Greatest Need" section, page 6



5. The comparison of Army's *planned* versus *need-based* apportionment of CDCs, Appendix D in Draft Report, which the DoDIG used to support *Finding A* is flawed.

a. The DoDIG Report states that using *needs-based* apportionment would have resulted in more closely meeting each base's CDC child care space requirements. However, the DoDIG failed to consider the Garrison's responses as discussed with the DoDIG during a meeting with the Deputy ACSIM, Dr. College, on 12 November 2009:

(1) Fort Bragg CDC Facility (232 child space capability). The DoDIG's *need-based* apportionment recommendation to increase the CDC size to a 338 capacity facility is not viable: the identified site could not accommodate a 338 capacity CDC and re-competing the contract would cause additional expense and delay. Although a need is still reflected in the CYS Services Garrison Capability Model (GCM) Fort Bragg has not requested or presented a further need beyond the facilities still projected to open through FY12. Once all new facilities are open child care demand will be reviewed again. Until that time and before all new facilities are fully up and operational the garrison will continue to meet any interim needs through Family Child Care Homes and Army-sponsored off post programs *e.g., Army Child Care in Your Neighborhood, Military Child Care In Your Neighborhood, and Operation Military Child Care in Your Neighborhood*.

(2) Fort Carson CDC Facility (232 child space capability). The DoDIG's *needs-based* apportionment recommendation to decrease the CDC size to a 126 capacity facility is not viable: the planned CDC will replace three temporary re-locatable facilities (now providing 249 child care spaces) that will be closed when the 232 CDC is operational.

(3) Fort Drum CDC Facility (126 child space capability). The DoDIG's *needs-based* apportionment recommendation to increase the CDC size to a 232 capacity facility is not viable: the garrison is to retain a temporary re-locatable facility (providing 100 child care spaces) which was originally planned to close by FY14. Furthermore, the garrison determined that the 126 capability CDC will meet their needs.

(4) Fort Hood CDC Facility (338 child space capability). The DoDIG's *needs-based* apportionment recommendation to decrease the size to 232 capacity facility is not viable: the 338 capacity CDC is required to meet the garrison child care demand. This facility will augment and replace a re-locatable facility for 100 child care spaces to meet the child care demand associated with the Army transformation.

6. In summary, the DODIG Report fails to acknowledge:

- a. Child care spaces in re-locatable facilities were only a stop gap measure
- b. Significant penalties would have been incurred to cancel existing construction contracts or change the ARRA CDC project designs



- [REDACTED]
- c. Delays in CDC openings would impact child care for 1000+ children
 - d. Additional options (other than CDCs) for child care are available at Garrisons

7. Draft DoDIG Report *Finding A* has no recommendations, yet the Army's methodology is discredited as needing improvement.

8. The DoDIG report states that the Army needs to revise its methodology for accessing CDC child care capacity and use operational capacity vs. design capacity to meet the projected child care demand for future CDCs. OACSIM non-concurs with the *Finding B* recommendation that the Army should apply a corrective factor percentage to its child care projection. This DoDIG recommendation would reduce the numbers of children that can be served in CDCs built using the new 2008 flexible Army CDC standard designs.

a. *Finding B* concludes that the Army overestimated planned CDC capacity. This DoDIG statement is based on a misunderstanding of the Army's assessment tool - the *CYS Services 2008 Garrison Capability Model (GCM)* which projects CDC operational capability for 2008 and out-year CDC construction projects. A graphic depiction of the process used to assess gaps and identify child space delivery requirements to meet projected child care demand caused by future Army population changes is at Encl 5.

b. The new Army standard CDC designs approved in 2008 now have a *child space capability range* built into the designs that the Army's older 303 CDC *traditional defined child space capacity* standard design (seen by the DoDIG at four of the installations) did not have. Using the new *capability model vs. defined capacity model* gives Army the needed flexibility to adjust to the changing child care needs and avoids costly retrofitting of classrooms as child population/need fluctuates, e.g., deployment related baby booms, changes in adult/child supervision ratios, Army transformation and BRAC troop movements. We believe this capability range does in fact address the DoDIG concerns about the Army's planning process.

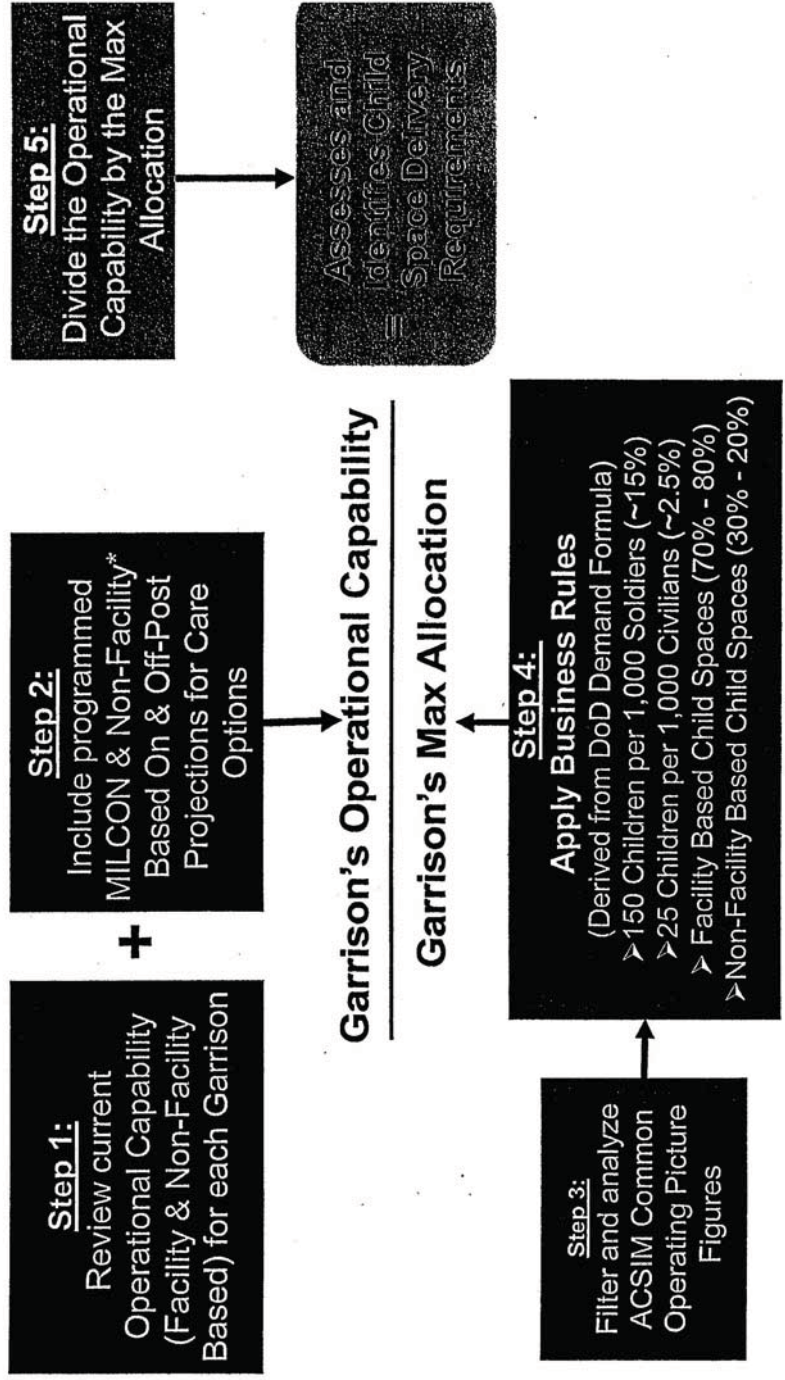
c. Note: The Army CDC facility inventory includes many older non-standard facilities built prior to 2008 that have since been renovated and do not have the flexibility that the new Army CDC standard designs provide. These renovation efforts have changed the original design space capacity in these CDCs to their current operational capability needed for increasing numbers of infants and toddlers.

9. ACSIM/IMCOM/FMWRC staff stand ready to assist the DoDIG with making adjustments in the report to accommodate agreement.



Garrison Capability Model (GCM)

Process



* Non-Facility based care includes programs such as Family Child Care and outreach
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Enclosures 2, 3, and 4 are not included. Reasons are stated on pages 20-21.



Inspector General Department of Defense

