LEGISLATIVE AUDIT COMMISSION

Review of
Department of Public Health
Two Years Ended June 30, 2015

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REVIEW: 4467
DEPARTMENT OF PUBLIC HEALTH
TWO YEARS ENDED JUNE 30, 2015

FINDINGS/RECOMMENDATIONS - 24

ACCEPTED - 21
IMPLEMENTED - 3

REPEATED RECOMMENDATIONS - 16

PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 19

This review summarizes the auditors' report of the Illinois Department of Public Health for the two years ended June 30, 2015, filed with the Legislative Audit Commission May 12, 2016. The auditors performed a compliance examination in accordance with State law and *Government Auditing Standards*.

The Department of Public Health promotes the health of the people of Illinois through the prevention and control of disease and injury. The Department, in partnership with local health departments and other agencies, employs population-based approaches in its prevention programs. The Department carries out its mission through seven major program areas: Policy, Planning and Statistics; Health Promotion; Health Care Regulation; Health Protection; Women's Health; Men's Health; and Preparedness and Response.

During the first 18 months of the two-year period under review, Dr. LaMar Hasbrouck was the Director of the Department. Dr. Hasbrouck resigned on January 15, 2015. Dr. Nirav D. Shah was appointed Director effective January 20, 2015. Dr. Shah was not previously employed by the Department; he was formerly a physician, attorney, and public health economist.

The average number of employees was:

Division	FY15	FY14	FY13
Director's Office	97	94	74
Office of Preparedness and Response	49	44	46
Office Finance and Administration (IT)	119	117	115
Office of Policy, Planning and Statistics	69	71	72
Office Health Promotion	54	52	54
Office of Health Care Regulation	415	399	340
Office Health Protection (Laboratories)	341	351	355
Office of Women's Health	39	37	19
TOTAL	**1,183**	**1,165**	**1,075**

Expenditures From Appropriations

The General Assembly appropriated $604.1 million to the Department in FY15. Of the total appropriation, $130.5 million was from the General Revenue Fund, and the remaining $473.4 million was from 58 other funds. Total expenditures were $405,772,214 in FY15 compared to $466,819,534 in FY14, a decrease of $61.1 million, or 13.1%. Appendix A presents a summary of appropriations and expenditures for FY15-FY13 by both fund and major object code. Expenditures from most funds showed small changes from FY14 to FY15. Some of the significant changes in expenditures were as follows:

- $76 million decrease in awards and grants was mostly due to a $59.6 million decrease for completion of capital projects during the fiscal year, as well as a $15.9 million decrease as a result of the Department's active migration of HIV/AIDS patients to the Affordable Care Act so that the patients will have comprehensive health insurance.
- $9.7 million increase in the Long-Term Care Monitor/Receiver Fund was due to increased personal services expenditures for more facility surveyors.

Lapse period expenditures were $60.1 million, or 14.8%, most of which were attributable to grant payments that are made on a reimbursement basis.

Cash Receipts

The Department of Public Health has collection responsibility for licenses, fees, or other types of revenue. Overall receipts increased from $245.6 million in FY14 to $259.9 in FY15. The increase was due to a $10.7 million increase from higher indirect cost rate allocations approved by DHHS compared to FY14. FY15 receipts were higher because of FY14 vaccine reimbursements from HFS received during the year. Appendix B provides a summary of the Department's cash receipts. Most of the Department's receipts are from federal grant revenue ($189 million) and fees and licenses ($42.6 million).

Changes in State Property

Appendix C provides a summary of the changes in State property for which the Department was accountable during FY15 and FY14. The value of the Department's property decreased from $24,203,009 as of July 1, 2013 to $23,736,332 as of June 30, 2015. The Department's property is entirely comprised of equipment.

Activities and Performance Indicators

Appendix D provides a summary of the Department's activities and performance indicators. The information was taken directly from the Agency's Service Efforts and Accomplishments forms for FY15 and FY14.

Accountants' Findings and Recommendations

Condensed below are the 24 findings and recommendations included in the audit report. Sixteen were repeated from prior audits. The following updated responses are presented on the basis of updated information provided by Joel A. Meints, Chief Internal Auditor, via electronic mail received October 21, 2016.

Accepted or Implemented

1. **Develop and enforce a comprehensive grant administration program that includes the use of Government Accountability and Transparency Act (GATA) rules for grants and development and implementation of written procedures over the awarding and monitoring of all of the Department's grant awards. The comprehensive grant administration program should include reviewing the programmatic and financial reports of grant recipients; developing a checklist or other method to sufficiently document the monitoring of grantees through quarterly reporting, desk reviews, site reviews and audit report reviews; and scheduling, conducting, and documenting grantee site visits. Also, implement a risk-based methodology to determine the level of monitoring that should be performed on each grantee, including on-site reviews of higher risk grantees. (Repeated-2007)**

Finding: The Illinois Department of Public Health (Department) did not adequately administer and monitor its awards and grants programs.

During FY14 and FY15, the Department expended over $488 million (56%) of its approximately $873 million total expenditures for awards and grants. Auditors sampled 30 grant programs from the following offices: Policy, Planning and Statistics; Health Promotion; Health Protection; Women's Health; Preparedness and Response; and Center for Minority Health; and examined 60 grant agreements totaling $90,395,704 and noted the following:

- The Department did not have written procedures established to uniformly guide the administration of the awards and grants under its jurisdiction.
- The Department had not established administrative rules for grants with the Joint Committee on Administrative Rules (JCAR).
- The Department did not have a standardized methodology, formal criteria, or mandatory site visits for monitoring grantees.
- The Department did not enforce the submission of audited financial statements required by the grant agreement nor was a review made on all audited financial statements received from grantees. Twenty-five of the 48 (52%) grantees, which received grants totaling $26,735,724, did not submit their audited financial statements for FY14. Twelve of the 48 (25%) grantees, which received grants totaling $13,362,766, submitted their audited financial statements but there was no evidence of review performed.
- The Department did not sufficiently document its review and receipt of the quarterly and/or monthly reports submitted for grants.

Accepted or Implemented – continued

Department management stated the finalization of the draft grants review manual and grant administration rules were deferred in view of the recent passage of the GATA in July 2014. Management stated they decided to wait for the enactment of GATA's administrative rules so the Department can align its own grants and awards policy with the requirements of GATA. Department management further stated grant administration and monitoring weaknesses were due to individual grant program complexities, turnover of some vital staff responsible for overseeing grants, and limited resources.

Response: Accepted. The Grant Accountability and Transparency Act (GATA) became law on July 16, 2014 as Public Act 98-0706. The purpose of GATA is to establish uniform administrative requirements, cost principles, and audit requirements for state and federal pass-through awards to non-federal entities. A Grants Manual will be developed to support GATA implementation. Separate sections will be dedicated to state grant making agencies and the grantee community. Common definitions will be articulated along with instructions to support the use of GATA frameworks, policies and procedures. The Manual will be provided online for ease of reference and maintenance. IDPH will award grants under its jurisdiction in alignment with GATA and the State's Grants Manual.

Administrative rules for grants are being addressed through the State's GATA implementation process. The Governor's Office of Management and Budget's Grant Accountability and Transparency Unit (GATU) has successfully completed the JCAR process for the adoption of the Uniform Federal rules for federally funded grants. In addition, GATU has received unanimous agreement of state agency staff and grantee community subcommittee volunteers on the general state, federal and federal pass-through grant rules. GATU is currently working with JCAR and ready to begin the process of posting the agreed-upon rules for comment on the remaining state rules and the amendments to the federal and federal pass-through rules. Once approved, the rules pertaining to GATA will apply to all grant-making state agencies. Once the GATA rules are adopted, the Department will evaluate to see if any expansion of the GATA rules is necessary. The Department cannot change or override anything in the GATA rules, but if the Department has specific rules it wants to implement it would then work on these additional rules.

Under GATA, the state is required to conduct an assessment of the risk posed by an applicant prior to making an award. Additional monitoring requirements may be imposed based on the risk assessment. The fiscal and administrative portion of this risk assessment will be centralized, conducted once and shared with grant making agencies thereby reducing redundancy among agencies. The risk assessment process will include an internal control questionnaire, review of fiscal stability and methodology to rank the grantee as low, medium and high risk based on the fiscal and administrative risk posed. IDPH must comply with the requirements identified under GATA as it pertains to assessing risk and monitoring grantees in the post-award phase. The Department will work with GATA to ensure the grant administration program includes reviewing the programmatic and financial reports of grant recipients; developing a checklist or other method to sufficiently document the monitoring of grantees through quarterly reporting, desk reviews, site reviews and audit report reviews; and

scheduling, conducting, and documenting grantee site visits. Under GATA, several of the aforementioned monitoring functions will be centralized for all state grant-making agencies, including IDPH.

With regards to the Department not enforcing the submission of audited financial statements required by the grant agreement or conducting a review made on all audited financial statements received from grantees, the new manager for the Office which is currently assigned this responsibility, has inadvertently had this repository for this information and has been unable to devote the time and effort needed to conduct basic monitoring of the receipt of the reports as a result of staffing changes. In addition, the Office was unable to locate the written policies and procedures that outline the limited desk review activities the Department previously stated it was following.

Updated Response: Accepted. The Department is currently working on procedures. The Department has several representatives that are participating in the various GATU committees and subcommittees to ensure the corrective actions taken by the State also resolve some of the findings cited for IDPH. The Chief Accountability Officer and Chief Fiscal Officer are both members of the GATA Streamlining Subcommittee On-Site Review Monitoring Workgroup that is in the process of developing the financial on-site monitoring tool and procedures.

2. Strengthen internal controls over physical inventories to ensure fiscal year-end inventory balances are accurate and complete. (Repeated-2013)

Finding: The Department did not conduct complete physical inventories and ensure the accuracy of fiscal year-end commodities inventory balances.

During testing of the Department's June 30, 2015 year-end commodities inventory balance, auditors noted the following:

- The Department's Health Protection Division did not report its media inventory, resulting in an understatement of $77,799. In addition, the Division's other inventory supplies were overstated by $161,880.
- There were 11 Department programs or divisions that did not report the dollar amount of their commodities inventory in the June 30 balance.
- There were 51 of 938 commodity items in the inventory list whose cost per item was omitted, resulting in the understatement of the inventory.
- Ten of 211 commodity items inspected by the auditors during the observation of the year-end physical count were not included in the inventory list.

The Department reported a commodities inventory balance of $5,556,650 as of June 30, 2015. The understated inventory balance was reported to the Illinois Office of the Comptroller (IOC) in the Department's year-end financial reporting packages.

Department personnel indicated that the understatement of the commodities inventory was an oversight.

Accepted or Implemented – continued

Response: Accepted. Warehouse space is limited, which causes an inability to store all inventory items together in one location. That can result in inventory items being overlooked when conducting the warehouse inventory. One step OHP staff in the Sexually Transmitted Diseases (STD) Section has taken to avoid overstatement of inventory items is to compare inventory counts with prior years' counts. Large discrepancies will be investigated and the count will be performed again to ensure accuracy. In addition, the OHP Division of Laboratories is currently working on a solution to better track inventories. Currently, the Springfield Laboratory is evaluating a software solution designed to monitor supplies. This software is a free web-based service which is accessible from any internet-connected device. The Division of Laboratories is also developing a standard operating procedure (SOP) to direct laboratory supervisors to use a consistent methodology for inventory maintenance. Depending on the results of the software pilot in Springfield, use of that system may be incorporated into the SOP.

Updated Response: Accepted. The Division of Laboratories is developing a standard operating procedure (SOP) that will instruct laboratory supervisors to use a consistent method for maintaining inventory. In addition, the Springfield Laboratory is evaluating a web-based software solution designed to monitor supplies.

3. Immediately perform a detailed inventory of computer equipment and determine whether confidential information is stored on each unit; review current practices to determine if enhancements can be implemented to prevent the theft or loss of computers; establish procedures to immediately assess if a computer may have contained confidential information whenever it is reported lost, stolen or missing during the annual physical inventory, and document the results of the assessment; and establish policies and procedures to ensure compliance with the Data Security on State Computers Act. (Repeated-2011)

Finding: The Department was unable to locate 65 computers during FY14 and FY15. Some of these computers may have contained confidential information. The Department had no policy regarding clearing of data and software from electronic systems before sale, donation, or transfer.

The Department conducts an annual physical inventory of all equipment with an acquisition cost of $500 or more and reported that the Department was unable to locate missing computer inventory totaling $55,986 in FY14 and $20,449 in FY15.

The Department considers all 65 of the computer equipment items (38 desktop computers and 27 laptop computers) to be lost, as none had been reported as stolen prior to the annual physical inventory. Department personnel were unable to provide property transfer forms or any other documentation indicating what happened to the computers. In addition, the Department did not perform a detailed assessment at the time it determined the computers to be missing; and, therefore, had not determined whether the missing computers contained confidential

information. Auditors performed inquiries with Department personnel to gain an understanding of the type of information that would have been maintained on the missing computers. However, the Department was unable to determine whether any of the missing computers contained confidential or sensitive information. The Department had not protected all of its computers with encryption software, thus increasing the risk that confidential or sensitive information could be exposed.

The Department personnel confirmed that there is no process performed to clear data and software from computer equipment before transfer either outside or within the Department. The Information Technology Division of the Department is not involved in any way in the transfer process, hence clearing of data and software was not performed.

Department management stated due to ineffective processes, older computers were not properly transferred to State surplus property. Management stated that older operating systems run slowly after encryption software has been installed, and a determination was made that encryption software would not be installed on older computers which lacked sufficient processing power. Typically, computers were over seven years old and most of them are out of service. Management stated they lacked an internal policy and procedure for data wiping because the Department of Central Management Services performs data wiping for the Department's computers through a vendor and the Department previously believed there was no need to take any measures at the agency level. However, the Department is still ultimately responsible for ensuring data wiping occurs, including preparing or obtaining documentation of compliance.

Response: Accepted. The Department is currently performing an inventory audit of existing PCs and is working with the IT Coordinators. In order to address this finding, IDPH will revise and update its IT Directives and Guidance to reiterate and reinforce the existing requirement that storage of data that may contain sensitive or personally identifiable information on a device drive requires written permission from the agency Chief Information Officer (CIO). Additionally, IDPH will develop a survey document to identify the agency programs where sensitive and/or personally identifiable information would be likely to be accessed as a part of programmatic activities. The Department will purchase and provide to the IT coordinators for those identified programs, software to wipe the drive of any electronic data processing equipment utilized in those identified programs and will require as a part of the process that the IT coordinators wipe those computers prior to transfer or surplus. The Department will continue to complete a CMS Enterprise Service Request **(**ESR) to surplus equipment which is collected by Central Management Services. Central Management Services has implemented a policy to mandate that all hard drives of surplus electronic data processing equipment be erased, wiped, sanitized, or destroyed in a manner that prevents retrieval of sensitive data and software before being sold, donated, or transferred. The Department will ensure they receive the certificates back from CMS documenting the hard drive has been wiped. While the Department's continued control will be to ensure an ESR is completed by authorized Department staff in order to surplus or transfer equipment (etc. an IT Coordinator or IT Security Staff), the added layer of identification and erasure of all data from devices utilized in program areas where sensitive data may be utilized will further ensure compliance with the requirements identified in this finding. Current practices covered under the "Guideline

Accepted or Implemented – continued

07-01, 03/27/2012 Information Technology (IT) Policies" and "Division of Information Technology Surplus Inventory Procedures" will be reviewed and revised, as necessary, to enhance and reduce or prevent the theft or loss of computers. Changes to existing guidelines or practices for PC transfers, surplus, or storing of sensitive data on PC's will be documented and communicated to the IT Coordinators.

Updated Response: Accepted. An inventory of all missing computers was completed. An assessment was made to determine if the missing computers had encryption.

4. Strengthen and monitor controls to ensure appropriate signatory approvals are obtained on all contracts over $250,000 and accurate information is filed on contract obligation documents with the State Comptroller. (Repeated-2013)

Finding: The Department did not ensure contracts were properly approved and reported.

During testing of 60 contractual agreements for FY14 and FY15, auditors noted the following:

- Seven tested contracts over $250,000, totaling $6,022,033, were not approved in writing by the Chief Executive Officer, Chief Fiscal Officer and Chief Legal Counsel.
- Fifteen contract obligation documents (CODs) tested had missing or incorrect information, including the Illinois Procurement Bulletin (IPB) publication date, IPB reference number, IPB exemption, award code, and/or signature by the individual who authorized the obligation.

Department management stated agency oversight, human error, and lack of attention to detail resulted in contract obligation documents not being completed accurately and contracts not being signed by all parties.

Response: Accepted. In reference to the finding that the Department did not ensure contracts were properly approved and reported, in particular contracts over $250,000, the new administration has taken several steps toward ensuring contracts are properly reviewed and approved by the Director, General Counsel and Chief Fiscal Officer. Current efforts include the following:

- All Deputy Directors and their fiscal managers have been advised that all contracts, regardless of their value, are to be signed by the Director or his documented designee.
- All contracts over the $250,000 threshold are first reviewed by an attorney within the Division of Legal Services for inclusion of appropriate terms and conditions prior to the Department's General Counsel sign off on the $250,000 Form. The $250,000 Form approval packet which includes the contract, fully approved initial Request for Contractual Services or grant application and contract award recommendation form (also referred to as the Section 8 Form), Procurement Business Case printout that includes a note referencing the State Procurement Officer's sign off, and if applicable, Small Business Set-Aside Waiver Form, is then forwarded to the Department's Chief Fiscal Officer (CFO) who checks all documents for consistency, paying particular

attention to the contract amount, contract term, contract number and appropriation. Once the CFO signs off, the packet is forwarded to the Director for final review and signature on the $250,000 Form preceded by an email to his assistants and the respective Deputy Director submitting the request for approval of its pending arrival. To orient the Director, the email includes key facts about the request, i.e., vendor name, contract purpose, contract amount, funding source, and requesting Office.

- Finally, regardless of the contract value which drives the contracting method, the Department's primary procurement officials which includes the CFO/Agency Procurement Officer (APO), Chief Information Officer (CIO), Alternate APO, Office of Information Procurement Manager, Professional and Artistic Services Procurement Manager, and Fiscal Control Manager who is responsible for the procurement of commodities through coordination with Central Management Services (CMS), have been meeting on a regular basis to review the current procurement processes from request initiation to contract award, and are documenting a step-by-step process so the programs will know exactly what is required and can be held accountable should these written procedures not be followed.

Updated Response: Accepted. All members of the Department's primary procurement officials are currently undergoing training for the State's new automated procurement system, BidBuy. The system will help standardize documentation requirements and proper approvals process for all procurements $2,000 or greater.

5. Designate sufficient trained backup staff and strengthen procedures over property and equipment to ensure timely and accurate recordkeeping for all State assets. Include a supervisory review process in procedures to ensure clerical, technical, and other errors are promptly detected and corrected. Also, regularly survey inventories for transferable equipment and report any such equipment to the Property Control Division of CMS. Assets that are obsolete, damaged or unused should be identified and, if necessary, removed from the Department's records. (Repeated-2013)

Finding: The Department did not maintain accurate property and fixed asset records.

During testing of the Department's FY14 and FY15 property records, some of the weaknesses noted by the auditors were as follows:

- For 82 additions, no cost was recorded in the property records as of June 30, 2015. These assets were added to the property records 30 days before year end.
- Twenty-four of 60 (40%) items removed from property records with a total cost of $214,260 did not have the required deletion form properly completed.
- Nine of 60 (15%) asset deletions with a total cost of $50,720 lacked approval by the Department of Central Management Services (CMS).
- Thirty of 60 (50%) items removed from property records with a total cost of $467,920 were delivered to CMS as surplus without prior notice sent to notify all inventory coordinators regarding the available surplus property.

Accepted or Implemented – continued

- For six of 60 (10%) items tested with a total cost of $6,398, property records were not updated to reflect the current location or transfer to CMS as surplus.
- Two of 60 items with a total cost of $16,740, and two of 60 items physically inspected did not have a property tag attached to the items.
- Four of 60 (7%) items found during the physical inspection (two cameras, a postage scale, and a steel cabinet) were not recorded in the property records.
- One vehicle, which cost $15,288, was recorded twice in the property records.
- Twelve of 120 (10%) items with a total cost of over $12,000 were obsolete or unused during the physical inspection. Further, the Department had no policies and procedures in place for the regular identification of obsolete, damaged or unused equipment.

During testing of the Department's FY14 and FY15 annual physical inventory reports submitted to CMS, auditors noted the following:

- The FY15 Agency Inventory Summary was understated by $298,024.
- The FY15 Inventory Discrepancy Report excluded seven property items, which were not assigned to a location code or recorded in the property records.
- Four of 60 (7%) property deletions tested with a total cost of $24,230 that were classified as not located/lost were not reported in the Discrepancy Report.

Auditors tested all four of the Department's FY15 capital lease assets and noted the following:

- For all four (100%) of the capital lease assets, fair values at inception and the lease terms were inaccurately reported on the Accounting for Leases-Lessee (SCO-560) Form. The purchase price of the capital lease agreements was understated by $22,784 and reported lease terms in the SCO-560 Form differed by 12 to 24 months from the lease agreements. Department personnel stated the difference in fair value was due to exclusion of maintenance costs, but no supporting documentation was provided.
- All (100%) capital lease assets totaling $76,570 were omitted from property records.
- Capital lease assets reported in the C-15 Report were understated by $24,723 and did not agree with supporting schedules.

Department management stated that current period exceptions on the annual physical inventory reporting were due to oversight. Management stated other exceptions were due to lack of a property control coordinator for most of the period and employees with competing demands and lack of expertise filling in.

Response: Accepted. The finding regarding the Department's not maintaining accurate property and fixed asset records is driven by the limitations associated with only having one individual dedicated to the Property Control function for several dispersed locations and the extended vacancy in that position, as well as the accountability for ensuring the adequacy of the annual inventory submission not being placed at a high enough level to reinforce the importance of the exercise.

Because of the extended vacancy in the Property Control Coordinator position, efforts to complete property transfer forms were not prioritized given the Unit Manager's primary

responsibilities and the associated changes were sometimes not incorporated into the inventory system. Now the Coordinator position has been filled and new management has taken over at both the Unit-level and Deputy Director-level, during the learning process, gaps in the process have been identified and improved. Enhanced and standardized procedures are in the process of being documented such that the Property Control Liaisons for each location can eventually be trained on the new requirement. In doing so, accountability can be enforced. In fact, accountability enhancements began with the annual inventory currently in process, whereby the respective Deputy Director for each location was required to sign off on their inventory submissions for the first time.

In an effort to minimize the number of discrepancies discovered at the end of the year when the annual inventory is conducted, the new procedures developed will require Property Control Liaisons at the various locations to submit quarterly assessments regarding the disposition of individual assets valued at $10,000 or more.

Updated Response: Accepted. The Department is in the process of creating an enhanced and standardized procedure to ensure accountability. The Department is cross training employees, requiring supervisory reviews, consolidating and reconciling assets, and reviewing reports monthly instead of quarterly.

6. Ensure completion of audits of major systems of internal accounting and administrative control at least once every two years, and report to the Director annually on how the audit plan was carried out, the significant findings, and the extent to which recommended changes were implemented. Also, promptly arrange an external assessment of internal audit activity to comply with the Institute of Internal Auditors' Standards. (Repeated-2013)

Finding: The Department failed to comply with the Fiscal Control and Internal Auditing Act and International Standards for the Professional Practice of Internal Auditing. The Department did not complete most planned audits, its FY14 annual internal audit report, or a peer review by the end of FY15.

During review of the Department's internal auditing activities, auditors noted the following:

- Seventeen of the 18 (94%) audits and reviews included in the approved two-year internal audit plan for FY14 and FY15 were not completed during FY15. One other audit was completed which was not included in the audit plan.
- No audits were completed relating to internal accounting and administrative controls, including testing of: (1) the obligation, expenditure, receipt, and use of public funds of the State and of funds held in trust; (2) grants received or made by the Department completed during the last two years; and (3) reviews of the design of major new electronic data processing systems and major modifications of those systems.
- No annual internal audit report for FY14 was submitted to the Director of the Department.

Accepted or Implemented – continued

- The Department's Internal Audit division did not undergo a peer review by June 30, 2015, which was five years after the July 1, 2010 transfer of chief internal auditor responsibilities from the Department of Central Management Services to the Department.

During the examination period, the Department expended over $488 million (56%) of $873 million in total expenditures for awards and grants and received over $505 million. The Department also maintained over 50 computer applications used for all aspects of operations, including billing, recording receipts and inventory, tracking federal funds, producing licenses, recording personal medical information, long term care data, and healthcare worker background checks, and which include critical, confidential, and financially significant data for Department operations.

Department management stated the issues noted are the result of a vacancy in the Chief Internal Auditor position over a significant period of time and staffing issues in the Department.

Response: Accepted. The division of internal audit will work to complete planned audits related to internal accounting and administrative controls, including testing of: (1) the obligation, expenditure, receipt, and use of public funds of the State and of funds held in trust; (2) grants received or made by the Department completed during the last two years; and (3) reviews of the design of major new electronic data processing systems and major modifications of those systems. In addition, the division of internal audit will submit required reports and complete a peer review.

Updated Response: Accepted. The Department has completed the peer review and the annual internal audit report was submitted timely. The Chief Internal Auditor is working toward completing audits of major systems of internal accounting and administrative control at least once every two years.

7. Implement controls and enforce policies and procedures. (Repeated-2011)

Finding: The Department employees worked overtime during the examination period without proper prior approval.

The Department paid a total of $3,039,531 for nearly 67,000 hours of overtime during FY14 and FY15. Auditors tested a sample of 19 pay periods and 60 employees who worked overtime during FY14 and FY15. The employees in the auditors' sample incurred 2,811 hours of overtime during the pay periods tested. Based upon review of the overtime requests, auditors noted 19 of 60 employees had overtime requests for a total of 507 hours that were not pre-approved by the supervisors. These requests were approved one to 10 days after the overtime was worked.

Department management stated competing work demands and Department oversight was the reason overtime requests were not approved timely.

Updated Response: Accepted. The Department has revised the Time Protocols Directive to clarify the process for submission of all time records and requests, including Overtime Pre-approvals, Overtime Worked Approvals, use of benefit time, and weekly timesheet submission. Additionally, the Department has worked with CMS to tighten controls for the submission of Overtime to ensure it cannot be submitted unless the appropriate Overtime Pre-Approval has been completed.

8. Employ the mandated number of surveyors to ensure adequate monitoring of long term care facilities and establish administrative rules for certification fees, as required by statute, or seek legislative remedy. (Repeated-2013)

Finding: The Department failed to comply with provisions of the Department of Public Health Powers and Duties Law related to surveyors for long term care beds and the establishment of administrative rules related to Medicare or Medicaid certification fees.

During the current examination period, the Department did not employ the required minimum number of surveyors per licensed long term care beds during FY14 and FY15, which is one surveyor for every 300 beds or .33%. Auditors selected a sample of six months during the examination period to determine if the required numbers of surveyors were employed, and noted for all six months tested the Department employed surveyors at the rate of .11% to .28%.

In addition, the Department still did not create administrative rules for the establishment of Medicare or Medicaid certification fees to be charged to facilities or programs applying to be certified to participate in the Medicare or Medicaid program to cover costs incurred by the Department.

Department management stated that although the Department hired 85 surveyors during the examination period, with 76 outstanding Electronic-Personal Action Requests working their way through the hiring process, hiring challenges remain due to staff turnover and transfers within programs, the lengthy hiring process, and often a shortage of registered nurse candidates at the hiring locations. Department management further stated that rules for certification fees were not prepared and filed because the federal government presently reimburses the State for the application, inspection and the survey of facilities applying to participate in the Medicare and Medicaid programs. Officials stated a legislative remedy is needed to strike the provision for the Department to establish a Medicare or Medicaid certification fee, but wasn't made a priority during FY14-FY15.

Response: Accepted. The Office of Health Care Regulation (OHCR) continues to hire surveyors in order to meet the Law. The Department has hired additional surveyors in the past year. Vacancies are posted in accordance with contractual obligations. Hiring is done per contractual obligations. OHCR is seeking a legislative remedy to strike the provision for OHCR

Accepted or Implemented – continued

to establish a Medicare or Medicaid certification fee as those costs are covered by the federal government and no additional fee is necessary.

9. Comply with the requirements of the Law or promptly seek legislative remedy. (Repeated-2013)

Finding: The Department failed to establish a Center for Comprehensive Health Planning.

During the prior examination, auditors noted that the Department failed to establish a Center for Comprehensive Health Planning. In the prior finding response, officials indicated that steps were being taken to implement the Law. Officials responded that appropriation authority was requested in the FY15 budget request, draft organizational charts had been created, and draft position descriptions were being developed. In addition, officials also stated that the Department was also engaging the Department of Central Management Services (DCMS) about establishing positions for the new Center.

Current year's testing showed Department personnel did take these initial steps to establish the Center such as organizational charts for the Center were modeled, position description for the Chief of the Center and other staff have been written, and Department staff took steps to contact DCMS about establishing position. However, officials stated the new leadership of the Department concluded that seeking the repeal of the mandate would be appropriate, after determining the following: a) the utility of the Center is questionable, b) adequate funding is not secured or sustainable, and c) the demands on general revenue in FY15-FY16 and for the foreseeable future are extraordinary. Management also stated that the administrator and chair of the Health Facilities and Services Review Board have agreed on pursuing a repeal of the mandate after discussion with the Department.

Updated Response: Implemented. With the passage of HB 4517, the statute will be repealed on January 1, 2017.

10. Continue to work with the other human services agencies to ensure compliance with the requirements of the Human Services Act and Law. (Repeated-2013)

Finding: The Department failed to establish joint rules with other public service agencies on a cross-agency prequalification process, common service taxonomy, and a master service agreement for contracting with human service providers.

Department management cited a lack of independent authority for establishment of administrative rules as the reason for failure to meet this requirement. The Department is referenced in the Act as an agency that is required to "collaborate" with DHS in the establishment and adoption of joint rules for pre-qualification of human service providers. Management stated the Department, unlike other "human service" agencies, does not generally

provide the types of direct services that DHS and other similar agencies provide. Department programs are generally population-based and not direct services. Although the Department has participated in a contracts work group when requested by the lead agency, and common financial grant language was developed and implemented, joint rules were not established due to complexities of aligning the functions and processes of multiple State agencies.

Response: Accepted. The Department will continue to ensure adequate representation and participation on committees and sub-committees, and work with DHS as the lead agency and the other Human Services agencies to ensure compliance with requirements of the Act.

11. Enforce internal controls to ensure performance evaluations are completed and reviewed in a timely manner for all employees in accordance with the Illinois Administrative Code. (Repeated-2007)

Finding: The Department did not perform employee performance evaluations in a timely manner.

During testing, auditors noted the following:

- Thirty-three of 60 employees' performance evaluations were not completed within 30 days of the end of the evaluation period. The delinquencies ranged from eight to 262 days late.
- Eight of 46 employees did not have a performance evaluation performed for the fiscal year tested.

Department personnel stated the untimely evaluations were due to competing priorities and Department oversight.

Updated Response: Accepted. The Department provides a monthly report to all Deputy Directors informing them of the past due, currently due, and upcoming evaluations. Additionally, this information is shared during Senior Staff meetings to call attention to the need for compliance with time frames. Objectives for the timely completion of performance evaluations are being incorporated into the performance evaluation for management staff.

12. Strengthen controls over submission of required Agency reports to ensure reports are accurate and filed in a timely manner. Also, file corrected Agency Workforce Reports per the Illinois State Auditing Act within 30 days of the audit release. (Repeated-2003)

Finding: The Department did not timely and/or accurately file statutorily required reports.

During testing, auditors noted the following:

- The Department did not file the two Travel Headquarter Reports (TA-2) Reports required for the period July 1, 2013 through June 30, 2014 with the Legislative Audit Commission.

Accepted or Implemented – continued

- Also, the TA-2 Report for the period July 1, 2014 to December 31, 2014 was submitted 162 calendar days late.
- For two of 23 employees tested, the official headquarters was missing on the TA-2 Report.

The Department reported amounts on its FY13 and FY14 Agency Workforce Reports which did not agree to the supporting documentation provided to the auditors. Discrepancies were noted on the data and statistical percentages presented for 14 of 16 employee groups within the Reports.

The Department has also incorrectly defined professionals for the purpose of reporting the information within the Department's FY13 and FY14 Agency Workforce Reports. Thus, it couldn't be determined the correct number of professionals for both fiscal years. The Department reported 918 of 1,085 (85%) employees as professional in its FY13 Report and 955 of 1,143 (84%) employees in its FY14 Report.

Department management stated that human error and Department oversight are the reasons for the deficiencies.

Response: Accepted. The Department concurs with the finding related to Travel Headquarter Reports (TA-2) Reports. The Department will improve follow-up and communication with program offices on employee's headquarters designation by setting a deadline to submit their information well in advance of the filing deadline sufficient to issue delinquency notices to the respective Deputy Directors for follow up with their staff. The Travel Office will improve verification that the home address for a staff member is in compliance with the documentation submitted as well as complete verification of changes in personnel information with the Department's Office of Human Resources prior to completion of the TA-2 Report's submission to the Legislative Audit Commission. In addition, Regional Administrative Offices will be asked to submit any changes to employee headquarters and commuting mileage on a quarterly basis to the Travel Office. It is anticipated that these additional measures will enable the Department to submit the transmittal memorandum and required TA-2 forms to the Legislative Audit Commission by the filing deadlines.

The Department concurs with the finding related to the Agency Workforce Report. The EEO Officer responsible for preparing the report will: 1) revise statistical calculations to reflect appropriate percentages and; 2) work with the Office of Human Resources to identify the accurate number of employees who fall into the "Professionals" category as referenced in the State Employment Records Act. In addition, the Department will file corrected reports within 30 days of the audit release.

Updated Response: Accepted. The Department submitted amended agency workforce reports and will strive to submit all statutorily required reports timely.

13. Take measures to ensure timely compliance with all aspects of the distressed facility requirements of the Nursing Home Care Act.

Finding: The Department did not comply with provisions of the Nursing Home Care Act to publish and notify distressed facilities, establish a mentor program and sanctions, and report on revocation criteria and recommended statutory changes.

During testing, auditors noted the Department did not generate and publish a quarterly list of distressed facilities. However, the Department had conducted multiple test runs of substitute criteria developed to meet the GAO report requirement and had determined reliability of the proposed methodology for designating distressed facilities. In addition, auditors also noted the Department did not: (1) adopt criteria to identify non-Medicaid-certified facilities that are distressed or publish a quarterly list; (2) establish by rule a mentor program for owners of distressed facilities and sanctions against distressed facilities that are not in compliance with the Act and with federal certification requirements; and (3) report to the General Assembly on the results of negotiations about creating criteria for mandatory license revocations of distressed facilities and making recommendations about any statutory changes. As of June 30, 2015, the Department had identified 47 facilities in the test run for distressed facilities.

Department officials stated, in order to create very specific methodology and to meet the criteria of the GAO report, it took the Department considerable time to define distressed facilities according to the Act. Officials further indicated that rules need to be adopted before the Department can move forward with establishing the criteria for designating distressed facilities for skilled and intermediate facilities, the mentor programs for identified distressed facilities, and fulfilling the rest of the requirements of the Act. In addition, officials stated the Department did not use the GAO criteria while developing its own criteria due to lack of understanding, resources, and staff to implement the GAO criteria in the interim.

Response: Accepted. Amendments were made to 77 Ill. Adm. Code 300; 77 Ill. Adm. Code 330; 77 Ill. Adm. Code 340. The Office of Health Care Regulation (OHCR) is in the final stages to implement the provisions of Section 3-304.2 of the Nursing Home Care Act (NHCA). OHCR has conducted multiple test runs of substitute criteria developed to meet the GAO report requirement and has determined reliability of the proposed methodology. The methodology has been incorporated into proposed rules. OHCR is awaiting rule adoption to proceed with identification of distressed facilities and fulfill the remainder of the NHCA requirements.

14. Adhere to the requirements of the Water Well Construction Code Act.

Finding: The Department did not timely comply with certification provisions of the Water Well Construction Code Act.

During testing of statutory mandates, auditors noted the Department had not certified any of the 10 closed loop well contractors tested in the sample by the mandated date of August 15, 2013. These certifications were 224 to 640 days late. There were 60 active closed loop well contractors as of the testing date.

Accepted or Implemented – continued

Department officials stated once the statute was passed in 2011, it took the Department working with stakeholders to get approved administrative rules through the Joint Committee on Administrative Rules. Officials stated that the development of agreed-upon administrative rules caused the biggest delay to the contractor certification process. The administrative rules (77 Ill. Adm. Code 920) took effect on November 25, 2013, 102 days after certifications were mandated. Management stated additional delays were due to applications submitted by contractors after the statutory deadline for certification.

Updated Response: Implemented. The Department is now in compliance with the requirements of the Act.

15. Comply with the Alzheimer's Disease Assistance Act mandate or seek legislative changes.

Finding: The Department failed to establish policies and procedures for data gathering on victims of Alzheimer's disease and related disorders; and failed to inform and educate medical examiners and coroners regarding autopsies to diagnose the disease.

During testing of statutory mandates, auditors noted the following:

- The Department did not establish policies, procedures, standards, and criteria for the collection, maintenance, and exchange of confidential personal and medical information necessary for the identification and evaluation of victims of Alzheimer's disease and related disorders including the critical role that autopsies play in the diagnosis and in the conduct of research into the cause and cure of Alzheimer's disease and related disorders.
- The Department did not provide information to medical examiners and coroners in the State regarding the importance of autopsies in the diagnosis and in the conduct of research into the causes and cure of Alzheimer's disease and related disorders.
- The Department did not arrange for education and training programs that will enable medical examiners and coroners to conduct autopsies necessary for a proper diagnosis of Alzheimer's disease or related disorders as the cause or a contributing factor to a death.

There are approximately 102 coroners and medical examiners in Illinois.

Department officials stated the Department does not have the expertise to establish policies, procedures, standards, and criteria for the collection, maintenance, and exchange of confidential personal and medical information necessary for the identification and evaluation of victims of Alzheimer's disease and related disorders. Officials also stated the Department does not have the funding or expertise to develop education and training programs that will enable medical examiners and coroners to conduct autopsies necessary for a proper diagnosis of Alzheimer's disease or related disorders as the cause or a contributing factor to

a death. Department officials further stated funding for this project was never requested from the General Assembly.

Updated Response: Accepted. The Department concurs that a legislative remedy should be sought and will work with the Governor's Office and through the State's legislative processes to do so.

16. Either comply with mandates or seek legislative changes to eliminate certain statutory requirements. Further, identify all obsolete mandates and continue to seek their repeal.

Finding: The Department did not comply with or seek repeal of obsolete duties mandated by State statute.

During testing of statutory mandates, auditors noted the following:

- The Department's administrative rules differ from statutory requirements for notification of new water well pump or equipment installations. The Department has adopted rules and regulations over the installation of water well pumps and equipment which requires the contractor to submit a report of pump installation within 30 days to the Department post installation. The Department received over 2,500 applications for new water well pump installations annually.

  Department management stated final pump installation is dependent upon the existence or installation of power lines and plumbing to serve the building, and prior notification is not a reliable indicator of the actual installation date. Management further indicated notification post-installation is a more accurate indicator to public health agencies of the availability to collect a water sample.

- The Department is mandated by State Law to ensure certain bodies meet as defined. The Department failed to abide by the meeting requirements during the examination period. The task force did not meet during calendar years 2014 and 2015.

  Department management stated the task force was rendered obsolete and needs legislative change to eliminate the task force requirements with the creation of the Illinois Stroke Advisory Subcommittee (Subcommittee) per Public Act 96-0514. Management stated several members of the task force migrated to participate in the Subcommittee. Officials noted that both the task force and the Subcommittee are advisory groups working on similar issues related to stroke prevention and treatment issues.

Response: Accepted. The Department will work with stakeholders to seek legislative changes or repeal to eliminate these statutory mandates.

Accepted or Implemented – continued

17. Strengthen controls to ensure employees' time records are completed, submitted in a timely manner, and approved by their supervisor.

Finding: The Department did not exercise adequate controls over employee time reporting to ensure employees' work hours were timely reported.

Auditors selected 60 employees and reviewed the Daily Time Reports (DTRs) for the pay period tested. There are two pay periods each month and a total of 118 DTRs were reviewed.

During testing, auditors noted the following:

- Forty-two of 118 DTRs tested were not timely completed. The employees completed their DTRs one to 483 days after they were due.
- Nine of 118 DTRs required to be completed were not submitted, and the employees were still paid despite the lack of required time reports.
- Three of 118 DTRs tested were not approved by the employee's supervisor.

Department management stated competing work demands and Department oversight were the reasons for the Daily Time Reports not being submitted and approved timely.

Updated Response: Accepted. The Department has revised the Time Protocols Directive to clarify the process for submission of all time records and requests, including Overtime Pre-approvals, Overtime Worked Approvals, use of benefit time, and weekly timesheet submission. Additionally, the Department has worked with CMS to tighten controls for the submission of Overtime to ensure it cannot be submitted unless the appropriate Overtime Pre-Approval has been completed.

18. Designate and train sufficient staff and backup staff to assume responsibilities to ensure continuous compliance with State laws, rules and regulations, as well as continuous enforcement of established controls. Monitor the submission of accident reports to ensure the requirements are being met as required by the Illinois Administrative Code and the State of Illinois-Self Insured Motor Vehicle Liability Plan. Enforce vehicle maintenance schedules to ensure vehicle safety, to reduce future year expenditures for repairs, and to extend the useful lives of vehicles. Enforce controls to ensure proper reporting of fringe benefits related to personal use of a State vehicle. Review and enforce procedures over the timely filing of the required annual certifications of license and liability insurance. Finally, remind staff of reporting requirements, and develop a monitoring process to ensure all employee vehicle assignment changes, as well as the required annual report on Individually Assigned Vehicles, are submitted to CMS by the established due date. (Repeated-2007)

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Finding: The Department did not have adequate controls over reporting of vehicle accidents, fringe benefits for personal use of State vehicles, changes to vehicle assignments, maintaining vehicle records, or obtaining annual certifications of license and vehicle liability coverage.

The Department's fleet consisted of 87 vehicles at June 30, 2014 and 84 vehicles at June 30, 2015. Of those vehicles, 52 were personally assigned to employees during FY14 and 54 in FY15.

During testing of 13 vehicle accidents involving State vehicles, auditors noted:

- Five vehicle accident reports were never filed with the Department of Central Management Services (CMS);
- One (8%) Auto Liability Uniform Cover Letter was not submitted to the CMS Risk Management Division Auto Liability Unit; and
- Two (15%) vehicle accident reports were submitted two days late.

During testing of 37 vehicle maintenance records, auditors noted the following:

- Eighteen vehicles did not undergo an annual inspection in FY14 and/or FY15;
- Thirty-five (95%) vehicles tested received oil changes 100 to 19,100 miles or one to 11 months past the allowed oil change interval; and
- Thirty (81%) vehicles tested did not receive a tire rotation every two oil changes as required.

During testing of personal use of State vehicles, auditors noted the following:

- Sixty-eight (100%) monthly vehicle logs and vehicle use certification forms tested were not reviewed and reconciled for the determination of the fringe benefit value submitted for tax purposes. The Department only used the commuting days reflected in the certification forms to report fringe benefits.
- Five of 37 employee's assigned State vehicles reported commuting miles of more than 30% of the vehicle's total mileage in FY14. The justification for the commuting miles was submitted between 451 and 493 days late.

Auditors tested 89 required annual certifications of license and automobile liability coverage form (certification form), and noted the following:

- Fifty-four of 89 (61%) required annual certifications were not filed;
- Thirty-two of 46 (70%) FY14 certifications were submitted 230 to 281 days late;
- Timeliness of submission could not be determined for five of 37 (14%) annual certifications because vehicle assignment forms were not prepared to reflect the assignment date to the employee.

During testing of vehicle assignment reporting to CMS, auditors noted the following:

- The FY14 Annual Report on Individually Assigned Vehicles was not fully completed and timely submitted to CMS. An incomplete report, lacking required details and management certifications, was submitted 217 days late.
- No changes to vehicle assignments were reported to CMS as required by the Illinois Administrative Code. While the exact number of changes that should have been reported could not be determined, auditors noted at least 11 changes not reported.

Accepted or Implemented – continued

Department management stated the exceptions noted during the current examination were primarily due to the extended absence of the Department Vehicle Coordinator without reassignment of related responsibilities to an alternative staff member. In addition, the FY14 Annual Report on Individually Assigned Vehicles was delayed due to the time required to compile months of backlogged employee utilization report submissions and corrections to incomplete monthly reports. Department management stated the exceptions noted relating to the annual certification forms were due to a lack of awareness by various Department divisions that changes to vehicle assignments need official approval by the Director and completion of the certifications. Untimely submission of certifications of license and liability coverage was due to a lack of adequate employee time to monitor missing filings due to other conflicting assignments.

Response: Accepted. In response to the finding that controls over reporting of vehicle accidents, fringe benefits for personal use of State vehicles, changes to vehicle assignments, maintaining vehicle records, or obtaining annual certifications of license and vehicle liability coverage, the Department acknowledges these findings and is putting in place the following changes that resulted from previously noted staffing constraints and inadequate communications between all parties involved:

- Reassignment of Vehicle Coordinator responsibilities to the Department's Travel Coordinator given the logical synergies between the two functions and the observation by the new Deputy Director for Finance and Administration that the workload of the previous Vehicle Coordinator when combined with this individual's extended leave may have impacted the deficiencies noted in this audit.
- Development of a revised Vehicle Policy that indicates in detail the Department's implementation of the Statewide vehicle requirements, with documented receipt of the revised policy to all individuals with individually assigned vehicles, and posting of the revised policy on the Department's intranet for all others. Included in the revised policy will be the following:
    - Standardization of the monthly vehicle usage report forms and timely follow up on missing submissions with notification to the associated staff member's Deputy Director of delinquencies which should facilitate more timely consolidation of information for annual reports to be submitted to CMS by stated deadline.
    - Vehicle reassignment procedures and final sign off by the Vehicle Coordinator.
    - Accident reporting requirements with stated documentation required and timelines for various requirements and individuals and external entities that must be advised.
    - Log to track notification of required maintenance and documentation to confirm maintenance has been conducted for inclusion in the vehicle's file.
- Flow of commuting mileage reporting, i.e., Vehicle Coordinator to advise Payroll to ensure consistency. Senior management is also considering whether several of the vehicles where commuting miles exceed the 30% usage level should be converted to pool vehicles for a more effective use of this limited asset given statewide demand for vehicles during this economically challenging period.

Updated Response: Accepted. A draft Vehicle Policies and Procedures directive is in process which will ensure consistency with existing law, rules, directives, and guidelines. In addition, the Department is now in compliance with reporting of vehicle accidents, fringe benefits for personal use of State vehicles, changes to vehicle assignments, maintaining vehicle records, or obtaining annual certifications of license and vehicle liability coverage.

19. Comply with all aspects of the requirements of the Field Sanitation Act or promptly seek legislative remedy. (Repeated-2003)

Finding: The Department did not assess fines to violators upon inspection of farm operations as required by the Field Sanitation Act.

During testing of 22 field inspections for FY14 and FY15, auditors noted all seven (100%) field inspections conducted by the Department where violations were cited failed to include an assessment of fines. The Department performed nine inspections in FY14 and 13 inspections in FY15, with no fines being assessed for either year.

During the current examination, Department management stated they deemed it unnecessary to assess fees, as violations were corrected on-site with field inspectors present. Management also stated a legislative amendment would be required to more accurately reflect field sanitation activities and regulatory actions.

Response: Accepted. Violations are corrected on-site with field inspectors present so assessing fines is unnecessary. Additionally, the State's Attorney of the county in which the violation occurs or the Attorney General is responsible for prosecuting such actions; they are unlikely to pursue cases with minimal fines. The Department will seek a legislative remedy to more accurately reflect field sanitation activities and regulatory actions.

Updated Response: Accepted. The Department continues to seek a legislative remedy to reflect field sanitation activities and regulatory actions more accurately; language has been drafted to modify the Field Sanitation Act.

20. Comply with the Code and appoint members to the Childhood Cancer Research Board to use the $70,702 in the Childhood Cancer Research Fund for the purpose intended or seek legislative remedy. Timely fill the vacancies on the Home Health and Home Services Advisory Committee as required by the statute. Seek to fill vacancies on the Health Maintenance Advisory Board as required by the HMO Act or seek legislative remedy to eliminate the Board continuation requirement. (Repeated-2011)

Finding: The Department did not comply with committee and board requirements mandated by State law.

Accepted or Implemented – continued

The Department is required by State law to ensure the composition of certain committees and boards as defined. Testing noted the Department failed to abide by the following statutory committee and board requirements during the examination period:

- The Civil Administrative Code creates the Childhood Cancer Research Board as an advisory board within the Department. The Code establishes the membership composition of the Board of 11 members. During testing, auditors noted that appointments to the Board had not been made as specified in the Code.
- The Home Health, Home Services, and Home Nursing Agency Licensing Act mandates the Director of the Department appoint a Home Health and Home Services Advisory Committee (Committee) composed of 15 persons to advise and consult with the Director on the development of rules for the licensure of home services agencies and home nursing agencies operating in the State. As of June 30, 2015, the Committee was comprised of 13 members. Two positions were vacant during some part of the examination period for two and 12 months.

Department management stated that recruiting and maintaining candidates to serve on non-paying boards can be challenging. In regard to the Childhood Cancer Research Board, the Department cited that the $70,702 in the special state fund is insufficient to implement a competitive grant application process, review of which is the purpose of the Board. According to officials, as insufficient funding to implement research grants was available, appointment and convening of the advisory board to review and recommend grant applications for funding was illogical at this time. The Board was to be funded by an Illinois income tax check-off, which was discontinued due to failure to achieve the minimum required annual check-off receipt amount. In regard to the Health Maintenance Organization Advisory Board, Department management stated the Board has not met for more than 20 years as there is no statutory requirement to do so. Given the lack of meetings over this long period of time, membership on the Board has not been kept current.

Response: The Department concurs with this finding. The Department is actively seeking to fill all vacancies who meet the vacancy criteria. Some of the recommended candidates failed to qualify for membership. The Department has been aggressively reaching out to public and private contacts for recommendations for Board appointments. The Department is continuing to follow up with the Office of Governmental Affairs for status on Governor's Office approvals or recommendations for general public members that may have an interest. Further, the Department will seek legislative remedy when needed.

21. Comply with the various reporting requirements or seek legislative remedy for statutory mandated provisions. (Repeated-1997)

Finding: The Department did not adhere to various reporting requirements established in the following laws:

- The Specialized Mental Health Rehabilitation Act of 2013 (210 ILCS 49/4-103).
- The Nursing Home Care Act (210 ILCS 45/3-804).

- The Department of Public Health Powers and Duties Law requires the Department prepare and submit to the Governor and General Assembly an annual report by January 1 each year regarding its administration of the Hospital Capital Investment Program.

Department personnel stated that, in addition to staff time necessary to prepare the reports, the importance of verifying and analyzing all the information received in order to produce a quality report is also a reason for the late submissions. Management stated delays in filing emergency rules for provisional licensure were due to additional time needed to reach consensus among nearly three dozen stakeholder groups and three State agencies. For the issue reporting on the Hospital Capital Investment Program, Department officials stated the Certificate of Need Determination was not referenced in the 2013 and 2014 annual reports due to oversight.

Response: The Department concurs with this finding. The final rules for Specialized Mental Health Rehabilitation Facilities (SMHRF) were adopted in November 2014. The 2015 General Assembly Report for 2015 was submitted by July 1, 2015. Internal controls are in place to ensure reports are submitted by due dates.

22. At least annually, assess each program accepting credit card payments, the methods in which payments can be made, and match these methods to the appropriate Self-Assessment Questionnaire (SAQ). Complete the appropriate SAQ(s) for the environment and submit documentation supporting validation efforts to the Treasurer's Office and the E-Pay program vendor. Finally, maintain contact with the Treasurer's Office to ensure sufficient knowledge and awareness of PCI Compliance status, issues, and guidance surrounding the E-Pay program.

Finding: The Department had not completed all requirements to demonstrate full compliance with the Payment Card Industry Data Security Standards (PCI DSS).

In FY14 and FY15, the Department handled over 21,500 transactions for approximately $1.96 million and over 25,700 transactions for approximately $2.9 million, respectively.

Upon review of the Department's efforts to ensure compliance with PCI DSS, auditors noted the Department had not:

- Formally assessed each program accepting credit card payments, the methods in which payments could be made, matched these methods to the appropriate Self-Assessment Questionnaire (SAQ), and contacted service providers and obtained relevant information and guidance as deemed appropriate.
- Completed a SAQ addressing all elements of its environment utilized to store, process, and transmit cardholder data.
- Submitted compliance documentation to the Treasurer's E-Pay program vendor.

Department personnel stated that due to a lack of resources and lack of complete listing of programs processing credit card transactions, PCI requirements were not complied with.

Accepted or Implemented – concluded

Updated Response: Accepted. The Department has assessed each program accepting credit card payments and the methods in which payments can be made. The Department is now in the process of obtaining or deciding which SAQ's need to be completed.

23. Develop and implement a comprehensive system development methodology and change control procedures which document current processes and ensure new system developments and modifications to existing systems are developed and implemented in a manner that ensures they are adequately planned, developed, tested, documented, approved, and implemented. Further, restrict programmer access to all production programs and data. Establish and enforce compensating controls to ensure appropriate management oversight and approval of changes, if determined that programmer access is necessary in some situations.

Finding: The Department did not have formal System Development Methodology or Change Control Procedures.

The Department had not formally implemented system development methodology and change control procedures to ensure new systems and major changes to existing systems were adequately developed, tested, documented, approved and implemented. In addition, the Department did not have an effective separation of duties for programmers developing or maintaining its computer systems.

Department personnel stated that this issue is due to the vacancy of the Chief Information Officer position and lack of knowledge and staff resources constraints.

Updated Response: Accepted. The Department is in the process of documenting its current processes and developing procedures to ensure new system developments and modifications to existing systems are developed and implemented in a manner that ensures they are adequately planned, developed, tested, documented, approved, and implemented.

24. Coordinate with the Department of Children and Family Services, the Department of Human Services, the Illinois State Board of Education, the Department of Juvenile Justice, and the Department of Healthcare and Family Services to establish and enter into an interagency agreement as required by the Custody Relinquishment Prevention Act or seek legislative remedy.

Finding: The Department was not in compliance with the Custody Relinquishment Prevention Act.

During testing, auditors noted the Department had not entered into an interagency agreement with the Department of Children and Family Services (DCFS), the Department of Human

Services, the Illinois State Board of Education, the Department of Juvenile Justice, and the Department of Healthcare and Family Services as of June 30, 2015 as required by the Act.

Department personnel stated they were unaware of the amendments made in the Custody Relinquishment Prevention Act, as the Act is under the purview of DCFS. Department personnel believed that DCFS is naturally charged with initiating an effort to comply with this section of the Act. In addition, officials stated the Department's role is unclear as the Department does not provide direct clinical services to individuals in any Department programs.

Updated Response: Implemented. The Department has entered into an interagency agreement as required by the Custody Relinquishment Prevention Act.

Emergency Purchases

The Illinois Procurement Code (30 ILCS 500/) states, "It is declared to be the policy of the State that the principles of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts...." The law also recognizes that there will be emergency situations when it will be impossible to conduct bidding. It provides a general exemption when there exists a threat to public health or public safety, or when immediate expenditure is necessary for repairs to State property in order to protect against further loss of or damage to State Property, to prevent or minimize serious disruption in critical State services that affect health, safety, or collection of substantial State revenues, or to ensure the integrity of State records; provided, however that the term of the emergency purchase shall not exceed 90 days. A contract may be extended beyond 90 days if the chief procurement officer determines additional time is necessary and that the contract scope and duration are limited to the emergency. Prior to the execution of the extension, the chief procurement officer must hold a public hearing and provide written justification for all emergency contracts. Members of the public may present testimony.

Notice of all emergency procurement shall be provided to the Procurement Policy Board and published in the online electronic Bulletin no later than three business days after the contract is awarded. Notice of intent to extend an emergency contract shall be provided to the Procurement Policy Board and published in the online electronic Bulletin at least 14 days before the public hearing.

A chief procurement officer making such emergency purchases is required to file an affidavit with the Procurement Policy Board and the Auditor General. The affidavit is to set forth the circumstance requiring the emergency purchase. The Legislative Audit Commission receives quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission is directed to review the purchases and to comment on abuses of the exemption.

During FY14 and FY15, the Department filed no affidavits for emergency purchases.

Headquarters Designations

The State Finance Act requires all State agencies to make semiannual headquarters reports to the Legislative Audit Commission. Each State Agency is required to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which official duties require them to spend the largest part of their working time.

The Department filed a report on July 7, 2015 which indicated there were no employees assigned to locations other than official headquarters. Finding No. 12 relates to the TA-2 reports filed by the Department.

REVIEW: 4467
DEPARTMENT OF PUBLIC HEALTH
TWO YEARS ENDED JUNE 30, 2015

APPENDIX A

Summary of Appropriations and Expenditures
I. By Fund

	FY15	FY14	FY13
Total Appropriations	**$ 604,074,227**	**$ 623,808,043**	**$ 548,958,892**
Expenditures			
General Revenue Fund	$ 110,692,948	$ 126,640,518	$ 121,451,186
Food & Drug Safety Fund	1,319,913	835,474	1,373,508
Penny Severns Breast,Cervical & Ovarion Cancer Research Fund	436,722	130,666	
Fire Prevention Fund	596,501	803,823	785,421
Alzheimer's Disease Research Fund	89,630	94,457	156,692
Public Health Services Fund	169,598,533	171,357,857	138,452,018
Hospital Licensure Fund	14,569	-	-
Compassionate Use of Medical Cannabis Fund	3,143,827	-	-
Community Health Center Care Fund	55,977	224,885	425,172
Safe Bottled Water Fund	-	14,665	-
Facility Licensing Fund	2,319,743	2,376,985	731,466
Heartsaver AED Fund	31,468	32,791	58,056
Illinois School Asbestos Abatement Fund	620,624	889,761	997,270
Diabetes Research Checkoff Fund	133,000	-	53,755
Carolyn Adams Ticket for the Cure Grant Fund	1,429,083	322,731	160,920
Illinois Health Facilities Planning Fund	1,863,359	1,828,924	1,675,629
Emergency Public Health Fund	3,664,310	4,251,437	4,183,658
Public Health Water Permit Fund	48,232	67,102	44,923
Nursing Dedicated & Professional Fund	1,152,637	1,200,000	1,191,936
Long Term Care Monitor/Receiver Fund	22,198,341	12,527,100	11,241,422
Home Care Services Agency Licensure Fund	1,015,681	706,213	886,450
Used Tire Management Fund	441,867	448,727	473,944
African-American HIV/AIDS Response Fund	-	1,191,167	-
Tattoo & Body Piercing Establishment Registration Fund	225,936	222,450	121,020
Public Health Lab Services Revolving Fund	2,287,286	2,836,848	1,244,199
Long Term Care Provider Fund	1,321,921	1,172,323	1,127,629
Lead Poisoning, Screening, Prevention and Abatement Fund	1,718,456	2,301,433	3,606,803
Tanning Facility Permit Fund	236,630	280,185	261,280
Plumbing Licensure & Program Fund	1,674,729	1,142,315	1,551,067
Regulatory Evaluation & Basic Enforcement Fund	30,447	25,114	23,933
Trauma Center Fund	1,433,351	4,974,032	5,128,995
EMS Assistance Fund	712,951	406,694	348,072
Multiple Sclerosis Research Fund	1,921,907	1,302,868	580,514
Quality of Life Endowment Fund	1,396,662	1,456,477	1,262,837
Health Facility Plan Review Fund	1,941,677	1,713,001	1,077,613
Pesticide Control Fund	368,306	400,787	306,230
Death Certificate Surcharge Fund	1,585,621	1,325,837	1,187,468
Healthy Smiles Fund	251,383	354,361	236,345
DHS Private Resource Fund	6,931	67,120	354,864
Assisted Living, Shared Housing Regulatory Fund	720,237	585,428	443,738
Tobacco Settlement Recovery Fund	12,496,639	12,451,090	11,887,033
Pet Population Control Fund	232,122	367	183,851
Private Sewage Disposal Program Fund	218,645	234,785	203,878

Appendix A - continued

	FY15	FY14	FY13
Public Health Federal Projects Fund	121,524	120,403	118,914
Maternal & Child Health Services Block Grant Fund	18,353,991	16,938,041	2,760,551
Preventive Health/Health Services Block Grant Fund	2,326,208	1,402,934	1,688,649
Public Health Special State Projects	19,002,192	14,159,750	6,271,263
Metabolic Screening and Treatment Fund	13,542,479	14,550,296	14,127,624
Hearing Dispenser Exam & Disciplinary Fund	70,013	94,988	92,793
Illinois State Podiatric Disciplinary Fund	49,514	48,804	-
Build Illinois Bond Fund	657,491	60,305,520	20,700,753
Total	**$ 405,772,214**	**$ 466,819,534**	**$ 361,241,342**

II. By Major Object

Expenditures	FY15	FY14	FY13
Personal services	$ 97,854,689	$ 90,949,175	$ 84,638,726
State employee retirement	21,825,009	17,533,469	16,222,337
Social Security/Medicare contributions	7,176,732	6,643,574	6,269,774
Group insurance	11,721,085	10,864,478	12,332,838
Contractual services	46,518,555	40,067,230	35,787,947
Travel	3,185,596	2,922,889	2,648,627
Commodities	167,957	179,848	226,396
Printing	7,981,779	11,002,348	8,091,987
Equipment	537,373	760,506	1,000,302
EDP	-	228	533
Telecommunication	1,834,634	2,931,136	2,351,865
Operation of auto equipment	143,887	181,880	187,919
Interest-Prompt Payment	2,592	2,550	13,416
Interfund cash transfers	679,000	679,000	700,000
Awards and grants	206,090,978	282,064,262	190,717,115
Remodeling and renovation	-	-	14,339
Refunds	52,348	36,961	37,221
Total Expenditures	**$ 405,772,214**	**$ 466,819,534**	**$ 361,241,342**

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APPENDIX B

Summary of Cash Receipts

General Revenue Fund	FY15	FY14	FY13
Fees and Licenses	$ 42,627,205	$ 39,103,210	$ 38,062,648
Federal Grant Revenue	188,981,649	186,600,273	141,590,234
Non-Operating	408,565	632,920	474,911
Other Revenue			
Fines and Penalties	1,380,374	1,195,304	2,386,377
Interest	-	-	3,883
Scholarships	172,474	264,145	239,642
Swimming Facilities	206,270	321,388	264,292
Third Party Reimbursements	484,718	471,373	612,576
CMS vs AFSCME Wages Trust Fund	-	-	2,881,021
Long Term Care	1,253,849	893,948	-
Long Term Civil Penalties	1,095,139	793,380	689,579
Pharmaceutical Rebates	3,588,622	6,800,992	3,936,463
Healthcare & Family Services	18,268,039	7,415,385	18,874,112
Other, Miscellaneous	1,494,720	1,146,047	1,448,281
Total Cash Receipts	**$ 259,961,624**	**$ 245,638,365**	**$ 211,464,019**

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APPENDIX C

Changes in State Property

	FY15	FY14
Balance, July 1	**$ 23,430,607**	**$ 24,203,009**
Additions	1,916,132	1,867,587
Deductions	(237,377)	(294,119)
Transfers	(1,373,030)	(2,345,870)
Balance, June 30	**$ 23,736,332**	**$ 23,430,607**

APPENDIX D

Summary of Activities and Performance Indicators

	FY15	FY14
Health Protection		
Number of prescriptions filled through AIDS Drug Assistance Program (ADAPT)	115,186	152,199
Number of lead poisoning cases investigated	1,293	1,520
Total newborn screening tests performed	1,937,902	1,910,000
Number of all other lab tests performed	483,995	610,000
Number of children screened for blood lead poisoning	263,230	277,669
Number of children referred for lead following up exceeding 10 mcg/dl	2,279	3,055
Immunization rates for all children under 2 years of age including Chicago	45%	76%
Total newborn screening test results reported	178,040	1,600,000
Preparedness and Response		
Number of trauma cases	42,865	48,811
Number of hospitals designated as trauma centers	66	66
Health Care Regulation		
Number of licensed LTC beds	-	-
Number of complaints received against LTC facilities	5,471	4,137
Number of LTC facility annual inspections	993	977
Number of LTC state licensed facilities (as of July 1)	1,424	1,097
Number of residents served in a long term facility	72,841	-
Percent of Long Term Care facilities in compliance at annual inspection	7%	39%
Number of Long Term Care facilities with a licensure Type "A" violation	88	64
Health Promotion		
Number of newborns screened or genetic/metabolic disorders	177,994	157,500
Number of vision and hearing screenings performed	150,899	NA
Number of preshool children vision screens statewide	157,267	NA
Percentage of newborns screened	-	-
Number of infants confirmed with genetic/metabolic conditions	350	307
Women's Health		
Number of requests to Women's Health Helpline	202	4,600
Number of women receiving screening services	25,000	27,142
Percent of women with abnormal breast screening results who received diagnostic follow-up	97.8%	NA
Percent of women with abnormal Pap screening results who received diagnostic follow-up	98.4%	NA
Policy, Planning & Statistics		
Number of new students awarded nursing scholarship award and number of continuing nursing scholarship awards	110	NA
Estimated number of hours providers of patients seen by providers is shortage areas	72,000	-