LEGISLATIVE AUDIT COMMISSION

October 28, 2025

Meeting Room Access
(LAC Members, Auditors, Invited Agency Officials and Media Personnel)

Live Streaming for Public and Media Viewing for the Meeting at:

https://lac.ilga.gov/commission/lac/lac_home.html

Time: 9:00 am

Location: 114, Capitol Building Springfield, Illinois

AGENDA

I. Review of Audits

A. Office of the State Fire Marshal FY 21-22 Compliance Audit - Review #4594

B. Department of Public Health FY22-23 Compliance Audit - Review #4595

C. University of Illinois FY23 Compliance Audit - Review #4596

II. Consent Calendar

III. Minutes from LAC Meeting October 14, 2025

IV. Other Items

A. Department of Human Services FY20-21 Compliance Audit
B. Department of Human Services FY22-23 Compliance Audit
C. Community Integrated Living Arrangement Program Performance Audit
D. Department of Human Services Office of Inspector General Performance Audit

V. Acknowledgement Report

A. Auditor Generals' Quarterly Report: FY 25 Lapse Period, FY 26 Q1

LEGISLATIVE AUDIT COMMISSION

Review of
Office of the State Fire Marshal
Two Years Ended June 30, 2022

620 Stratton Office Building
Springfield, Illinois 62706
217/782-7097

REVIEW: #4594
OFFICE OF THE STATE FIRE MARSHALL
TWO YEARS ENDED JUNE 30, 2022

RECOMMENDATIONS – 23

IMPLEMENTED/PARTIALLY IMPLEMENTED – 22*
UNDER STUDY – 1*
***(A few findings were listed as both partially implemented and under study)**

REPEATED RECOMMENDATIONS – 14

PRIOR AUDIT FINDINGS/RECOMMENDATIONS – 21

This review summarizes the auditors' report of Office of the State Fire Marshal for the two years ended June 30, 2022 filed with the Legislative Audit Commission on December 21, 2023. The auditors conducted a compliance examination in accordance with state law and Government Auditing Standards.

The Office of the Illinois State Fire Marshal (OSFM) was created through an Act of the General Assembly on June 15, 1909. The Act required the Governor to appoint a State Fire Marshal who would be responsible for overseeing the agency. The initial charge to the agency was to inspect buildings to ensure they were safe from dangerous conditions, as well as to conduct cause and origin investigations of fires and, if evidence existed, to require the arrest of individuals for the crime of arson. In order to fund the operations of the agency, the General Assembly established a tax to be paid by insurance companies on the gross premium receipts collected on fire insurance policies. This tax still exists today and remains the primary funding source for the agency.

The Office provides its services through the following operating divisions:

- Arson Investigation
- Fire Prevention and Building Safety
- Boiler and Pressure Vessel Safety
- Petroleum and Chemical Safety
- Personnel Standards & Education
- Elevator Safety
- Technical Services

The Office is located in Springfield, with additional offices in Chicago and Marion, Illinois. The Chicago office was moved from the JRTC to 555 W. Monroe in Chicago.

Mr. Matthew Perez served as State Fire Marshal during the audit period. James Rivera was appointed in February 2023 and served until Michele Pankow was appointed in June 2025. Michele Pankow is the first woman to hold the position and previously served as

the first female Fire Chief of the Rockford Fire Department. She began her career with the Rockford Fire Department in 1992 as a Firefighter/Paramedic/EMT.

Appropriations and Expenditures

Appropriations ($ thousands)	FY21		FY22	
	Approp	Expend	Approp	Expend
OTHER STATE FUNDS				
Personal Services	26,233.6	21,933.7	25,603.9	23,951.3
Contractual Services	1,531.9	1,419.0	1,511.9	1,423.1
Other Operations	3,536.3	3,273.3	3,451.3	3,239.0
Designated Purposes				
Community Risk Reduction	50.0	3.7	50.0	17.7
Computer-Based Firefighter Certification Test.	170.0	54.6	590.0	157.6
Cornerstone	350.0	350.0	350.0	350.0
Explorer-Cadet Program	65.0	27.1	65.0	65.0
Firefighter Online Training Mgmt. System	195.0	190.0	380.0	380.0
Firefighter Training Programs	280.0	280.0	230.0	230.0
IL Firefighter Peer Support	60.0	0.0	60.0	60.0
Medal of Honor Ceremony, Scholarships, and Memorial Maintenance	200.0	122.9	200.0	200.0
Minimum Basic Firefighter Training	1,000.0	1,000.0	1,000.0	1,000.0
Senior Officer Training	55.0	14.5	55.0	0.0
Total Designated Purposes	2,425.0	2,042.8	2,980.0	2,460.3
Grants				
Chicago Fire Depart. Training Program	3,041.6	3,041.6	3,279.8	3,279.8
Development of New Fire Districts	0.5	0.0	0.5	0.0
Hazardous Materials Emergency Resp. Reimbursement.	10.0	0.0	10.0	0.0
IL Fire Department COVID Asst. Grants	0.0	0.0	1,000.0	327.2
Mutual Aid Box Alarm System Admin. Costs	125.0	125.0	240.0	240.0
Payment To Local Gov't Agencies that Participate in State Training Programs	950.0	665.0	1,450.0	1,450.0
Small Equipment Grant Program	3,500.0	3,474.0	2,500.0	2,499.9
Supplemental Payment to reimburse Local Gov't Associated with Training	500.0	500.0	0.0	0.0
Underground Storage Tank Prog. In Chicago	550.0	550.0	550.0	550.0
Total Grants	8,677.1	8,355.6	9,030.3	8,346.9
Capital Improvements				
Fire Museum Building Rehabilitation	2,000.0	0.3	2,000.0	0.0
Maintenance & Rehab. Of Museum Bldg. & Artifacts	75.0	0.0	75.0	0.0

Total Capital Improvements	2,075.0	0.3	2,075.0	0.0
TOTAL OTHER STATE FUNDS	**44,478.9**	**37,024.7**	**44,652.4**	**39,420.6**
FEDERAL FUNDS				
U.S. Resource Conservation Recovery Act Underground Storage Tank Program	1,000.0	522.4	1,000.0	818.6
TOTAL FEDERAL FUNDS	**1,000.0**	**522.4**	**1,000.0**	**818.6**
TOTAL	**45,478.9**	**37,547.1**	**45,652.4**	**40,239.2**

Accountants' Findings and Recommendations

Condensed below are the 23 findings and recommendations included in the audit report. Of these, 14 are repeated from the previous audit. The following recommendations are classified on the basis of information provided by the Office of the State Fire Marshal, via electronic mail received December 21, 2023.

1. The auditors recommend the Office work with the Department of State Police to obtain arsonist registration information and create a hyperlink/database that can be published and made available for the public via the Office's website, or seek a legislative remedy.

FINDING: *(Failure to Establish and Maintain a Statewide Arsonist Database) – First reported 2016, last reported 2022.*

The Office of the State Fire Marshal (Office) did not establish and maintain a Statewide Arsonist Database or make such database available to the public via its website as required by the Arsonist Registration Act (Act).

The Act (730 ILCS 148/60(b)) requires the Department of State Police to furnish to the Office the registration information concerning persons who are required to register under the Act. Then, the Office is to establish and maintain a Statewide Arsonist Database for the purpose of making that information available to the public on the Internet by means of a hyperlink labeled "Arsonist Information" on the Office's website.

This finding was first noted in the Office's State Compliance Examination for the two years ended June 30, 2016. Office management has been unsuccessful in implementing a corrective action plan to remedy this condition.

Office management indicated, as it did during prior examinations, that due to a lack of funding, the Department of State Police has not provided the Office with arsonist registration information. Therefore, the Office has been unable to establish a Statewide Arsonist Database and publish it on the Office's website.

Failure to establish and maintain a Statewide Arsonist Database and make such a database available to the public via the Office's website represents noncompliance with the Act and limits public awareness of arsonist information.

OFFICE RESPONSE:
The Office accepts the finding. As noted in the Act, the Department of State Police (ISP) is required to provide the Office with registration information of persons who are required to register under the Act. This information is not currently being collected by ISP nor being sent to the Office. Once the Office begins receiving Arsonist registration information from ISP, a hyperlink titled "Arsonist Information" will be included on the State Fire Marshal website, and the information will be made available to the public.

UPDATED RESPONSE:
Implemented. The Office has included a hyperlink on our website where Arsonist Registration Information will be made available to the public, once the information has been provided to the Office by the Illinois State Police.

2. **The auditors recommend the Office implement controls to obtain sufficient information about responsible parties to enable the collections of accounts receivable, or seek a legislative remedy to require up-front payment for an inspection at the time when an inspection is scheduled. Further, the Office should refer qualifying debt to the Bureau for external collection efforts.**

FINDING: *(Inadequate Controls over Fees and Accounts Receivable) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not exercise adequate controls over its collection of fees and accounts receivable.

During testing, auditors noted the following:

- During review of the Office's process for collecting inspection fees for boilers and pressure vessels, auditors noted the Office lacked an adequate process for identifying the party responsible for paying the fee. The Office has three ways for triggering an inspection by the Office, each of which lacked a process to gather all information needed to collect on the resulting account receivable, such as the identity of the responsible party and its corresponding taxpayer identification number (TIN). Then, when the actual inspection occurs, the Office's inspector only confirms the mailing address and, if the person providing the inspector access to the boiler is willing to provide it, the e-mail address for the entity that pays the building's costs. After the inspection, the Office sends an invoice to the address confirmed by the inspector and, if the amount is not timely paid, the Office sends quarterly statements demanding payment.

  Under this process, the Office does not gather enough information to establish and collect each account receivable as established by the Illinois State Collection Act

of 1986. The Illinois State Collection Act of 1986 (30 ILCS 210/5(c-1) and (g)) requires the referral of all debts of $250 or more and 90 days past due to the Office of Comptroller's Offset System and the referral of all delinquent debt to the Department of Revenue's Debt Collection Bureau (Bureau).

In order to refer debt to the Office of Comptroller's Offset System, the Statewide Accounting Management System (SAMS) Manual (Procedure 26.40.20) requires the Office to provide the debtor's name and federal employer's identification number (FEIN) or social security number (SSN).

In order to refer delinquent debt to the Bureau, the Illinois Administrative Code (74 Ill. Admin. Code 1200.60(e)) requires the Office to provide the Bureau with information about the debtor. For individuals, this includes the debtor's identity, address, and social security number. For businesses, this includes the debtor's name and business organization type, the business's federal employer identification number, and the social security numbers of the officers of the business.

The SAMS Manual (Procedure 26.20.10) notes detailed information related to an account receivable is needed to support the recognition and tracking of receivables. The SAMS Manual recommends maintaining, at a minimum, (1) the debtor's name, FEIN or SSN, and last known address, (2) the amount owed and the nature of the debt, (3) the initial due date, and (4) documentation of all collection efforts.

Both in the prior examination and the current examination, Office personnel stated the Office does not believe it is cost effective to collect all of the information required to identify the party responsible for paying the receivable.

- For all remaining fees, the Office did not refer any of its delinquent accounts receivable to the Bureau. The Illinois Administrative Code (74 Ill. Admin. Code 1200.50) defines delinquent debt as all amounts owed of $10 or more which are more than 90 days past due.

  Both in the prior examination and the current examination, Office personnel stated, the Office does not believe it is cost effective to refer delinquent accounts to the Bureau.

Finally, this finding was first noted in the Office's State Compliance Examination for the two years ended June 30, 2018. Office management has been unsuccessful in implementing a corrective action plan to remedy this condition.

On its June 30, 2022 accounts receivable reports, the Office reported receivables totaling $11.812 million, including $11.638 million reported as more than 90 days past due.

Failure to gather adequate information about the responsible party to enable the establishment of accounts receivable could result in lost revenue or delayed cash collections for the State. Further, failure to refer qualifying delinquent debt to the Bureau could result in the State realizing less cash than possible from its account receivable and represents noncompliance with State laws and regulations.

OFFICE RESPONSE:
The Office agrees with the finding. The Office has been aware that it does not collect sufficient detail for boiler inspection fees to verifiably identify the party responsible for the receivable. There are often issues determining what party maintains ultimate responsibility for a boiler or pressure vessel. Neither state statute nor administrative rule gives the Office authority to mandate that a TIN is provided to the Office. Without this information it is difficult to file an offset or engage in other collection methods for delinquent invoices. The Office will continue to examine this issue and work on ways that it may be able to obtain the information necessary to file offsets for overdue boiler and pressure vessel inspection invoices. However, the Office does not believe that requiring upfront payment for inspections is the appropriate solution.

As to referrals to the Department of Revenue's Debt Collection Bureau, the Office in the past has engaged the services of collection agencies identified by the Bureau. The Office had no success in utilizing these services and determined that the administrative work necessary to engage these services is not a good use of time. The Office refers the largest portion of its accounts receivable (underground storage tank fines and penalties) to the Comptroller's offset system and the Office has been successful at receiving some payments utilizing this system.

UPDATED RESPONSE:
Under Study. Boilers doesn't have the ability to collect necessary information to collect all fees. A legislative remedy is thought to take a year or longer. For reporting of delinquent accounts to IDOR's Debt Collection Bureau, the office will review to determine if there is a feasible and cost-effective method to do so.

3. **The auditors recommend the Office work with the Governor and General Assembly to ensure sufficient resources exist to timely conduct public school building inspections. In addition, the Office should enhance its internal controls to provide assurance violation reports are timely sent to the school's applicable superintendent. Further, the Office should ensure copies of all inspections performed are retained.**

FINDING: *(Failure to Perform School Fire Inspections or Report Violations) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not perform all inspections of public schools or always report identified violations to the regional superintendents (superintendent).

During testing, auditors noted the following:

- The Office did not perform annual fire safety inspections of each public school within the State. The auditors noted 807 of 3,420 (24%) and 185 of 3,393 (5%) schools were not inspected during Fiscal Year 2021 and Fiscal Year 2022, respectively.

  The School Code (Code) (105 ILCS 5/3-14.21(c)) requires the Office, or a qualified fire official to whom the Office has delegated its authority, to conduct an annual fire safety inspection of each school building in this State.

- The Office did not have sufficient controls in place to ensure violations identified during school inspections performed by qualified fire officials to whom the Office delegated its authority during the examination period were sent to the superintendent within 15 days of the completed inspection. In cases where local fire departments performed the necessary inspections, the Office relied on the local fire department to communicate the noted violations to the regional superintendent of schools, and the Office did not receive documentation to substantiate such communication had occurred in all instances.

  The Code (105 ILCS 5/3-14.21(c)) requires the Office to report any violations in writing to the superintendent and reference the specific code selection where a discrepancy has been identified within 15 days after the inspection has been conducted. Furthermore, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with the applicable law.

- Fifty-four of 60 (90%) sampled inspections of public schools conducted by the Office or a qualified official to whom the Office has delegated its authority during the examination period contained violations noted by the inspector. For those 54 inspections containing violations, auditors noted the following:
  - Eight (15%) reports with violations did not have evidence the report had been submitted to the superintendent.
  - One (2%) report with violations was reported to the superintendent 2 days late.

The Code (105 ILCS 5/3-14.21(c)) requires the Office, or a qualified official to whom the Office has delegated its authority, to report violations in writing to the superintendent within 15 days after the inspection was conducted, which triggers a requirement for the superintendent to address violations not timely corrected. Under the Code (105 ILCS 5/3-14.21(b)), if a superintendent finds a school board failed to timely correct a violation, the superintendent shall order the school board to adopt and submit a plan to the superintendent for the immediate correction of the violation. The school board must adopt this plan after conducting a public hearing where notice of the meeting was given in a

newspaper of general circulation within the school district. If, during the next annual inspection, the superintendent finds the violations have not been corrected, the superintendent must submit a report to the State Board of Education recommending withholding of the school district's general State aid or evidence-based funding so the superintendent can enter into contracts to correct the outstanding violations. During a hearing, after providing notice to both the superintendent and the school board, the State Board of Education can order the diversion of State fund to the superintendent to correct the violations.

- The Office was unable to provide supporting documentation for 1 of 60 (2%) inspections performed. As such, auditors were unable to determine whether the inspection was coordinated with the regional superintendent, the inspection was based on the fire safety code authorized in the Code (105 ILCS 2-3.12), and whether any violations were noted and if so, whether violations were reported to the regional superintendent in writing within 15 days after the inspection and referenced specific code sections where the discrepancy was identified.

  The Code (105 ILCS 5/3-14.21(c)) requires the Office, or a qualified fire official to whom the Office has delegated its authority, to conduct an annual fire safety inspection of each public-school building in the State. The inspection shall be coordinated with the regional superintendent and based on the fire safety code authorized in Section 2-3.12 of this code. Any violations shall be reported in writing to the regional superintendent and reference the specific code selections where a discrepancy has been identified within 15 days after the inspection has been conducted. Additionally, the State Records Act (5 ILCS 160/8) requires the Office to make and preserve records containing adequate and proper documentation of the organization's functions.

Finally, this finding was first noted in the Office's State Compliance Examination for the two years ended June 30, 2018. Office management has been unsuccessful in implementing a corrective action plan to remedy this condition.

As in the prior year examination, Office management indicated they do not have the resources necessary to ensure all schools within the State are inspected annually. Office management also indicated the fire department is responsible for sending the inspection report to the applicable superintendent. Additionally, the fire inspection system used by the Office lacks the necessary controls to ensure that fire departments are submitting violations to superintendents as required.

Failure to perform fire safety inspections at all public schools and properly report violations increases the risk that schoolchildren are being educated in dangerous and unsafe conditions and represents material noncompliance with the Code.

OFFICE RESPONSE:
The Office agrees with the finding. The Office has implemented a new internal procedure to ensure all public schools are inspected annually and achieved 100% compliance during

the last school year. Additionally, the Office believes it has identified a method to ensure when qualified fire officials (QFOs) complete inspections, the QFO's will be able to email the school Superintendents directly. Should a report that is sent to the Office that does not show the report being sent to the Superintendent, the report will be sent back to the QFO's to properly complete. Finally, the Office will continue its efforts to ensure that documentation of all inspections is retained and available for review.

UPDATED RESPONSE:
Partially Implemented. 100% of School Inspections were performed in Fiscal Year 2023, this part of the finding has been corrected. As for the inspection reports being sent by local QFO's to school superintendents, each report gets sent to OSFM and is reviewed. Training will be provided to local QFO's inspecting schools to ensure that they are aware to send inspection reports to both the Regional Superintendent and the Office's Fire Prevention Division. If OSFM is unable to determine that a report was emailed to the Superintendent, then the report will be rejected and will need to be resubmitted. Finally, the Office will continue its efforts to ensure that all inspection reports are retained.

4. The auditors recommend the Office work with the Department to formally reduce the agreements to perform inspections on the Office's behalf to writing.

FINDING: *(Lack of Interagency Agreements with the Department of Public Health) – First reported 2020, last reported 2022.*

The Office of the State Fire Marshal (Office) did not have interagency agreements with the Department of Public Health (Department) to ensure fire safety inspections were being performed to comply with licensing requirements for various facilities.

The following statutes (collectively, the Acts) require the Office to perform necessary fire inspections of various facilities to comply with licensing requirements:

- Community Living Facilities Licensing Act (210 ILCS 35/8.5),
- MC/DD Act (210 ILCS 46/3-216), and
- ID/DD Community Care Act (210 ILCS 47/3-216).

In addition, the Acts indicate the Office may enter into an agreement with another State agency to conduct fire safety inspections if qualified personnel are employed by the agency.

The auditors testing indicated the Office did not enter into formal interagency agreements with the Department to ensure the required fire safety inspections were being performed by qualified personnel. As a result, the auditors could not conclude if the Office performed any inspections of the facilities licensed under the Acts.

During the prior and current year examinations, the Office management indicated the Department has adopted the responsibility for conducting inspections of community living

facilities, medically complex facilities for the developmentally disabled, and intermediate care facilities for the developmentally disabled, but an interagency agreement for the Department to assume that responsibility had not been formally reduced to writing.

As the Office has the overarching responsibility to ensure the inspections are being performed, failure to develop formal interagency agreements detailing the relationship between the Office and the Department increases the risk of inspections not being performed as required at each licensed facility and represents noncompliance with State law.

OFFICE RESPONSE:
The Office agrees with the finding. The Office will continue its efforts to work with the Department of Public Health to enter into a formalized agreement outlining each party's responsibilities in relation to the Act.

UPDATED RESPONSE:
Partially Implemented. The Office has submitted two IGA's to IDPH to address this finding. Once signatures are obtained, this finding will be resolved. This is expected to be remedied prior to the end of Fiscal Year 2024.

5. The auditors recommend the Office conduct annual inspections as required by the Act. Additionally, they recommend the Office implement measures to ensure populations provided to facilitate sample selection are accurate and complete.

FINDING: *(Inadequate Controls over Boiler and Pressure Vessel Inspections) – First reported 2020, last reported 2022.*

The Office of the State Fire Marshal (Office) did not have sufficient controls over the performance of inspections required by the Boiler and Pressure Vessel Safety Act (Act).

After selecting a sample of power boilers under the Office's jurisdiction during the examination period and testing the required inspections, auditors noted 15 of 56 (27%) items selected for testing were not power boilers and were instead historical boilers, such as traction engines, used solely for exhibition purposes and subject to different inspection requirements than power boilers. As such, these items should not have been included within the requested population of power boilers. Additionally, after selecting a sample of low-pressure steam heater boilers under the Office's jurisdiction during the examination period and testing the required inspections, auditors noted 1 of 16 (6%) items selected for testing was a power boiler, which is subject to different inspection requirements than low pressure steam heater boilers. As such, this item should not have been included within the requested population of low-pressure steam heater boilers. Furthermore, after selecting a sample of pressure vessel systems under the Office's jurisdiction during the examination period and testing the required inspections, auditors noted 2 of 60 (3%) items selected for testing were constructed subsequent to the examination period. As such,

these items should not have been included within the requested population of pressure vessel systems.

Due to these conditions, the auditors were unable to conclude whether the Office's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36) to test the Office's power boiler inspections, low pressure steam heat boiler inspections, and pressure vessel system inspections.

Even given the population limitations noted above which hindered the auditor's ability to conclude whether selected samples were representative of the population as a whole, they performed testing and noted the following:

- For 27 of 76 (36%) annual internal power boiler inspections required for the 38 boilers selected for testing, the inspection was not performed by the Office or an external special inspector.

  The Act (430 ILCS 75/10(a)(1)) requires power boilers proposed to be used within the State be inspected by the Office or an external special inspector annually. Annual inspections are required for both internal and external inspections of power boilers while they are not under pressure, and external inspections of power boilers while they are under pressure, if possible.

- For 3 of 60 (5%) low pressure boiler systems, including low pressure hot water heating boilers, low pressure hot water supply boilers, and low-pressure steam heater boilers, selected for testing, the Office failed to perform the required biennial inspections.

- For 1 of 60 (2%) low pressure boiler systems, including low pressure hot water heating boilers, low pressure hot water supply boilers, and low-pressure steam heater boilers, selected for testing, the Office failed to perform an inspection of the system prior to the expiration of the related certificate. The inspection was performed 167 days after the previous certificate expired.

  The Act (430 ILCS 75/10(a)(2)) requires low pressure hot water heating boilers, low pressure hot water supply boilers, and low-pressure steam heater boilers to be inspected biennially. Good internal controls should ensure inspections are performed prior to the expiration of the previous inspection.

- For 21 of 60 (35%) pressure vessel systems selected for testing, the Office failed to perform an inspection of the system prior to the expiration of the related certificate. The inspections were performed 3 to 267 days after the previous certificates expired.

  The Act (430 ILCS 75/10(a)(4)) requires pressure vessels not subject to internal corrosion to receive a certificate inspection every three years. Good internal

controls should ensure inspections are performed prior to the expiration of the previous inspection.

- For 3 of 14 (21%) traction steam engine boilers and other boilers selected for testing, the Office failed to perform the required inspections every two years.

  The Act (430 ILCS 75/10(a)(3)) requires traction steam engine boilers and other boilers constructed before the effective date of the Act and operated solely for exhibition purposes to be inspected every two years.

Office management indicated the error noted with the population of low-pressure boiler systems was due to the inability of the Office's database to separate certain types of categories of systems by high or low pressure. Additionally, Office management indicated the error noted with the population of pressure vessel systems is due to employee oversight. Moreover, Office management indicated the responsibility to have a boiler or pressure vessel system inspected prior to operation lies with the owner/user. Office management further indicated inspection timing and scheduling are greatly impacted by access and availability in stored locations. Finally, Office management indicated failure to perform inspections prior to the expiration of the related certificate is due to employee oversight.

Failure to perform timely required inspections of boiler systems and pressure vessel systems used or proposed to be used in the State as required by the Act represents a risk of compromising the safety of the general public. Further, without the Office providing complete and accurate documentation to enable testing, the accountants were impeded in completing their procedures and providing useful and relevant feedback to the General Assembly regarding the Office's compliance with the Act.

OFFICE RESPONSE:

The Office accepts the finding. There are system limitation issues in how the Boilers are categorized, in the Office's existing system. The Office is in current contract negotiations with a new database that would resolve issues of category population. The Office would like to note that the owner-user of the boiler system is responsible for scheduling inspections of their equipment. Additionally, during FY22, the Office had an open inspector position all year, and that work was being performed by a team with other inspectors. Each finding bullet is addressed below:

- For the 27 of 76 internal power boilers that weren't inspected by either the Office or an external special inspector, the Office agrees with 16 of the inspection reports not being available. We feel that we provided support for the other 12. One reason for 7 of the 12 is that the Office doesn't have copies of these inspections, possibly because the boiler(s) were in compliance and the boiler or pressure vessel was not determined to be unsafe or in violation of rules, therefore, not required to be provided to the Office.

- For the 3 of 60 (5%) of low-pressure boiler systems where the Office failed to perform biennial inspections, we agree that two inspections were not performed. The third inspection relates to a boiler that was manufactured in 2019 and a first-time inspection was completed in October of 2022. That report was provided, but it does not indicate "initial inspection' on the report, so it remained an audit issue. The Office believes this boiler system to have been in compliance.

- For the 1 of 60 (2%) low pressure boiler systems that was not completed prior to the expiration of the certificate, the Office agrees.

- The Office agrees that 21 of 60 (35%) pressure vessel systems had inspections performed after certificates expired.

- For the 3 of 14 (21%) of traction steam engine boilers that did not have inspections performed every two years, the Office agrees; however, Traction Engines are generally operated anywhere from one day to a week for the entire year. The inspection timing and scheduling with owners are greatly affected by access and availability in stored locations.

UPDATED RESPONSE:
Partially Implemented. Boilers is transitioning to a new system that should assist with the search functionality related to various Boiler types, the Office believes this will ultimately correct the sample issues. The expected timeframe to be on the new system is June 30, 2025. Training will be provided to remind inspectors that Internal and External inspections are required and the timeframes required for each. The Boiler and Pressure Vessel Safety Division being fully staffed should also help remedy this issue.

6. The auditors recommend the Office routinely review access rights to its applications and data to ensure only authorized users have access and to prevent unauthorized use. They also recommend the Office retain accurate and complete populations of application users.

FINDING: *(Inadequate Controls over Access Rights) - New*

The Office of the State Fire Marshal (Office) did not maintain adequate controls over termination and review of access to its applications and data

During their testing, auditors noted the Office:

- Could not provide a population of application users of the Attendance Tracking System during the examination period. Office personnel indicated the population of application users was the same as the population of employees during the examination period. However, the auditors were unable to verify whether all employees included within the population of employees had access to the

application, or whether the population of employees includes individuals who did not have access to the application.

Due to these conditions, auditors were unable to conclude the Office's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36). Even though the Office's population of application users could not be relied upon, the auditors tested a sample of users' access rights, noting no exceptions.

- Did not routinely review access rights to the Attendance Tracking System, Central Payroll System, Personnel Standards and Education System, or Underground Storage Tank (UST) Inspection and Contractor Licensing System.

- Did not terminate access for a former employee who continued to have access rights to the Office's evidence tracking system.

  The Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST), Access Controls section, require entities to develop access provisioning policies and procedures and establish controls to ensure authorized users only have needed access.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Office management indicated they believed a review of access to various systems in conjunction with employee onboarding and offboarding as adequate for an agency their size.

Inadequate internal controls over access to the Office's applications and data could lead to unauthorized access and unauthorized use of its applications and related data.

OFFICE RESPONSE:
The Office accepts the finding. The Office believes that the informal process in place to review access rights as employees are onboarding and offboarding is an adequate process for an agency our size. A user population for the Office systems noted in the finding will be printed each June 30th moving forward. Finally, we agree that a former employee still had access rights to the Evidence Tracking System. We would like to point out that the individual was the recently retired Arson Division Manager. Also, the system resides in a secure room within the Office building that would not have been accessible as badge access had been revoked.

UPDATED RESPONSE:
Partially Implemented. The Office has a draft policy in place to address access rights reviews. The policy is expected to be finalized in April, with rights reviews beginning prior to the end of Fiscal Year 2024. The Office believes it provided a full population of employees during the audit.

7. The auditors recommend the Office implement and document formal change management policies and procedures to control changes to their applications and data. In addition, they recommend the Office implement compensating controls to mitigate the segregation of duties weakness.

FINDING: *(Inadequate Internal Controls over Applications) - New*

The Office of the State Fire Marshal (Office) failed to implement internal controls over changes to its applications and data.

During their testing, auditors noted the Office:

- Did not have change management policies and procedures to control changes to their applications and data.

  The Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST) (Special Publication 800-53, Fifth Revision), Configuration Management section, requires entities to develop and document a change management policy that addresses purpose, scope, roles, and responsibilities in change management.

- Did not document mitigating controls for an inadequate segregation of duties identified in the auditors testing. The auditors noted two Office employees had access to and overlapping roles within the Office's evidence tracking software, and while the software maintains an audit trail to document actions taken by individuals within the system, the Office was unable to provide documentation substantiating any independent reviews of the actions taken within the system were performed during the examination period.

  The Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST) (Special Publication 800-53, Fifth Revision), Configuration Management section, requires entities to implement internal controls to ensure proper segregation of duties.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls

to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation and to maintain accountability over the State's resources.

Office management indicated they believed the change management practice used was adequate for an agency their size. Office management also indicated compensating controls exist related to the evidence tracking software which they also believed to be adequate.

Failure to implement internal controls over changes to applications and data could result in unauthorized changes being made. Further, failure to ensure an adequate segregation of duties puts the validity of the evidence tracking at risk.

OFFICE RESPONSE:
The Office accepts the finding. The Office believes that managing the contractually paid IT staff via status reports, regular meetings, etc. is an adequate method to monitor internal controls over applications. The Office will work to develop documentation of testing system changes as well as acceptance/approval of system changes. Additionally, the Office will work to provide auditors assurances that the Evidence Tracking information is monitored and duties are segregated.

UPDATED RESPONSE:
Partially Implemented. The Office is in the process of determining the best way to document these changes, and what systems/changes should be included in such documentation. The Office has implemented a more formal review process to document mitigating controls related to the Evidence Tracking System.

8. **The auditors recommend the Office implement controls to provide assurance:**
   1. **Vehicles receive required maintenance in a timely manner;**
   2. **Maintenance records are complete and accurate;**
   3. **Motor vehicle accidents are timely reported to DCMS;**
   4. **Vehicle mileage records are carefully reviewed for errors and discrepancies; and,**
   5. **The vehicle use policy includes procedures regarding daily vehicle use logs.**

FINDING: *(Inadequate Controls over State Vehicles) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not maintain adequate controls over the administration of its State Vehicles. More specifically, the following issues were noted.

Vehicle Maintenance Testing

During their testing of maintenance records for State vehicles, auditors noted the following:

- 20 of 26 (77%) vehicles tested did not have routine oil changes performed within the mileage or time intervals required by the Department of Central Management Services (DCMS). The oil change overages ranged from 57 to 29,449 miles beyond the allowed interval. For these 20 vehicles, the number of untimely oil changes noted for each vehicle ranged from one to nine instances during the examination period.

- 6 of 26 (23%) vehicles tested did not have any support for oil changes during the period. Each of these vehicles met the mileage requirement for at least one oil change during the period.

  The DCMS' Vehicle Usage Policy requires standard lube, oil, and filter changes to be performed every 5,000 miles or 12 months, whichever comes first for vehicles nine years old and newer.

- 20 of 26 (77%) vehicles tested did not have routine tire rotations performed within the mileage or time intervals required by the DCMS. The tire rotation overages ranged from 874 and 24,449 miles beyond the allowed interval. For these 20 vehicles, the number of untimely tire rotations noted for each vehicle ranged from 1 to 3 instances during the examination period.

- 4 of 26 (15%) vehicles tested did not have support for the required tire rotations during the period. Each of these vehicles met the mileage requirement for at least one tire rotation during the period.

  The DCMS' *Vehicle Usage Policy* requires tire rotations to be performed on all passenger vehicles at every other oil change.

- 16 of 26 (62%) vehicles tested did not receive an annual inspection as required by DCMS during Fiscal Year 2021, and 11 of 26 (42%) vehicles tested did not receive an annual inspection as required by DCMS during Fiscal Year 2022.
  The DCMS' *Vehicle Usage Policy* requires State vehicles to undergo an annual inspection each fiscal year by a DCMS garage or an authorized vendor.

  The Illinois Administrative Code (Code) (44 Ill. Admin. Code 5040.400) requires all State-owned or leased vehicles to undergo regular service and/or repair in order to maintain the vehicles in road-worth, safe, operating condition.

Accidents Involving State Vehicles

During their testing of accidents involving State vehicles, auditors noted the following:

- The population of accidents occurring during the examination period provided by Office personnel was not complete and accurate. The listing excluded one accident they were subsequently able to locate support for. This accident did occur during the examination period but was not reported to the DCMS.

  Due to these conditions, the accountants were able to conclude the Office's population records for operation of automobile accidents were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C §205.36).

- The Office did not timely file its Motorist's Report of Illinois Motor Vehicle Accident Reports (Form SR-1s) for 3 of 7 (43%) accidents tested. These 3 accidents were reported 4 to 711 days late.

  The Illinois Administrative Code (44 Ill. Admin Code 5040.520) requires accidents reported on Form SR-1 to be reported to the DCMS no later than 7 days after the accident has occurred.

Assignment of Vehicles

During their testing of individually assigned State vehicles and required reporting, the auditors noted the following:

- The Office's Fiscal Year 2021 Individually Assigned Vehicle (IAV) report submitted to the DCMS did not include all required information. Specifically, the FY21 IAV report did not include each employee's headquarters and residence.

- The Office failed to inform DCMS of the assignment of 3 of 26 (12%) individually assigned vehicles during the period. Additionally, the Office did not accurately report to DCMS the assignment for 8 of 26 (31%) individually assigned vehicles during the period. Specifically, the name of the individual assigned to the vehicle was incorrect.

  The Code (44 Illinois Admin. Code 5040.340) states that the Office will be required to report to DCMS annually and when changes occur, including the name of each employee assigned a vehicle, the equipment number, and the license plate number of the assigned vehicle, employee's headquarters and residence, and any additional information requested by DCMS.

Testing of Vehicle Records

- During their testing of vehicle records, auditors noted the beginning mileage per the Office's vehicle listing for 1 of 26 (4%) vehicles tested does not appear to be accurate. In addition, the ending mileage per the Office's vehicle listing for 1 of 26 (4%) vehicles tested does not appear to be accurate.

The State Records Act (5 ILCS 160/8) requires the Office to make a preserve record containing adequate and proper documentation of the essential transactions of the Office designated to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Office's activities.

Vehicle Use Policy

- During their testing of the Office's vehicle use policy, auditors noted the policy does not include procedures regarding daily vehicle use logs.

  The State Vehicle Use Act (30 ILCS 617/10) requires the Office's vehicle use policy to include procedures regarding daily vehicle use logs and mileage recording.

Finally, this finding was first noted in the Office's State Compliance Examination for the two years ended June 30, 2018. Office management has been unsuccessful in implementing a corrective action plan to remedy these conditions.

During the prior examination, Office management indicated the errors noted were due to employee error and complications due to the COVID-19 pandemic. During the current examination, Office management indicated the errors described above continued to be caused by employee error.

Inadequate monitoring of the maintenance and record keeping of State vehicles could result in unnecessary costs to the State through additional repairs and shortened useful lives of State vehicles. Failure to timely file Form SR-1s exposes the driver and the Office to the risk of forfeiture of coverage under the State's auto liability plan. Failure to accurately report vehicle information to DCMS represents noncompliance with the Illinois Administrative Code and hinders oversight of the State's individually assigned vehicles. Further, a vehicle use policy is designed to facilitate and encourage accountability, monitor usage and costs, provide internal control, and serve as a management tool for oversight and decision-making. Failure to include all required provisions in the vehicle use policy increases the risk of unauthorized usage and represents noncompliance with the Act.

OFFICE RESPONSE:

The Office agrees with the finding. The Office is in the process of moving from a paper process to a new electronic recordkeeping system that was developed by the Illinois Department of Revenue and is maintained by the Department of Innovation and Technology. The new system will assist with recordkeeping and free the vehicle coordinator to perform more manual processes, like accident reporting. The Office is incorporating usage logs into the new Employee Manual with its next revision.

UPDATED RESPONSE:

Partially Implemented. The Office is moving to using a new vehicle maintenance system. Staff training occurred on March 28, 2024. The Office intends to go live on the new system prior to the end of Fiscal Year 2024. Additionally, all field staff have been reminded of the expectation to have vehicle maintenance performed in a timely manner. The employee reference manual has been updated to include information on vehicle use and usage logs. Finally, due to the automation provided by the new system, the Vehicle Coordinator will have additional time to address the timeliness of accident reporting.

9. The auditors recommend the Office design and maintain internal controls to provide assurance its data entry of key attributes into the ERP system is complete and accurate. Further, they recommend the Office strengthen its controls over timeliness of voucher approvals and ensure surplus property affidavits are filed prior to purchasing new furniture over $500.

FINDING: *(Inadequate Controls over Voucher Processing) - New*

The Office of the State Fire Marshal (Office) did not exercise adequate controls over voucher processing.

Due to their ability to rely upon the processing integrity of the Enterprise Resource Planning System (ERP) operated by the Department of Innovation and Technology (DoIT), the auditors were able to limit their voucher testing at the Office to determine whether certain key attributes were properly entered by the Office's staff into ERP. In order to determine the operating effectiveness of the Office's internal controls related to voucher processing and subsequent payment of interest, auditors selected a sample of key attributes (attributes) to determine if the attributes were properly entered into the State's ERP based on supporting documentation. The attributes tested were 1) vendor information, 2) expenditure amount, 3) object(s) of expenditure, and 4) the later of the receipt date of the proper bill or the receipt date of the goods and/or services.

The auditors testing noted three of 140 (2%) attributes were not properly entered into the ERP System. Therefore, the Office's internal controls over voucher processing **were not operating effectively**.

The Statewide Accounting Management System (SAMS) (Procedure 17.20.20) requires the Office to, after receipt of goods or services, verify the goods or services received met the stated specifications and prepare a voucher for submission to the Comptroller's Office to pay the vendor, including providing vendor information, the amount expended, and object(s) of expenditure. Further, the Illinois Administrative Code (74 Ill. Admin. Code 900.30) requires the Office to maintain records which reflect the date goods were received and accepted, the date services were rendered, and the proper bill date. Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance expenditures are properly recorded and accounted for to maintain accountability over the State's resources.

Due to this condition, the auditors qualified their opinion because they determined the Office had not complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

Even given the limitations noted above, auditors conducted an analysis of the Office's expenditure data for Fiscal Year 2021 and Fiscal Year 2022 and noted the following noncompliance:

- The Office did not timely approve 170 of 3,613 (5%) vouchers processed during Fiscal Year 2021 and Fiscal Year 2022, totaling $590,411. The vouchers were approved between 1 and 91 days late.

  The Illinois Administrative Code (74 Ill. Admin. Code 900.70) requires the Office to timely review each vendor's invoice and approve proper bills within 30 days after receipt.

- For 1 of 35 (3%) vouchers selected for testing, totaling $5,352, the Office did not complete and file with the Department of Central Management Services (DCMS) a State Surplus Property - New Furniture Affidavit prior to the purchase of the equipment.

  The State Property Control Act (Act) (30 ILCS 605/7a) requires agencies that desire to purchase new furniture, with a purchase price of $500 or more, to first check with the Director of DCMS if any of the surplus furniture under the Director of DCMS' control can be used in place of new furniture. The Act further requires, if an agency finds that it is unable to use the surplus property, the agency shall file an affidavit with the Director of DCMS prior to any purchase, specifying the types of new furniture to be bought, the quantities of each type of new furniture, the cost per type, and the total cost per category. The affidavit shall also clearly state why the furniture must be purchased new as opposed to obtained from the DCMS' surplus.

Office management indicated the deficiencies noted above were due to employee error.

Failure to properly enter the key attributes into the State's ERP when processing a voucher for payment hinders the reliability and usefulness of data extracted from the ERP, which can result in improper interest calculations and expenditures. Further, failure to timely process proper bills and ensure required documentation is filed with the DCMS represents noncompliance with State laws and regulations.

OFFICE RESPONSE:

The Office partially agrees with the finding. The Office agrees that a discrepancy existed in the dates entered for the identified attributes which were not entered incorrectly. Once the auditors identified these issues, the Office took steps to correct this error. The Office agrees that a new furniture affidavit was not completed. The Office will ensure that these

affidavits are completed in the future, as required. The Office does not believe that in all cases the auditors correctly identified the dates to be utilized in determining whether an invoice was approved in a timely manner. Each invoice received by the agency is date stamped with a receipt date, an approval that the good or service has been received, and an approval to pay. The invoice is then provided in an email to the accounts payable unit. The Office is confident in its procedures and does not believe any further action needs to be taken to ensure invoices are approved in a timely manner. Further, since the Office doesn't utilize the General Revenue Fund, it has not been required to pay prompt payment interest in the past, due to payments being expedited.

ACCOUNTANT'S COMMENT:

The Statewide ERP has defined the pertinent date fields within the ERP to ensure documentation is maintained of the timely approval of the voucher. Further, the defined date fields are utilized by the ERP in determining the calculation of the prompt payment interest. Lastly, the ERP is the State's book of record; therefore, all information within must be complete and accurate.

UPDATED RESPONSE:

Implemented. The Office has changed the process in which vouchers are processed. The Fiscal Manager will train the new Purchasing Officer regarding the New Furniture Affidavit issue.

10. The auditors recommend the Office establish adequate cybersecurity programs and practices to minimize the possibility of the Office's confidential and personal information becoming subject to cyber-attacks and unauthorized disclosure.

FINDING: *(Inadequate Controls over Cybersecurity) - New*

The Office of the State Fire Marshal (Office) did not maintain adequate internal controls related to cybersecurity programs and practices.

The Illinois State Auditing Act (30 ILCS 5/3-2.4) requires the Auditor General to review State agencies and their cybersecurity programs and practices. During their examination of the Office's cybersecurity programs and practices, auditors noted the Office:

- Had not established and communicated policies, procedures, and processes to manage and monitor the regulatory, legal, environmental, and operational requirements;
- Had not established and documented cybersecurity roles and responsibilities;
- Had not performed a formal risk assessment to identify and ensure adequate protection of information most susceptible to attack;
- Had not classified data to establish the types of information most susceptible to attack to ensure adequate protection;

- Had not adequately assessed the overall risks or vulnerabilities of information systems and data; and,
- Had not ensured the overall cybersecurity practices are effective and adequate for the Office.

The Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standard and Technology (NIST) requires entities to consider risk management practices, threat environments, legal and regulatory requirements, mission objectives and constraints in order to ensure the security of their applications, data, and continued business mission.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation and to maintain accountability over the State's resources.

Office management indicated they believed this to be a Department of Innovation and Technology (DoIT) responsibility.

The lack of adequate cybersecurity programs and practices could result in unidentified risks and vulnerabilities, which could ultimately lead to the Office's confidential and personal information being susceptible to cyber-attacks and unauthorized disclosure.

OFFICE RESPONSE:

The Office respectfully disagrees with the finding. Specifically, the Office disagrees with the Auditor's assertion that cybersecurity is the responsibility of the agency. The Department of Innovation and Technology (DoIT) is the state's designated information technology agency (established by Executive Order 16-1 and codified at 20 ILCS 1370) and is responsible for all functions related to information technology, including cybersecurity, and in fact has an entire area within DoIT that focuses solely on cybersecurity. All items noted in the finding are addressed by DoIT on a statewide basis. Additionally, the law designates security as a function of DoIT. As stated in 20 ILCS 1370/1-15(c), the law states, in part, the following:

> *"The Department shall develop and implement standards, policies, and procedures to protect the security and interoperability of State data with respect to those agencies under the jurisdiction of the Governor."*

With respect to providing employees information related to cybersecurity, all Office employees take training each year which addresses cybersecurity. While the Office will formally adopt DoIT's cybersecurity policy as part of the Office's policies and procedures, the Office relies on and will continue to rely on DoIT's expertise as the state cybersecurity agency.

ACCOUNTANT'S COMMENT:

Cybersecurity is not just the responsibility of DoIT, but a shared responsibility between DoIT and the Office. The Office, not DoIT, is responsible for the security controls over their applications and data. Such facts are specifically addressed in the various DoIT policies and procedures documented on DoIT's website.

In addition, Section 4.01 of the Intergovernmental Agreement the Office entered into with DoIT states the "Client Agency is responsible for developing and prioritizing its IT or IT related needs in consultation with its designated agency Chief Information officer (CIO) or Group CIO." Furthermore, Section 5 of the Intergovernmental Agreement states DoIT will provide "certain infrastructure IT or IT related services" and "the Client Agency shall work with DoIT and provide support to achieve security and consistent operations" in protecting the security, processing, integrity, availability, and confidentiality of the Office's applications and data.

UPDATED RESPONSE:
Partially Implemented. The Office is reviewing the Cybersecurity template provided by DoIT and is working towards adopting a Cybersecurity Policy of its own. The policy is expected to be finalized prior to the end of Fiscal Year 2024.

11. The auditors recommend the Office evaluate and secure information technology equipment to ensure confidential information is protected to prevent theft or unauthorized access to the Office's data.

FINDING: *(Inadequate Controls over Electronic Devices) – First reported 2020, last reported 2022.*

The Office of the State Fire Marshal (Office) did not maintain adequate controls over electronic devices.

During their testing, auditors noted the Office:

- Could not provide a population of State-owned information technology equipment disposed of during the examination period. As a result, they were unable to perform testing to determine whether the hard drives of equipment were erased, wiped, sanitized, or destroyed in a manner preventing the retrieval of sensitive data prior to disposal.

  The Data Security on State Computers Act (20 ILCS 450/20) requires the Office to implement 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 by (i) overwriting the previously stored data on a drive or a disk at least three times or physically destroying the hard drive and (ii) certifying in writing that the overwriting process has been completed by providing the following information: (1) the serial number of the computer or other surplus electronic data processing

equipment; (2) the name of the overwriting software or physical destruction process used; and (3) the name, date, and signature of the person performing the overwriting or destruction process.

- Recorded a lost laptop on its Fiscal Year 2021 Inventory Certification; however, the Office was unable to provide any information as to what data, including personal data, was stored on the laptop, whether encryption was deployed and if an analysis had been completed to determine if the notification requirements of the Personal Information Protection Act (815 ILCS 530) were required.

  The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. The State Property Control Act (30 ILCS 605/4 and 6.02) requires the Office to be accountable for the supervision, control, and inventory of all items under its control. Additionally, the Office has the responsibility to ensure confidential information is protected from disclosure and provisions in the Personal Information Protection Act (815 ILCS 530) are followed.

Office management indicated they believed the security of information on State laptops to be the Department of Innovation and Technology's (DoIT) responsibility.

Failure to ensure adequate internal controls over the wiping of information technology equipment could result in the theft of or unauthorized access to the Office's data. Failure to maintain adequate controls over information technology equipment has resulted in a missing laptop and the potential for unintended exposure of confidential information.

OFFICE RESPONSE:
The Office respectfully disagrees with the finding. The Office did, in fact, provide the auditors with all property control deletions during the audit period. The information utilized by the audit team for this finding was obtained from discussion with Department of Innovation and Technology (DoIT) personnel, related to electronic devices under their control.

Related to the lost laptop and how the data on the laptop is secured: DoIT's policy is to secure laptops by imaging them with encryption technology. The encryption technology employed is a data protection feature that integrates with the operating system and addresses the threats of data theft or exposure from lost, stolen, or inappropriately decommissioned computers. Confidential information is secure on Office laptops if lost or stolen. This was verified by the auditors during audit testing completed for compliance examination.

The Intergovernmental Agreement (IGA) that DoIT and the Office entered into states "In providing services and resources to its client agencies, DoIT operates a robust framework of IT security policies. These policies establish prescribed standards and operational

requirements, for both DoIT and its client agencies, aimed at protecting the security, processing, integrity, availability, and confidentiality of State of Illinois systems and data." It then goes on to state that "DoIT shall adhere to these policies in providing services to Client Agency and in maintaining data on behalf of Client Agency." It is the Office's opinion that this clause clearly identifies that DoIT will provide a service to ensure that Agency data is secured.

ACCOUNTANT'S COMMENT:

We acknowledge the Office did provide a population of items deleted from its property system during the examination period; however, we identified risks and shortcomings in the information provided, compared to the objective of our testing, and therefore could not conclude the population provided was sufficiently complete and detailed for the purposes of our testing. Our request was for a list of all equipment transfers out and deletions made during the examination period, and the population provided by the Office in response to our request was limited to items equal to or above the $1,000 tagging threshold specified in the Statewide Accounting Management System (SAMS) (Procedure 29.10.30). Risks and shortcomings identified with placing reliance on that population as complete included the exclusion of electronic items valued under the $1,000 tagging threshold, such as USB drives, printers, and scanners, which may include hard drives or other memory-containing mechanisms which require proper disposal measures. In addition, Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C 205.36) require us to evaluate whether information produced by the auditee is sufficiently reliable for our purposes, including, as necessary, obtaining evidence about the accuracy and completeness of the information and evaluation whether the information is sufficiently precise and detailed for our purposes.

With regard to the Office's comments regarding encryption technology, the Office was unable to provide documentation substantiating the lost laptop was equipped with encryption technology to ensure the data residing on the laptop was appropriately secured. While our staff did observe encryption technology deployed on a sample of other Office laptops during our fieldwork, we simply cannot assume all laptops, including this one which was lost during the examination period – and for which the Office could not locate evidence of following the proper procedure to report such a loss to DoIT – was equipped with encryption technology. To make such an assumption, particularly in the case of a lost laptop, would be reckless and would undermine the importance of data security.

Lastly, we are taken aback by the Office's lack of responsibility for ensuring the protection of its confidential data.

UPDATED RESPONSE:

Implemented. A reminder email was sent to employees to inform them what to do when they lose or misplace state equipment. This finding had information about a laptop that was noted as lost/missing during inventory. The Office believes the laptop was secure and any confidential information would have been protected.

12. The auditors recommend the Office timely prepare reconciliations as required by the SAMS Manual and increase oversight and review efforts to ensure the reconciliations are performed.

FINDING: *(Inadequate Controls over Monthly Reconciliations) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not maintain adequate controls over monthly reconciliations.

During their testing of the Office's monthly reconciliations, auditors noted the following:

- Twelve of 24 (50%) monthly reconciliations of the Office's receipt and expenditure records to the Comptroller's Cash Report (SB05) were not completed.

- Four of 24 (17%) monthly reconciliations of the Office's receipt and expenditure records to the Comptroller's Cash Report (SB05) were performed 4 to 64 days late.

- Eight of 29 (28%) monthly reconciliations of the Office's appropriation records to the Comptroller's Appropriation Transfer Report (SB03) were not dated; therefore, auditors could not determine if the reconciliations were completed timely.

  The Statewide Accounting Management System (SAMS) Manual (Procedure 07.30.20) requires the Office to perform monthly reconciliations of its internal records to the Comptroller's SB01, SB03, SB04, and SB05 within 60 days of each month's end.

- 15 of 29 (52%) monthly reconciliations of the Office's contract records to the Comptroller's Agency Contract Report (SC14) or Obligation Activity Report (SC15) were not completed.

  The SAMS Manual (Procedure 15.30.30), effective July 1, 2020, requires the Office to perform monthly reconciliations of its internal records to the Comptroller's SC14 or the SC15 within 60 days of each month's end.

Finally, this finding was first noted in the Office's State Compliance Examination for the two years ended June 30, 2018. Office management has been unsuccessful in implementing a corrective action plan to remedy this condition.

During the prior examination, Office management indicated they relied on Shared Services for part of that examination period to perform various reconciliations and noted the FY19 and FY20 SB05 reconciliations were not completed due to a lack of staffing and resources at Shared Services. Later during the prior examination period, Office personnel indicated they began performing the reconciliations in-house, and Office management noted the conditions persisted due to management error. During the current examination,

Office management indicated the Fiscal Year 2021 reconciliations were not completed due to management error, and the Fiscal Year 2022 reconciliations were not documented and completed timely due to employee oversight.

Failure to ensure reconciliations are timely and accurately prepared and reviewed could result in errors or other irregularities going undetected for a significant period of time and represents noncompliance with the SAMS manual.

OFFICE RESPONSE:
The Office accepts the finding. All required reconciliations were not performed during the audit period. However, due to the timing of when the previous Compliance Examination ended, the Office was not aware of this audit issue until already into the scope of the current Compliance Examination. Once notified of the finding, that Office began completing the reconciliations, and all reconciliations are currently being completed.

ACCOUNTANT'S COMMENT:
The timing of when the previous State Compliance Examination ended has no bearing on when the Office became obligated to complete required reconciliations. This finding was originally written for the Fiscal Year 2017 and Fiscal Year 2018 examination period. In addition, in the management assertion letters appearing in this report, covering Fiscal Year 2021 and Fiscal Year 2022, as well as the reports for the examination periods covering Fiscal Year 2017, Fiscal Year 2018, Fiscal Year 2019, and Fiscal Year 2020, Office management has signed and acknowledged its responsibility for the identification of, and compliance with, all aspects of laws, regulations, contracts, or grant agreements that could have a material effect on the Office's operations.

UPDATED RESPONSE:
Implemented. These reconciliations are being performed and the expectation is to have them completed by the 15th of the following month – well ahead of the 60-day timeframe in SAMS.

13. The auditors recommended the Office work to adopt administrative rules consistent with the Fire Sprinkler Contractor Licensing Act to facilitate proper enforcement and administration of the Act or seek legislative remedy.

FINDING: *(Noncompliance with the Fire Sprinkler Contractor Licensing Act) - New*

The Office of the State Fire Marshal's (Office) administrative rules did not fully address all requirements of the Fire Sprinkler Contractor Licensing Act (Act) (225 ILCS 317). During testing, auditors noted the following:

- The Office has not adopted by administrative rule procedures for determining whether a laboratory is nationally recognized.

The Act (225 ILCS 317/30) requires the equipment used to service fire sprinkler systems to be listed by a nationally recognized testing laboratory or comply with nationally accepted standards. The Act further requires the Office to adopt by rule procedures for determining whether a laboratory is nationally recognized, taking into account the laboratory's facilities, procedures, use of nationally recognized standards, and any other criteria reasonably calculated to reach an informed determination.

- The Office has not adopted by administrative rule a late filing fee to be assessed when a person fails to file a renewal application by the date of expiration. As a result, the Office did not charge late filing fees for activity of this type during the examination period. The auditors sample testing indicated 4 of 44 (9%) renewal applications tested were not filed with the Office prior to the expiration date of each license. Had a late filing fee been established by administrative rule as required, the Office would have been entitled to additional revenue related to these instances.

  The Act (225 ILCS 317/35(c)) requires the Office to determine by administrative rule a late filing fee to be assessed for any person who fails to file a renewal application by the date of expiration of a license.

The auditors did note the Office's administrative rules (41 Ill. Admin. Code 109.100) do require a reinstatement fee of $100 to be assessed whenever a business fails to renew its license within 60 days after the end of the license period. However, this reinstatement fee is not provided for in the Act (225 ILCS 317).

Office management indicated the Office does not have the appropriate expertise to determine if a laboratory should be nationally recognized. In addition, Office management indicated limited personnel and other factors, including the COVID-19 pandemic, delayed rulemaking efforts.

Failure to adopt all required administrative rules and ensure administrative rules align with the related statute represents statutory noncompliance and resulted in decreased revenue for the State.

OFFICE RESPONSE:
The Office agrees with the finding. The Office is in the process of adopting updated administrative rules that provide for a late filing fee as required by the statute. The Office is reviewing options to address other requirements of statute, including legislative remedy.

UPDATED RESPONSE:
Under Study/Partially Implemented. Office Administrative Rules were updated to include the late filing fee. The Office is working to determine the best way to remediate the first bullet of the finding, related to the Office adopting an Administrative Rule to determine whether a laboratory is nationally recognized.

14. The auditors recommend the Office implement the necessary controls to ensure the accuracy and timeliness of statutorily required reporting regarding pyrotechnic operator licenses. Further, the Office should implement additional procedures as necessary to ensure adequate supporting documentation is maintained reflecting the accuracy and timeliness of such reporting.

FINDING: *(Failure to Comply with the Pyrotechnic Distributor and Operator Licensing Act) - New*

The Office of the State Fire Marshal (Office) was not in compliance with the requirements of the Pyrotechnic Distributor and Operator Licensing Act (Act) (225 ILCS 227/36).

Specifically, the Office does not have adequate controls in place to ensure the accuracy and timeliness of statutorily required reporting regarding pyrotechnic operator licenses. The auditors were unable to determine the accuracy of the reports as the supporting documentation provided did not trace to the totals stated on the reports. Further, they were unable to confirm the reports were issued prior to the due date established by the Act.

The Act states that no later than May 1 of each year, the Office must prepare, publicly announce, and publish a report of summary statistical information relating to new and renewal license applications received and processed during the preceding calendar year. The State Records Act (5 ILCS 160/9) requires the Office to establish and maintain an active, continuing program for the economical and efficient management of the records of the Office to provide for effective controls over the creation, maintenance, and use of records.

Office management indicated the conditions noted above were due to employee error and a misunderstanding of the requirements.

Failure to ensure the reports agreed to underlying support and retain documentation to substantiate publication dates limits the Office's ability to substantiate compliance with statutory requirements.

OFFICE RESPONSE:
The Office agrees with the finding. Moving forward, the report and supporting documentation will be saved together and five years of data will be maintained on the Office's website.

UPDATED RESPONSE:
Implemented. When future reports are completed, the supporting documentation will be included in the Office copy stored on our network drives. Training has been conducted

with the employee who will be responsible for the report. The first report since the audit was issued is due May 1, 2024.

15. The auditors recommend the Office strengthen its internal controls over State property by regularly reviewing the Office's property listing, including recent equipment transactions, to ensure it is complete and accurate and timely recording equipment transactions.

FINDING: *(Inadequate Controls over State Property) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not exercise adequate controls over the recording and reporting of State property.

Forwards Testing

During testing, auditors noted the following:

- Two of 60 (3%) items selected for testing, totaling $2,961, could not be located.

- Six of 60 (10%) items selected for testing, totaling $2,454, could not be traced to the related transfer of ownership documentation; therefore, the auditor could not determine each item's location, condition, or status, or who had assumed ownership responsibility.

  The State Property Control Act (30 ILCS 605/4) requires the Office to be accountable for the supervision, control, and inventory of its property. Further, the State Property Control Act (30 ILCS 605/6.02) requires the Office to maintain a permanent record of all items under its jurisdiction and control.

- Three of 60 (5%) items selected for testing, totaling $28,982, were located in a different geographical location than reported on the Office's property listing.

  The Statewide Accounting Management System (SAMS) (Procedure 29.10.10) requires the Office to maintain current property records, including the location. Additionally, the Illinois Administrative Code (44 Ill. Admin. Code 5010.230) requires the Office to correctly enter each item's location code number on its property listing.

Equipment Additions and Deletions Testing

During testing, auditors noted the following:

- Increasing inventory adjustments for 5 vehicles purchased during the examination period did not agree to supporting documentation. As a result, the Office's property records were overstated by $500 as of June 30, 2022.

  SAMS (Procedure 03.30.20) states the basic cost of equipment usually is determined by all of the costs necessary to acquire the asset and place it into service. The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

- Seven of 24 (29%) items selected for deletions testing, totaling $101,925, were removed from the Office's property listing 101 to 436 days late.

  The Illinois Administrative Code (44 Ill. Admin. Code 5010.400) requires the Office to adjust property records within 90 days of acquisition, change, or deletion of equipment items.

Finally, this finding was first noted in the Office's State Compliance Examination for the two years ended June 30, 2018. Office management has been unsuccessful in implementing a corrective action plan to remedy this condition.

During both the previous and current examinations, Office management indicated the issues noted were due to employee error.

Failure to maintain accurate and complete property records to include each item's location, specific description, and purchase amount increases the potential for loss or theft of State property, reduces the reliability of Statewide fixed asset information, and represents noncompliance with State regulations.

OFFICE RESPONSE:
The Office agrees with the finding. The Office will strive to ensure State Property owned and utilized by the staff is accounted for as accurately as possible.

UPDATED RESPONSE:
Implemented. An email was sent to Office staff to remind them that if any state equipment is moved from one location to another, that the Property Control Officer should be notified. Additionally, related to the vehicles not having decals included in their cost, the Office has noted and will include these on future purchases. Finally, the Property Control Officer was reminded that property disposed via CMS needs to be removed from the Asset Reporting Module in ERP in a timely manner.

16. The auditors recommend the Office establish and maintain appropriate internal controls over its receipts by establishing a proper segregation of

duties over its receipts. Further, they recommend the Office ensure the receipt date is documented for all receipts received by the Office.

FINDING: *(Inadequate Controls over Receipts) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not maintain adequate internal controls over its receipt processing.

During testing, auditors noted the following:

- The Office failed to maintain an adequate segregation of duties over its receipt processing procedures. More specifically, they noted one individual performed three parts of the transaction cycle, including:

    - **Authorization** by reviewing and approving transactions, including both depositing funds into the State Treasury's clearing accounts and preparing Receipt Deposit Transmittal (C-64) forms.
    - **Custody** by handling physical checks and maintaining electronic and physical records.
    - **Recordkeeping** by preparing entries and maintaining the Office's internal accounting records.

    The Fiscal Control and Internal Auditing Act (Act) (30 ILCS 10/3001) requires the Office to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds are safeguarded against waste, loss, unauthorized use, and misappropriation. The Act further requires revenues or funds applicable to operations be properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

- Five of 60 (8%) receipts tested, totaling $25,581, and 5 of 7 (71%) refund receipts tested, totaling $45,484, were not date-stamped by the Office. As a result, auditors were unable to determine when the checks were received and whether the checks were deposited in a timely manner.

    The State Officers and Employees Money Disposition Act (Act) (30 ILCS 230/2(a)) requires the Office to keep proper books with a detailed itemized accounting of all moneys showing the date of receipt and to deposit receipts collected into the State Treasury within a specific number of business days, depending on the value of cash receipts on hand. The Act further allows the State Treasurer and State Comptroller to grant time extensions for the deposit of public funds, which has been granted to the Office. However, without documentation of the receipt date, the auditor is unable to determine whether the Office is in compliance with the deposit requirements.

- Eight of 60 (13%) receipts tested, totaling $20,100, were not timely deposited. These receipts were deposited between 1 and 16 days late.

  The State Officers and Employees Money Disposition Act (Act) (30 ILCS 230/2(a)) requires the Office to deposit into the State Treasury individual receipts or refunds exceeding $10,000 in the same day received, an accumulation of receipts of $10,000 or more within 24 hours, receipts valued between $500 and $10,000 within 48 hours, and cumulative receipts valued up to $500 on the next first or fifteenth day of the month after receipt. The Act further allows the State Treasurer and State Comptroller to grant time extensions for the deposit of public funds. Such deposit extensions granted to the Office have been incorporated into the accountant's calculation of the number of days late.

In the prior and current examination, Office management indicated the issues noted with receipt processing were due to limited staffing and oversight. Lastly, Office management indicated the untimely deposit of receipts was due to the Office's operational divisions failing to forward receipts to the fiscal division in a timely manner.

Failure to establish and maintain internal control over receipt processing increases the risk of revenue loss or theft, delays the recognition of available cash within the State Treasury, and represents noncompliance with State laws, rules, and regulations.

OFFICE RESPONSE:
The Office partially agrees with the finding. While the Office understands the auditors' concerns regarding segregation of duties, the Office has determined that it will accept the risk and does not plan on hiring additional staff to clear this finding. It should be noted that while one individual performs three parts of the transaction cycle, all deposits are reviewed by the manager of the Fiscal Division prior to final processing and all checks are taken to the bank and deposited by mailroom staff. The Office agrees that not all refunds receipts were date stamped. The Office will ensure that dates are stamped on all receipts.

The Office agrees that not all deposits were made timely. The Office has approved deposit extensions to address potential delays in deposits, but occasionally circumstances do not allow deposits to be made within those approved extension timeframes. Some payments are received in the Chicago Office and must be sent to the Springfield Office for processing. This can cause delays in deposits. Other circumstances may also result in delayed deposits, such as staff being out of the office.

UPDATED RESPONSE:
Partially Implemented/Partially Not Accepted. For the segregation of duties recommendation, the Office accepts the risk associated with the issue, as hiring another employee full-time to address the audit finding wouldn't be cost-beneficial. The Office also believes it has compensating controls/review processes in place already. The Office has begun using an electronic check scanner for deposits, which should help address the timeliness of deposits as well as better document receipt dates.

17. The auditors recommend the Office implement controls to timely execute statutory changes and adopt administrative rules. Further, they recommend the Office implement procedures to ensure all required documentation is obtained before issuing or renewing fire equipment licenses. Lastly, the auditors recommend the Office strengthen controls to ensure licensees are assessed applicable fees.

FINDING: *(Failure to Comply with the Fire Equipment Distributor and Employee Regulation Act of 2011) - New*

The Office of the State Fire Marshal (Office) did not comply with the requirements of the Fire Equipment Distributor and Employee Regulation Act of 2011 (Act) (225 ILCS 217).

During testing, auditors noted the Office did not obtain a copy of a valid government-issued photo identification from the prospective licensee before proceeding with renewing 6 of 60 (10%) fire equipment employee licenses tested.

The Act (225 ILCS 217/40) requires a candidate for a fire equipment employee license to provide a copy of a valid government-issued photo identification.

The auditors sample testing of fire equipment distributor licenses also identified an instance where the licensee was not assessed a reinstatement fee. For 1 of 60 (2%) fire equipment distributor license renewals tested, auditors noted the licensee was not assessed a $50 reinstatement fee after allowing their license to lapse.

The Act (225 ILCS 217/60) states if not renewed, a license shall become inactive 60 days after the expiration date of the license. The Act (225 ILCS 217/60) further states an inactive license may not be reinstated until a written application is filed, the applicant has demonstrated proof of qualifications for licensure, the renewal fee is paid, and a reinstatement fee is paid. Further, the Office's Administrative Rules (41 Ill. Admin. Code 280.50) set the reinstatement fee at $50 for inactive licenses.

Office management indicated the renewals were processed pursuant to the requirements set forth in the corresponding administrative rules (41 Ill. Admin. Code 280), and the administrative rules had not been fully updated to incorporate statutory changes made effective on April 29, 2022 by Public Act 102-715 due to timing. Office management indicated the reinstatement fee was not assessed for the lapsed license due to oversight.

Failure to ensure all documentation required by the Act is obtained before processing a renewal represents statutory noncompliance. Failure to assess reinstatement fees when circumstances warrant resulted in reduced revenue for the State.

OFFICE RESPONSE:

The Office agrees with the finding. The rules were updated to reflect statutory changes on October 26, 2023. The system now requires applicants to upload a driver's license or state id to submit their application. Additionally, the system is now set up for Office staff to input a date of birth, driver's license number, and driver's license expiration date before the application can be approved, rejected, or changes are saved to an application. Additionally, reinstatement fees have to be manually added, and the Office will work to ensure these are added, as required.

UPDATED RESPONSE:
Implemented. The Office has updated its Administrative Rules. A change has been made to require a photo ID within the Licensing system. Related to the reinstatement fee, training has been provided to the staff that processes licenses, and when necessary, the $50 reinstatement fee will be added to invoices.

18. The auditors recommend the Office comply with the interagency agreement or modify the wording of future interagency agreements to reflect actual Office practice.

FINDING: *(Noncompliance with Interagency Agreement with the Illinois Department of Revenue) - New*

The Office of the State Fire Marshal (Office) did not comply with its interagency agreement with the Illinois Department of Revenue (IDOR).

The Office entered into an interagency agreement (agreement) with IDOR effective November 28, 2011, to facilitate information sharing and serve mutually beneficial purposes for both agencies as follows:

- The Office entered into this agreement to meet administrative requirements of the Illinois Fire Sprinkler Contractor Licensing Act (225 ILCS 317), the Illinois Petroleum Equipment Contractor Licensing Act (225 ILCS 729), the Illinois Boiler and Pressure Vessel Repairer Regulation Act (225 ILCS 203), and the Illinois Fire Equipment Distributor and Employee Regulation Act of 2011 (336 ILCS 217). The agreement requires the Office to provide IDOR with a list of all licensees currently licensed by the Office pursuant to the statutory citations listed above.

- IDOR entered into this agreement to comply with the requirement of the Illinois Income Tax Act and the Retailers' Occupation Tax Act, which authorize IDOR to share information regarding compliance with State tax laws with State licensing agencies, such as the Office. In response to receipt of the licensee listings described above, the agreement requires IDOR to respond to the Office with a listing of licensees which are not in compliance with state tax requirements, as well as supporting documentation and other information to substantiate the fact the licensee is not in compliance with state tax requirements.

- Following receipt of this listing and related information from IDOR, the agreement requires the Office to take all necessary steps, including the issuance of notices required to comply with due process, to pursue disciplinary action against noncompliant licensees until such time as IDOR notifies the Office each matter has been appropriately resolved.

This agreement was executed as each agency possesses financial, enforcement, and other information which may help the other agency to more effectively carry out its administrative and regulatory responsibilities.

However, during their testing, auditors noted the Office did not, during the examination period, provide an electronic list of all licensees currently licensed by the Office, in a format and on a schedule mutually agreed upon by the Office and IDOR, containing data elements mutually agreed upon to identify providers, as specified in the agreement. As a result, the Office did not subsequently receive lists from IDOR of Office licensees who were not in compliance with State tax requirements and therefore did not have the information necessary to pursue disciplinary action against delinquent licensees as required by the agreement. Such disciplinary action can include the suspension or refusal to issue fire sprinkler contractor licenses, petroleum equipment contractor licenses, boiler and pressure vessel repairer licenses, and fire equipment distributor and employee licenses, after reasonable notice is provided to those licensees found to not be in compliance with state tax requirements, as set forth in the agreement as well as the respective licensure statutes.

Office management indicated the Office's approach to ensuring tax compliance had changed over the years since entering into this agreement, but the agreement had not been terminated and/or replaced to reflect current practices due to competing priorities between the responsible personnel.

Failure to perform the duties required in the agreement limits the Office's ability to take appropriate disciplinary action against licensees, represents noncompliance with the agreement as written, and may result in impeded tax collection efforts.

OFFICE RESPONSE:

The Office agrees with the finding. The Office and IDOR entered into an IGA regarding compliance with State of Illinois tax requirements for Office licensees on November 28, 2011. Based on the underlying statutes, the Office largely has an elective ability to verify compliance with State of Illinois tax requirements. During the audit period, instead of following the mechanisms identified in the November 28, 2011 IGA, Office personnel were using an alternative, more informal means to verifying tax compliance with the IDOR. As a result of this compliance audit, on April 13, 2023, the Office gave notice to terminate the November 28, 2011 IGA. The Office, in turn, entered into a new IGA with IDOR effective May 24, 2023 that better reflects the practices currently being used by the Office to access the IDOR portal in order to verify a licensee's compliance with State of Illinois tax requirements. With this new IGA in place, the Office believes it has fully resolved the finding.

UPDATED RESPONSE:
Implemented. This IGA was cancelled, and a new IGA was entered into that better reflects the process used by the Office to verify tax compliance.

19. The auditors recommend the Office's internal audit program review all major systems of internal and administrative control as required by the FCIAA to ensure adherence to an effective internal control system.

FINDING: *(Noncompliance with the FCIAA) - New*

The Office of the State Fire Marshal's (Office) internal auditing program did not fully comply with the Fiscal Control and Internal Auditing Act (FCIAA).

During their review of the Office's internal auditing activities, auditors noted the Office's program of internal auditing did not review all major systems within a two-year period as required by the FCIAA. More specifically, they noted the internal audit function's audits did not include testing of the following major systems of internal and administrative control: 1) budgeting, accounting, and reporting, 2) purchasing, contracting, and leasing, 3) property, equipment, and inventories, and 4) grant administration.

The FCIAA (30 ILCS 10/2003(a)(2)) requires the internal auditing program to include audits of major systems of internal accounting and administrative control conducted on a periodic basis so that all major systems are reviewed at least once every two years. The Statewide Accounting Management System (SAMS) Manual (Procedure 02.50.20) identifies the eleven FCIAA major event/transaction cycles as agency organization and management, administrative support services, budgeting, accounting, and reporting, purchasing, contracting, and leasing, expenditure control, personnel and payroll, property, equipment, and inventories, revenues and receivables, petty cash and local funds, grant administration, and electronic data processing.

Office personnel indicated the deficiencies noted above were due to competing priorities for, and limited resources available to, the individual responsible for these functions.

The major areas of internal control must be audited regularly to ensure adherence to an effective internal control system. Failure to perform regular audits of major systems of internal and administrative controls may result in weaknesses in internal control not being timely detected.

OFFICE RESPONSE:
The Office agrees with the Finding. The Chief Internal Auditor was brought on in July 2022 and has requested an additional staff person, which is in process. This should help bring the Internal Audit Department into compliance and test all major cycles identified in the SAMS manual. Further, Chief Internal Auditors around the state are working with the

Comptroller and General Assembly to align Internal Audit Shops with Auditing Standards, and a risk-based approach, hoping to replace the SAMS manual transaction cycles.

UPDATED RESPONSE:
Partially Implemented. The Office is in the process of hiring an additional staff member for Internal Audit. Additionally, the Chief Internal Auditor is implementing a new FCIAA process to ensure each area has control testing performed during the Annual Internal Control Certification to OAG.

20. The auditors recommend the Office perform timely licensing inspections to reduce the risk of facilities operating under expired licenses and residents occupying potentially unsafe spaces and to be in compliance with State law.

FINDING: *(Failure to Perform Timely Licensing Inspections at Child Care Facilities and Community-Integrated Living Arrangements) – First reported 2020, last reported 2022.*

The Office of the State Fire Marshal (Office) did not perform all inspections as requested by licensing agencies in a reasonable timeframe. The Office is required to provide the necessary fire inspections for agencies under various licensing acts. The Office receives requests for inspections directly from the licensing agency through the Fire Prevention System.

The Child Care Act of 1969 (225 ILCS 10/5.7(b)) requires the Office to perform the necessary fire safety and prevention inspections of child care facilities to comply with licensing requirements under the act. During their testing of 60 inspections conducted pursuant to this act, auditors noted the following:

- Five of 40 (13%) licensure renewal inspection requests were not conducted prior to the previous license's expiration date. While the Office did not receive such requests until between 14 to 42 days prior to the license's expiration date, the Office did not act swiftly to perform the required inspections. In 2 of these 5 (40%) instances, the inspections were performed 77 and 133 days after the inspection request was received. The auditors determined 60 days to be a reasonable timeframe during which such renewal inspections should be carried out.

  Further, while the Office did not receive 3 of 40 (8%) licensure renewal inspection requests until after the facility's license had already expired, the Office did not act swiftly to perform the required inspections upon receipt of a proper request. In 2 of these 3 (67%) instances, the inspections were performed 77 and 125 days after the inspection request was received. The auditors determined 60 days to be a reasonable timeframe during which such renewal inspections should be carried out.

- For 3 of 4 (75%) inspections for a new addition to the facility, auditors noted the Office performed the inspection, as requested by the licensing agency, 84 to 172

days after such requests were made. They determined 60 days to be a reasonable timeframe during which such inspections should be performed.

The Community-Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135/13) requires the Office to perform the necessary fire safety and prevention inspections of community-integrated living arrangements to comply with licensing requirements under the act. The auditors tested a total of 60 inspections conducted pursuant to this act and noted the following:

- For 2 of 3 (67%) new license inspections selected for testing, auditors noted the Office performed the inspections, as requested by the licensing agency, 87 and 92 days after such requests were made. For inspections for new licenses, they determined 60 days to be a reasonable timeframe during which initial inspections should be carried out following receipt of the request for such.

- While the Office did not receive 18 of 34 (53%) licensure renewal inspection requests until after the facility's license had already expired, the Office did not act swiftly to perform the required inspections upon receipt of a proper request. In 2 of these 18 (11%) instances, the inspections were performed 64 and 74 days after the inspection request was received. The auditors determined 60 days to be a reasonable timeframe during which such renewal inspections should be carried out.

- In situations where a previous inspection identified issues, follow up inspections are required to ensure the issues identified have been properly remedied. For 5 of 23 (22%) follow up inspections tested, auditors noted the inspections were performed 65 to 162 days after the follow up inspection was requested by the licensing agency. The auditors determined 60 days to be a reasonable timeframe during which a follow up inspection should be carried out following the receipt of a request for such.

During the prior examination, Office personnel cited limited staff resources, particularly in larger regions of the state, and the COVID-19 pandemic as challenges in ensuring inspections were performed timely. During the current examination, Office management continued to cite limited staff resources as a challenge.

Failure to perform timely licensing inspections as requested by the appropriate party increases the risk of facilities operating under expired licenses and represents material noncompliance with State law and increases the risk that residents and patrons of these facilities could be occupying potentially dangerous and unsafe spaces.

OFFICE RESPONSE:

The Office disagrees with this finding. Inspection requests for Child Care Facilities and Community-Integrated Living Arrangements are received by the Office via other State Agencies. The Office has a method in which inspectors prioritize inspections based on when licenses expire or on whether a facility is even ready to have an inspection. The

Office may receive an inspection request months before a license expires and before a facility is ready to have an inspection, while receiving requests closer to license expiration or from facilities that are ready for an inspection. Stating that the office should perform an inspection within 60 days of receipt does not allow the office to prioritize its inspections based on the reasonable method the Office utilizes to schedule inspections in which it considers the expiration date of the license and whether a facility is ready to have an inspection. The auditors noting 60 days as a timeframe to perform the inspections isn't defined in statute or administrative rules and there are no other standards that require the Office to perform inspections within a 60-day window of time. The Office is currently working on solutions that may address when these requests can be made and how inspectors can document circumstances where facilities are not prepared for their inspections.

ACCOUNTANT'S COMMENT:

The conditions described above are not new, and similar conditions were reported during the previous engagement. See Finding 2020-002 for details, and Office personnel agreed with the conditions as presented in that finding.

In an effort to be responsive to concerns regarding prioritization of license expiration over the timing of receipt of requests, as raised by Office personnel during our testing for Fiscal Year 2021 and Fiscal Year 2022, our testing considerations not only contemplated the 60-day reasonableness measure cited during the previous examination for performance of inspections as well as the timing for when such requests were received in comparison to upcoming license expiration dates. Our testing also took into consideration those situations where inspection requests were received more than 60 days prior to the expiration of the current license, and the condition presented above did not cite any of those instances as problematic.

The condition as presented above reflects an accurate, fair assessment of the Office's efforts to conduct the required inspections of the facilities in our sample, and the cause statement presented above attempts to appropriately reflect the resource constraints and limitations faced. However, in no situation can the Office argue that waiting longer than 60 days to inspect or re-inspect facilities, license expiration dates aside, is in the best interest of the individuals who operate these facilities or the individuals and families who are served by these facilities.

UPDATED RESPONSE:

Partially Implemented. The Office is working on this via additional staff training and a new policy/directive to address the 60-day timeframe. If a facility would not be ready within those 60 days, the request will be closed by the Office and the facility will need to submit another request when fully prepared for inspection.

21. The auditors recommend the Office adequately enforce and monitor terms and conditions of grant agreements to ensure proper use and payment of grant funds. In addition, they recommend Office develop and implement

policies, procedures, and agency-specific rules to ensure compliance with State laws.

FINDING: *(Inadequate Controls over Grant Agreements) – First reported 2018, last reported 2022.*

The Office of the State Fire Marshal (Office) did not exercise adequate controls over grant agreements and related administrative rules, policies, and procedures.

The Office operates multiple grant programs, including direct, small equipment, and fire grants. Specifically, the following issues were noted during the auditors testing of direct grant agreements effective during the examination period:

- For the FY21 Minimum Basic Firefighter Training Grant, totaling $1,000,000, auditors noted the close-out performance report provided by the grantee did not include the (1) number of students, by department represented; (2) number of students, by location; and (3) percentage of students receiving certifications.

  The Minimum Basic Firefighter Training Grant: Exhibit E – Performance Measures requires the grantee to report the (1) number of students, by department represented; (2) number of students, by location; (3) total classroom hours completed by students (in person and online); (4) total practical training hours completed by students; and (5) percentage of students receiving certification.

- For the FY21 Explorer Cadet Grant, totaling $65,000, auditors noted the close-out performance report provided by the grantee did not include the (1) number of attendees, by age, and the (2) lists of courses provided and enrollment by course.

  The Explorer Cadet Grant: Exhibit E – Performance Measures requires the grantee to report the (1) number of attendees, by age; (2) lists of courses provided and enrollment by course; and, (3) number of training hours provided.

In addition, the Illinois Administrative Code (Code) (44 Ill. Admin. Code 7000.80(f)(2) requires the Office to place grant awardees immediately in temporary Stop Payment Status on the Illinois Stop Payment List following any occurrences of noncompliance such as failure to clear fiscal or administrative monitoring issues.

The auditors also noted the Office lacked adequate internal controls over grant-oriented policies, procedures, and administrative rules as follows:

- The Office has not developed certain policies and procedures for grants which were required by the Code.
  The Code (44 Ill. Admin. Code 7000.120(a) and (c)) states payments to states are governed by the Cash Management Improvement Act and the Treasury State Agreement (TSA) default procedures codified at 31 CFR 205. The Code requires the Office to have implemented, written policies and procedures which comply with

the TSA and 2 CFR 200.305 and stipulates the policies and procedures must be approved by the Office's staff responsible for cash drawdowns, federal reporting, and the TSA interest calculation. In addition, the Code specifies the policies and procedures must ensure awardee grant payments conform to the TSA and this Section, awardee grant payments conform to requirements in 2 CFR 200.305, and awardees have policies and procedures that enable them to conform to the TSA and 2 CFR 200.305. The Code requires the Office to implement written policies and procedures for each grant payment method utilized by the Office such as advance payments, reimbursements, and working capital advances, and the policies and procedures must be approved by the Office's staff responsible for federal and State cash drawdowns and reporting. The Code (44 Ill Admin. Code 7000.260(b)(1)(A) and (B)) states if an awardee is not compliant with grant terms stated in Section 7000.80(f)(l), the Grant Compliance Enforcement System shall go into effect. The Code requires the Office to have protocols that dictate procedures for managing financial and programmatic reporting due dates. The Code requires the Office to apply due diligence with awardees to support the administration of reporting requirements stated in the executed Grant Agreement and/or subsequent amendments. The Code requires the Office to have protocols that establish a methodology for the Office to withhold payments at the entity level as prescribed in Section 7000.80(f(1)(C).

- The Office did not ensure all required elements were included when developing policies, procedures, and agency-specific administrative rules as required by the Grant Accountability and Transparency Act (30 ILCS 708/90) (GATA) and the Illinois Administrative Rules. Specifically, auditors noted the following elements were missing from the administrative rules developed by the Office when testing grants administered during the examination period:

Grant Name	Rules Missing
Small Equipment Grant (41 Ill. Admin. Code 291)	1. 44 Ill. Admin. Code 7000.80(f)(1)(B)
	2. 44 Ill. Admin. Code 7000.80(f)(1)(C)
	3. 44 Ill. Admin. Code 7000.80(f)(1)(D)
	4. 44 Ill. Admin. Code 7000.200(b)
Fire Protection District Grant (41 Ill. Admin. Code 295)	1. 44 Ill. Admin. Code 7000.80(f)(1)(A)
	2. 44 Ill. Admin. Code 7000.80(f)(1)(B)
	3. 44 Ill. Admin. Code 7000.80(f)(1)(C)
	4. 44 Ill. Admin. Code 7000.80(f)(1)(D)
	5. 44 Ill. Admin. Code 7000.200(b)

The GATA (30 ILCS 708/90) required the Office to implement the policies and procedures applicable to State and federal pass-through awards by adopting rules for non-federal entities by December 31, 2017. Furthermore, the Code (44 Ill. Admin. Code 7000.80(f)(1)) requires the Office to have rules which specify procedures for managing awardee submittal of required financial and performance reports, including a due diligence process for the Office to generate reminders to the awardee in advance of reporting due dates. The Code requires the Office to have rules that allow the grant making agency to extend the reporting deadline due to extenuating circumstances. Such reporting extensions must be justified in

writing by the grant making agency, and a report due date may only be extended one time. The State grant making agency shall withhold payments to the entity if a report is more than 15 business days past the original or extended due date. The Code requires the Office to have rules that include awardee notification of the Office's contact for Stop Payment Status inquiries. If the report is not submitted within 30 business days after the original or extended due date, the State grant making agency shall place the awardee in temporary Stop Payment Status on the Illinois Stop Payment List. (See Section 7000.260.)

The Code (44 Ill. Admin. Code 7000.200(b)) required the Office, as a State agency making State awards to non-federal entities, to adopt rules reflecting Uniform Administrative Requirements (UR) subparts B through F by July 1, 2017 unless different provisions were required by law or an exception was granted by the Grant Accountability and Transparency Unit (GATU) in accordance with Section 7000.60.

During the prior examination, Office management indicated the issues noted were due to competing priorities, including circumstances out of the Office's control such as COVID19. During the current examination, Office management indicated the issues noted were due to management error. Additionally, Office management indicated the individuals involved in the rulemaking process were unable to draft new administrative rules during the period due to competing priorities.

Failure to adequately enforce and monitor terms and conditions of grant agreements could result in improper use and payment of grant funds. Additionally, failure to develop policies, procedures, and agency-specific rules as required hinders oversight of grant requirements, increases the risk of unauthorized grant activity, and represents noncompliance with State statute and the Code.

OFFICE RESPONSE:
The Office agrees with the finding. The required reports were not provided. The Office will ensure that all reports required by grantees are submitted to the Office. The Office agrees that its administrative rules, policies and procedures do not meet the requirements outlined in the Grant Accountability and Transparency Act. The Office will work to update its administrative rules to comply with the requirements of GATA. It should be noted that the grants identified are paid on a reimbursement basis. The Office reviews invoices provided by grantees prior to issuing a payment. The Office is confident that its decision to pay grantees on a reimbursement basis mitigates any potential risks.

UPDATED RESPONSE:
Under Study/Partially Implemented. The Office has updated its Grant Agreements as necessary to reflect what reports are due and the expected timeframes. The Office will work on updating our Administrative Rules to ensure its compliance with the Grant Accountability and Transparency Act.

22. The auditors recommend the Office work with the Governor and the General Assembly to ensure sufficient resources exist to fully enforce the requirements of this Act, including the resources necessary to properly review and approve certifications applied for by owners of conveyance systems. They also recommend the Office ensure conveyances are inspected annually to ensure compliance with State law and for the safety of the general public when utilizing conveyance systems operated within the State.

FINDING: *(Inadequate Enforcement Program) – First reported 2020, last reported 2022.*

The Office of the State Fire Marshal (Office) failed to implement an adequate enforcement program to ensure annual conveyance inspections were performed as required.

The Elevator Safety and Regulation Act (Act) (225 ILCS 312/105) states it is the Office's responsibility to develop an enforcement program to ensure compliance with rules and requirements referenced in the Act. The Office codified its rules governing the enforcement of the program in the Illinois Administrative Code (Code) (41 Ill. Admin. Code 1000). The Code (41 Ill. Admin. Code 1000.150) requires the owner of the conveyance system to apply annually for a certificate of operation. Along with the application, the owner is required to provide to the Office a copy of the most recent annual inspection indicating the system has passed inspection by a licensed elevator inspector.

For 17 of 60 (28%) conveyances selected for testing, the auditors could not determine if an annual inspection was performed as required and/or the Office could not locate a copy of the annual inspection report to substantiate the required inspection had been performed. The auditors also noted 14,229 of 16,264 (87%) registered conveyances were listed as active in the Office's records, but of the 14,229 registered conveyances listed as active, 623 (4%) were most recently inspected prior to July 1, 2020, the beginning of the examination period.

These numbers do reflect substantial improvement over similar statistics compiled during the previous State compliance examination but also reflect an ongoing need for the Office to enhance its statutorily-required enforcement program to ensure appropriate action is taken when the owners of conveyance systems allow their certificates of operation to lapse and do not ensure the required annual inspections are being performed.

The Act (225 ILCS 312/120) states it is the responsibility of the owner of all new and existing conveyances located in any building or structure to have the conveyance inspected annually by a person, firm, or company to which a license to inspect conveyances has been issued. The person, firm, or company conducting the inspection shall use the inspection form prescribed by the Board pursuant to subsection (k) of Section 35 of this Act. Subsequent to inspection, the licensed person, firm, or company must supply the property owner or lessee with a written inspection report describing any and all code violations. Property owners shall have 30 days from the date of the published inspection report to be in full compliance by correcting the violations. The Administrator

shall determine, upon receiving a final inspection report from the property owner or lessee, whether such violations have been corrected and may extend the compliance dates for good cause, provided that such violations are minor and pose no threat to public safety.

During both the prior and current examinations, Office management indicated the Office lacks sufficient resources to fully enforce all requirements of the Act.

Failure to implement an adequate enforcement program to ensure conveyances are inspected annually as required by the Act represents an increased risk of compromising the safety of the general public when they utilize conveyance systems operated within the State and represents noncompliance with State law.

OFFICE RESPONSE:
The Office agrees with the finding. The Office has developed what we believe to be an adequate Enforcement Plan. The Office lacks sufficient resources to ensure compliance with the Elevator Safety and Regulation Act (Act). The Elevator Division is comprised of 7 geographically assigned field staff who enforce the Act. The Office oversees approximately 15,000 conveyances and another approximately 22,000 conveyances are enforced via municipality agreements. Third-party elevator companies conduct the inspections. The Office passed a rule, which will not let an elevator company work on an elevator unless it is inspected or has received a 60-day extension. This rule change has increased compliance considerably. The Office is re-evaluating the program to look for efficiencies and will work with the Governor and the General Assembly to increase resources to decrease the number of elevators out of compliance with the Act.

UPDATED RESPONSE:
Under Study/Partially Implemented. The Office has made a change, as of January 1, 2024, to begin scanning Inspection Reports in house. The reports that could not be located were not yet scanned into the Office's system. As far as the elevators and conveyances that appear to be overdue for inspection, there are factors that come into play that do not show up on a report that will be better communicated with the auditors in the future.

23. The auditors recommend the Office work with the Associated Fire Fighters of Illinois to complete the educational program and associated document and add the information to the Office's website.

FINDING: *(Failure to Comply with the Illinois Fire Protection Training Act) – First reported 2020, last reported 2022.*

The Office of the State Fire Marshal (Office) did not comply with certain requirements of the Illinois Fire Protection Training Act (Act). Specifically, the auditors noted an educational program or literature for fire fighters on the history of the fire service labor

movement had not been created as of June 30, 2022. Therefore, the Office did not make the educational program or literature available on its website as required by the Act.

The Act (50 ILCS 740/12.6) requires the Office to maintain on its website a link to an educational program or literature for fire fighters on the history of the fire service labor movement.

During the current and prior examinations, Office management stated the educational program was still being developed by the Associated Fire Fighters of Illinois and an external partner on the project, and completion of this project was delayed by the COVID-19 pandemic and staff turnover.

Failure to establish an educational program on the fire service labor movement prevents fire officials from being adequately educated on the history of the industry and represents noncompliance with the Act.

OFFICE RESPONSE:
The Office agrees with the finding. The Associated Fire Fighters of Illinois is still working with an external partner (professor at the University of Illinois) to develop the educational program. They are getting close to completing video trainings, which can be shared. The Office will add a link to the information as soon as it is available.

UPDATED RESPONSE:
Implemented. The Office has added a link to the training on its website.

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 procurements shall be provided to the Procurement Policy Board and published in the online electronic Bulletin no later than five 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 a statement with the Procurement Policy Board and the Auditor General 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 the audit cycle, the OSFM had one emergency purchase in the 2nd quarter of FY21. Estimated Cost - $187,500 for a vendor to provide resources to perform technical upgrades and functional changes to the Division of Petroleum and Chemical Safety's Underground Storage Tank System as a result of U.S. EPA mandates and outdated technology. This vendor was the most familiar and capable company to perform these services while the Agency issues and completes a competitive solicitation. A lapse in services could have put the Office in breach of the terms of the grant it received to modernize the Underground Storage Tank System.

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.

As of July 2022, the Office of the State Fire Marshal had 98 employees assigned to locations others than official headquarters.

LEGISLATIVE AUDIT COMMISSION

Review of
Department of Public Health

620 Stratton Office Building
Springfield, Illinois 62706
217/782-7097

REVIEW: #4595
DEPARTMENT OF PUBLIC HEALTH
TWO YEARS ENDED JUNE 30, 2023

RECOMMENDATIONS – 39

IMPLEMENTED/PARTIALLY IMPLEMENTED – 29
UNDER STUDY - 10

REPEATED RECOMMENDATIONS – 27

PRIOR AUDIT FINDINGS/RECOMMENDATIONS – 31

This review summarizes the auditors' report of the Department of Public Health (IDPH) for the two years ended June 30, 2023, filed with the Legislative Audit Commission on August 1, 2024. The auditors conducted a compliance examination in accordance with state law and Government Auditing Standards.

Agency Narrative

Vision:
Illinoisans empowered and supported to achieve their optimal health with dignity and acceptance in diverse and thriving communities.

Mission Statement:
The Illinois Department of Public Health is an advocate for and partner with the people of Illinois to re-envision health policy and promote health equity, prevent and protect against disease and injury, and prepare for health emergencies.

About the Director:
Dr. Sameer Vohra, MD, JD, MA, was appointed as the director of the Illinois Department of Public Health, effective August 1, 2022, by Governor JB Pritzker. Dr. Vohra is a general pediatrician who holds degrees in law and public policy. He is a cross-disciplinary leader in state and national health policy formulation, and his recent focus has been on improving health outcomes in Central and Southern Illinois. Prior to his appointment, Dr. Vohra was the Founding Chair of the Department of Population Science and Policy, a practicing primary care pediatrician, and an Associate Professor of Pediatrics, Public Health, Medical Humanities, and Law at the Southern Illinois University – School of Medicine (SIU-SOM) in Springfield, Illinois. A graduate of the University of Chicago, where he earned a Master of Arts in public policy, Dr. Vohra completed his medical residency in pediatrics at the University of Chicago. He holds a medical doctorate from SIU-SOM; a juris doctorate from SIU School of Law graduating first in his class; and a Bachelor of Arts in political science and science in human culture with honors from Northwestern University. Dr. Vohra previously served on the Illinois State Board of Health, the

Children's Mental Health Partnership, the Illinois Medicaid Advisory Committee, the Governor's Rural Affairs Council, the Illinois COVID-19 Response Fund Steering Committee as well as many national committees.

At the time of the compliance exam, the director was Dr. Ngozi Ezike.

IDPH Main Office Locations

IDPH Springfield Headquarters Office
- 525-535 West Jefferson Street, Springfield; and

IDPH Chicago Headquarters Offices
- 115 S. La Salle Street, Suite 700, Chicago, IL; and
- 69 W. Washington Street, 35th Floor, Chicago, IL.

Appropriations and Expenditures

Appropriations ($ thousands)	FY22		FY23	
	Approp	Expend	Approp	Expend
GENERAL FUNDS				
Total Personal Services & Fringe Benefits	54,727.9	53,571.4	67,757.6	55,107.0
Total Other Operations and Refunds	13.8	0.0	13.8	0.0
Designated Purposes				
Access to Primary Health Care Serv. Prog.	1,000.0	272.6	1,000.0	0.0
Community Health Worker Certificate Program	0.0	0.0	2,500.0	1,780.7
Costs Assoc. w/ Firearms Restrain. Order Awr.	0.0	0.0	1,000.0	300.0
Costs Assoc. w/ Healthy IL Survey	0.0	0.0	4,700.0	249.8
Exp. Assoc. w/ Breast & Cervical Cancer Screen.	14,512.4	10,307.2	14,512.4	11,057.8
Exp. Assoc. w/ Opioid Overdoes Prevention	1,625.0	1,064.1	1,625.0	402.2
Exp. Assoc. w/ School Health Centers	4,551.1	3,639.5	4,551.1	4,042.4
Exp. Assoc. w/ Childhood Immunization Prog.	156.2	139.1	156.2	156.2
Exp. For Expanded Lab Capacity	322.6	321.8	322.6	259.3
Exp. For Promotion of Women's Health	682.5	681.9	682.5	681.4
Exp. For U of I Chicago Sickle Cell Clinic	483.9	483.9	483.9	483.9
Exp. For Rapid Invest. & Control of Disease	448.5	199.2	448.5	264.3
Exp. Of Adverse Reporting, Patient Safety & Reporting System in Support of Infant Mortality Reduction	1,017.4	937.8	1,017.4	795.3
Exp. Of AIDS/HIV Educ., Services, Prescrip., Etc.	25,562.4	25,112.5	25,562.4	25,091.3
Exp. Of Alzheimer's Disease Research	1,000.0	930.5	2,000.0	972.7

Exp. Of Environmental Health Surveil. Rel. to Mercury Hazards & West Nile	299.2	255.3	299.2	198.7
Exp. Of State Cancer Registry	147.4	147.1	147.4	145.6
Exp. Of Sudden Infant Death Syndrome Prog.	244.4	244.4	244.0	244.4
Exp. Of Suicide Prevention Program	750.0	0.0	750.0	115.8
Exp. Related to Safe Gun Storage Awar. Camp.	0.0	0.0	3,500.0	0.0
For Deposit into Lead Poisoning Screen, Prev.	6,000.0	6,000.0	6,000.0	6,000.0
For Deposit into Sickle Cell Chronic Disease Fd.	0.0	0.0	1,000.0	1,000.0
For Lung and Colon Cancer Screening	0.0	0.0	2,000.0	688.8
HIV/AIDS Getting to Zero	0.0	0.0	10,000.0	4,809.8
Match for Maternal & Child Hth. Title V Mon.	4,800.0	1,026.6	4,800.0	2,049.1
Oper. Exp. To Provide Clinical & Environmental Public Health Lab. Services	3,389.3	3,386.9	6,389.3	5,694.8
Operational Expenses	12,373.3	12,332.5	32,726.0	31,528.5
Statewide 211	0.0	0.0	1,800.0	0.0
Total Designated Purposes	79,365.6	67,482.9	130,217.9	99,012.8
Grants				
Advocate Children's Hospital - Mobile Dental	252.0	151.6	0.0	0.0
Advocate IL Masonic Medical Center	375.0	349.3	375.0	375.0
Grant for Access to Care for Oper. Expenses	0.0	0.0	500.0	500.0
Grant to Equal Hope for Mammography Quality Improvement	0.0	0.0	250.0	0.0
Grant to Alton Memorial Hospital	0.0	0.0	55.0	55.0
Grant to IL Assoc. of Free & Charitable Clinics	0.0	0.0	9,000.0	6,750.0
Grant to Nat'l Kidney Foundation Of IL	350.0	297.4	350.0	307.7
Grant to the Oral Health Forum	250.0	243.7	100.0	100.0
Grants & Admin. Costs Assoc. w/ Health Care Tele mentoring	0.0	0.0	5,000.0	1,194.5
Grants & Other Exp. For Prevention & Treatment for HIV/AIDS for Minorities	1,218.0	919.6	1,218.0	240.0
Grants for Housing Opportunities for Persons w/ AIDS Program	720.0	688.1	720.0	559.3
Grants for Immunizations & Outreach Activit.	4,157.1	474.3	4,157.1	573.4
Grants for Prostate Cancer Awareness	646.6	587.6	146.6	90.4
Grants for Vision & Hearing Screening Progr.	441.7	318.4	441.7	272.8
Grants to Children's Memorial Hospital for IL Violent Death Reporting System	76.7	76.1	76.7	58.0
Grants to Family Planning Programs	5,823.4	5,487.8	5,823.4	5,180.2
Holistic Birth Collective	250.0	250.0	0.0	0.0
Hospital Grants	31,500.0	31,500.0	69,800.0	69,800.0
Perinatal Services	1,002.7	968.3	1,002.7	980.8
Reach Out & Read	0.0	0.0	500.0	0.0

Will County Health Department	335.0	335.0	335.0	335.0
Total Grants	47,398.2	42,647.2	99,851.2	87,372.1
TOTAL GENERAL FUNDS	**181,505.5**	**163,701.5**	**297,840.5**	**241,491.9**
OTHER STATE FUNDS				
Designated Purposes				
Costs Assoc. w/ Children's Health Programs	1,229.7	1,037.6	1,229.7	1,007.1
Deposit into Lead Poisoning Screening, Prevention & Abatement Fund	4,000.0	4,000.0	4,000.0	4,000.0
Exp. Assoc. w/ Health Care Facility Regulation	900.0	179.4	900.0	4.7
Exp. Assoc. w/ Health Outcomes Investigat.	3,000.0	414.8	3,000.0	321.4
Exp. Assoc. w/ Hospital Inspections	900.0	619.0	900.0	427.5
Exp. Assoc. w/ Public Educ., Res. & Enforc. Of Structural Pest Control Act	481.7	470.3	481.7	189.9
Exp. Assoc. w/ IL Adoption Registry	200.0	0.0	200.0	0.0
Exp. For Access to Primary Health Care Serv.	350.0	0.0	350.0	0.0
Exp. For Education & Treatment of Epilepsy	30.0	0.0	30.0	0.0
Exp. For Public Health Preparedness	950.0	539.1	950.0	684.5
Exp. For Adverse Health Care Event Rep. Syst.	1,500.0	271.5	1,500.0	458.0
Exp. For Safe Bottled Water Program	50.0	39.6	50.0	35.3
Exp. In Support of Health Facil. & Serv. Rev. Bd.	1,600.0	953.7	1,600.0	693.3
Exp. Of Admin. Distrib. Of Pymts. From EMS Asst. Fund	1,000.0	259.3	1,000.0	433.3
Exp. Of Admin. Distrib. Of Pymts. To Trauma Ctrs.	7,000.0	999.7	7,000.0	838.2
Exp. Of Admin. Home Care Services Agency Lic. Prog.	1,846.4	1,635.6	1,846.4	937.9
Exp. Of Admin. Private Sewage Disposal Program	250.0	211.3	250.0	208.1
Exp. Of Admin. Tattoo & Body Piercing Establishment Registration Program	550.0	500.9	550.0	321.6
Exp. Of Conducting Early Periodic Screening, Diagnosis & Treatment	48,200.0	19,438.2	48,200.0	8,849.0
Exp. Of Diabetes Research, Treatment & Programs	700.0	0.0	700.0	0.0
Exp. Of Early Periodic Screening, Diagnosis & Treat.	200.0	198.8	220.0	13.6
Exp. Of Public Health Programs	3,750.0	2,587.1	3,750.0	2,233.0
Exp. Of Statewide Database of Death Certificates	2,500.0	1,086.5	2,500.0	696.3
Exp. Of Alternative Health Care Delivery Syst. Prog.	150.0	71.6	150.0	7.5
Exp. Of Health Facilities & Services Review Board	1,200.0	678.1	1,200.0	619.8
Exp. Of Healthy Smiles Program	400.0	389.0	400.0	145.6
Exp. Of Medical Cannabis Program	6,772.6	2,374.3	6,772.6	4,763.9
Exp. Of Nursing Education Scholarship Law	2,000.0	1,276.1	0.0	0.0
Exp. Of Podiatric Scholarship & Residency Act	100.0	100.0	100.0	100.0
Exp. Of Stroke Data Program	150.0	0.8	150.0	0.0
Exp. Of Vector Control Prog., Incl. Mosquito Abate.	1,000.0	969.2	1,100.0	958.1

Exp. Of Women's Health Programs	200.0	4.1	200.0	6.6
Exp. Pursuant to Hearing Aid Consumer Protection	100.0	4.0	100.0	9.5
Exp. Related to J-1 Visa Waiver Applications	175.0	88.9	175.0	50.7
Exp. For Appt. of Long-Term Care Monitors & Rec.	28,000.0	22,157.2	28,000.0	25,568.4
Exp. Admin. & Exec. Asbestos Abate. Act	1,200.0	413.6	1,200.0	426.0
Exp. Admin. Food & Drug Safety Program	300.0	218.6	300.0	83.8
Exp. Admin. Groundwater Protection Act	100.0	31.4	100.0	28.3
Exp. Of Environmental Health Programs	3,000.0	2,911.7	3,000.0	2,083.1
Exp. Of Testing & Screening for Metabolic Diseases	11,100.3	7,563.4	12,100.3	8,525.1
Exp. Of Health Facility Plan Review Program	2,227.0	936.4	2,227.0	853.6
Exp. Of Lead Poisoning Screening & Prev. Progr.	8,414.6	5,580.6	8,414.6	2,611.4
Exp. Of Lead Poisoning Screening & Prev. Abat. Fd.	1,678.1	1,425.1	1,678.1	1,416.7
Exp. Admin. & Enforce IL Plumbing License Law	3,950.0	3,309.8	3,950.0	3,222.8
Exp. Admin. Public Health Lab. Prog. & Serv.	6,000.0	3,065.4	6,000.0	461.7
Exp. Admin. Tanning Facility Permit Act	300.0	56.2	300.0	147.3
Facilities Costs for Regional & Central Offices	2,250.0	2,005.5	2,250.0	570.8
Facility Costs for Lab at West Taylor Location	2,200.0	1,698.1	2,200.0	1,309.0
For Cost & Admin. Exp. Of Adult-Use Cannabis Pro.	500.0	0.0	500.0	0.0
Grants Assoc. w/ Heart saver AED Program	50.0	0.0	50.0	0.0
Identified Offenders Assessment	2,000.0	1,076.7	2,000.0	1,162.4
Mosquito Abatement to Curb Spread of West Nile	5,100.0	2,504.3	5,100.0	2,754.7
Operational Expenses for Maint. Lab. Billings	170.0	160.9	190.0	181.7
Operational Exp. For Metabolic Screen. Follow-Up	4,005.1	3,789.6	4,005.1	3,566.0
Operational Exp. Of Assist. Living & Shared Housing	3,300.0	1,352.5	3,300.0	1,894.3
Total Designated Purposes	179,280.5	101,655.5	178,420.5	85,881.5
Grants				
American Diabetes Association	125.0	125.0	125.0	111.2
Grant to Public & Private Entities in IL for Prostate Cancer Research	30.0	0.0	30.0	0.0
Grant to American Lung Assoc. for the Quitline	4,100.0	4,079.0	4,100.0	4,099.8
Grants for Awareness, Prevention, Care, & Treatment of Sickle Cell Disease	1,000.0	0.0	1,000.0	0.0
Grants for Breast & Cervical Cancer Research	600.0	0.0	600.0	0.0
Grants for Childhood Cancer Research	75.0	0.0	75.0	0.0
Grants for Free Distrib. Of Med. Prep. & Food Supp.	3,175.0	2,690.2	3,675.0	2,898.9
Grants for Hospice Services	30.0	0.0	0.0	0.0
Grants for Metabolic Screening Follow-Up Services	3,250.0	2,671.8	3,250.0	2,589.8
Grants for Research for the Treatment & Cure of Autoimmune Diseases	50.0	0.0	50.0	0.0
Grants for Comm. Health Ctr. Expansion Program	1,000.0	861.2	1,100.0	979.2
Grants for Lead Poisoning Screen. & Prev. Program	5,500.0	1,632.4	5,500.0	4,556.2

Grants for Tobacco Use Prev. Prog., Brothers & Sisters United Against HIV/AIDS Prog. & Asthma Prev. Prog.	1,000.0	921.0	1,000.0	985.4
Grants HIV/AIDS Quality of Life Programs	1,000.0	410.7	1,000.0	546.9
Grants Pursuant to Alzheimer's Disease Research Act	400.0	349.3	500.0	210.8
Grants to Assist Residents of Facilities Licensed under the Nursing Home Care Act	3,500.0	0.0	3,500.0	159.1
Grants to Organizations in IL that Conduct Multiple Sclerosis Research	1,000.0	400.0	1,000.0	516.1
Grants to Public & Private Entities in IL for Research on Breast Cancer & Services for Breast Cancer Victims	2,000.0	489.1	2,000.0	412.4
Grants to Susan G. Komen Foundation	0.0	0.0	117.0	0.0
Juvenile Diabetes Research Foundation	125.0	125.0	125.0	125.0
Local Health Protection Grants	19,098.5	19,069.1	19,098.5	19,021.3
Local Health Prot. Grants for Anti-Smoking Programs	5,000.0	4,162.7	5,000.0	4,223.1
Prevention & Treatment of HIV/AIDS	15,000.0	749.2	15,000.0	2,299.0
Spinal Cord Injury Paralysis Cure Research Trust Fund	500.0	0.0	500.0	0.0
Total Grants	67,558.5	38,735.7	68,345.5	43,734.2
TOTAL OTHER STATE FUNDS	**246,839.0**	**140,391.2**	**246,766.0**	**129,615.7**
FEDERAL FUNDS				
Total Personal Services & Fringe Benefits	52,343.0	28,396.6	0.0	0.0
Total Contractual Services	7,541.1	3,457.4	0.0	0.0
Total Other Operations and Refunds	8,033.1	687.6	85.0	0.0
Designated Purposes				
ARPA - DPH COVID-19 Response	0.0	0.0	20,000.0	0.0
ARPA - For Deposit into African-American HIV/AIDS Response Fund	15,000.0	5,000.0	10,000.0	0.0
Community Activities	20,000.0	1,655.6	20,000.0	0.0
Exp. Assoc. w/ Contact Tracing & Testing	600,000.0	34,068.6	600,000.0	25,991.8
Exp. Assoc. w/ Maternal & Child Health Programs	24,750.0	6,890.2	24,750.0	13,871.5
Exp. Assoc. w/ Monitoring in Long-Term Care Facil.	3,000.0	13.0	0.0	0.0
Exp. Assoc. w/ Ryan White Comprehensive AIDS Resource Emergency Act of 1990	100,000.0	70,185.9	100,000.0	71,438.9
Exp. Assoc. w/ the Support of Federally-Funded Public Health Programs	2,500.0	1,593.3	2,500.0	764.6
Exp. for Rural Health Centers to Expand the Availability of Primary Health Care	2,000.0	1,797.2	2,000.0	1,280.7
Exp. For Surveillance Prog. & Seroprevalence Studies of AIDS/HIV	2,750.0	1,150.2	2,750.0	866.4

Exp. Of Federally Funded Bioterrorism Preparedness	80,000.0	28,853.8	80,000.0	35,248.2
Exp. Of Federally Funded Public Health Programs	300.0	0.0	300.0	0.0
Exp. Of Federally Funded Women's Health Programs	3,000.0	671.0	5,570.8	2,140.8
Exp. Of Implementing Federal Awards	1,400,000.0	382,715.7	1,400,000.0	112,710.9
Exp. Of Implementing Federal Grants	16,484.5	1,797.4	45,670.5	18,100.9
Exp. Of Preventive Health & Health Serv. Needs Assess.	3,500.0	972.8	3,500.0	1,715.8
Exp. Of Preventive Health & Health Services Prog.	1,726.8	1,031.6	1,726.8	1,192.9
Exp. Of Programs for Prevention of AIDS/HIV	7,250.0	3,703.4	7,250.0	3,581.0
Exp. Related to Epidemiological Health Outcome Investigations & Database Development	17,110.0	10,409.4	0.0	0.0
For Costs Assoc. w/ Health Care Reg., Surv., & Monitoring	0.0	0.0	25,397.0	16,096.6
For Costs Assoc. w/ Health Promotion Programs	0.0	0.0	3,674.4	1,520.2
For Costs Assoc. w/ Policy, Plann., & Statistics Programs	0.0	0.0	29,845.1	11,691.3
For Costs Assoc. w/ Public Health Laboratories	0.0	0.0	8,268.9	1,208.1
Operational Exp. Of Maternal & Child Health Prog.	500.0	72.0	500.0	120.3
Operational Exp. To Develop Health Care Provider Recruitment & Retention Program	337.1	141.5	337.1	123.4
Operational Exp. To Maintain a Vital Records System	2,000.0	0.0	2,000.0	0.0
Operational Exp. To Support Refugee Health Care	514.0	202.1	514.0	275.4
Total Designated Purposes	2,302,722.4	552,924.7	2,396,554.6	319,939.7
Grants				
ARPA - COVID-19 Vaccine Incentive	3,000.0	3,000.0	0.0	0.0
ARPA - Hospital Grants	37,700.0	37,700.0	58,700.0	58,700.0
Exp. Of Health Outcomes, Research Policy & Surveillance	4,000.0	238.3	4,000.0	0.0
Grants for Breast & Cervical Cancer Screening	7,000.0	5,336.2	7,000.0	5,672.3
Grants for Maternal & Child Health Population-Based Prog.	495.0	307.6	995.0	415.8
Grants for Prevention Initiative Programs	1,000.0	477.9	1,000.0	471.2
Grants for Public Health Programs	9,530.0	5,635.3	9,530.0	6,608.3
Grants for Development of Refugee Health Care	1,950.0	129.2	1,950.0	279.3
Grants to Develop Health Care Provider Recruit. & Retention Program	450.0	71.2	450.0	56.0
Grants to Develop Health Prof. Educ. Loan Repayment Program	1,000.0	829.6	1,000.0	833.0

Grants to U of I Division of Specialized Care for Children	9,000.0	6,329.8	9,000.0	6,984.8
Grants to Chicago Depart. Of Health for Maternal & Child Health Services	6,000.0	4,320.4	6,000.0	4,772.8
Maternal and Child Health Services	3,000.0	2,413.2	3,000.0	2,489.6
Total Grants	84,125.0	66,788.7	102,625.0	87,283.1
TOTAL FEDERAL FUNDS	**2,454,764.6**	**652,255.0**	**2,499,264.6**	**407,222.8**
TOTAL	**2,883,109.1**	**956,347.7**	**3,043,871.1**	**778,330.4**

Accountants' Findings and Recommendations

Condensed below are the 39 findings and recommendations included in the audit report. Of these, 27 are repeated from the previous audit. The following recommendations are classified on the basis of information provided by IDPH, via electronic mail received August 1, 2024

1. **The auditors recommend the Department strengthen its controls over its state vehicles. Specifically, they recommend the Department:**

   - **Ensure vehicle mileage log reports are maintained to monitor utilization and maintenance of the State vehicle.**
   - **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 and documentation related to the personal use of State vehicles.**
   - **Review and enforce procedures over the timely filing of the required annual certifications of license and liability insurance.**
   - **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 properly completed and submitted to DCMS by the established due date.**

FINDING: *(Inadequate Controls over the Administration of State Vehicles) – This finding has been repeated since 2007.*

The Illinois Department of Public Health (Department) did not exercise adequate internal controls over State vehicles.

The Department's fleet consisted of 109 vehicles at June 30, 2022 and 98 at June 30, 2023. Of those vehicles, 36 were personally assigned to employees during Fiscal Year 2022 and 41 in Fiscal Year 2023.

During testing, the auditors noted the following:

- The Department was not able to provide the vehicle mileage log reports for three of 98 (3%) vehicles tested, as such, they were not able to determine whether these vehicles were efficiently utilized for the specific operational needs of the Department, properly maintained, and the mileage properly reported.

  The Department Vehicle Policy (Vehicle Policy) requires any employee who drives a state vehicle whether personally assigned or pooled to record the mileage of daily use. The Vehicle Policy also requires all mileage be recorded on a monthly mileage report and submitted to the Department's Vehicle Coordinator by the 10th day from the conclusion of the previous month. The State Records Act (5 ILCS 160/8) requires the head of each agency to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the agency's activities.

- The Department did not ensure its vehicles were properly maintained during the engagement period. The auditors reviewed the maintenance records for 22 vehicles and noted the following:

  - Nine (41%) vehicles tested received oil changes 128 to 4,679 miles past the allowed oil change interval. Additionally, two (9%) vehicles tested did not receive oil changes during the engagement period.

  - Four (18%) vehicles tested did not receive a tire rotation, as required. Additionally, one (5%) vehicle had tire rotation past the allowed interval and another vehicle (5%) had inadequate documentation, therefore, we were not able to determine whether this vehicle had tire rotation within the allowed interval.

  - Four (18%) vehicles tested did not undergo an annual inspection during the engagement period.

  - One (5%) vehicle was not found on the location indicated in the Department's property listing during the physical inspection of vehicles. In addition, the Department was not able to provide sufficient supporting documentation on the disposal and transfer of two (9%) vehicles.

  - The Department was not able to provide the maintenance records for three (14%) vehicles tested, as such, the auditors were not able to determine

whether these vehicles were properly maintained.

The Illinois Administrative Code (Code) (44 Ill. Adm. Code 5040.410(a)) requires agencies to have vehicles inspected at least once per year and to maintain vehicles in accordance with the Department of Central Management Services (DCMS) schedules for proper care and maintenance of vehicles. In addition, the Code (44 Ill. Adm. Code 5040.400) requires all State-owned or leased vehicles to undergo regular service and/or repair to maintain the vehicles in road worthy, safe, operating condition and appropriate cosmetic condition. The State Records Act (5 ILCS 160/8) requires the head of each agency to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the agency's activities.

- The Department did not exercise adequate control over the personal use of State vehicles. The auditors noted the following:

    - Seventy-two (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. In addition, five of 72 (7%) monthly vehicle logs and vehicle use certification forms tested differed as to the number of commuting days the State vehicle was used, resulting in the overstatement of reported fringe benefit payments for tax purposes totaling $45 in Fiscal Year 2022 and understatement of $15 in Fiscal Year 2023.

    - Thirty-seven of 72 (51%) vehicle use certification forms tested were not submitted to the Payroll Division on the 10th of the month following the usage. The vehicle use certification forms were submitted from four to 300 days late. Additionally, 13 of 72 (18%) vehicle use certification forms tested were not stamped with a receipt date, therefore, timeliness of submission of the forms cannot be determined. Further, one of 72 (1%) vehicles use certification forms tested was not submitted to the Payroll Division.

    - Two of 72 (3%) vehicle use certification forms tested did not agree with the payroll voucher, resulting in an understatement totaling $39 in Fiscal Year 2022.

    - The Department was not able to provide 17 of 72 (24%) monthly vehicle logs tested, as such, the auditors were not able to determine whether the number of commuting days and fringe benefit payments were properly reported.

The Internal Revenue Services' Employer's Tax Guide to Fringe Benefits (Publication 15-B) and Section IV of the Department's Vehicle Policy states that any commute

that an individual makes with an assigned vehicle is considered a fringe benefit and is to be valued at $1.50 per one-way commute, or $3 per day. Fringe benefits are to be included in the employee's wages for tax purposes.

Section IV of the Department's Vehicle Policy requires employees to record all days the State vehicle is driven for commuting purposes and report it to the agency Payroll Division on the 10th of the month following the usage. No employee should be assigned to a state vehicle solely for the purpose of commuting.

- The Department did not exercise adequate control over the required annual certifications of licensure and automobile liability coverage form (certification form). The auditors noted the following:

    - Five of 34 (15%) employees tested did not submit the certification forms during the engagement period.

    - One of 34 (3%) employees tested submitted the certification form 124 days late.

  The Illinois Vehicle Code (625 ILCS 5/7-601(c)) requires every employee of a state agency who is assigned a specific State-owned or leased vehicle on an ongoing basis to provide annual certification to the chief executive officer of the agency affirming that the employee is duly licensed to drive and that the employee has liability insurance coverage extending to the employee when the assigned vehicle is used for other than official State business. The certification is required to be provided during the period July 1 through July 31 of each calendar year or within 30 days of any new vehicle assignment of a vehicle, whichever is later. Additionally, employees using private vehicles on State business must have insurance coverage in an amount not less than that required by the Illinois Vehicle Code (625 ILCS 5/10-101(b)).

- The Department did not timely and properly report vehicle assignments to DCMS. The auditors noted the following:

    - The Department submitted the Fiscal Year 2022 Individually Assigned Vehicle (IAV) Report five days late.

    - The Department was not able to provide three of five (60%) vehicle assignment authorization forms tested.

    - One of 34 (3%) employees tested submitted the vehicle assignment authorization form 124 days late.

  The Code (44 Ill. Adm. Code 5040.340) states that vehicles may be assigned to specific individuals if authorized in writing by the head of the agency to which the vehicle is assigned and requires agencies to report to DCMS annually and when

changes occur, the name of each employee assigned a vehicle, the equipment number and license plate number of the assigned vehicle, and the employee's headquarters and residence.

This finding was first reported during the period ended June 30, 2007. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated, as they did during the prior engagement period, the deficiencies were due to staff turnover, competing priorities, and a lack of policies and procedures.

Failure to maintain daily mileage logs for the usage of State vehicles could impose challenges for the Department management in monitoring the efficient and effective utilization of these State properties. Regular maintenance on State vehicles ensures the safety and efficiency of State vehicles, including better fuel economy and fewer expenditures related to the repair or replacement of vehicles, lower fleet operating costs, reduced vehicle down time and conservation of limited State resources. In addition, obtaining certification of license and vehicle liability coverage helps to prevent uninsured, underinsured and/or unlicensed drivers operating State vehicles while performing State business. Further, failure to properly report vehicle assignment changes to DCMS lessens government oversight for fleet efficiency and accountability for State resources.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will ensure that controls and processes are strengthened to comply with the finding.

UPDATED RESPONSE:
Partially Implemented
The Department is in the process of training staff towards implementing a Fleet Management System that serves as a comprehensive automotive cost reporting system that will capture mileage on a monthly/daily basis as input is done to the system. The dual system approach will inform the department when and what type of maintenance is required and completed.

2. The auditors recommend the Department implement procedures to strengthen controls over equipment and ensure accurate recordkeeping, timely reporting, and accountability for all State-owned property is maintained.

FINDING: *(Property Control Weaknesses) – This finding has been repeated since 2013.*

The Illinois Department of Public Health (Department) did not maintain adequate controls over its property and related records.

During their testing, the auditors noted the following:

Property Additions:

- Eight of 60 (13%) property additions tested, totaling $33,810, were recorded 29 to 1,669 days late. The Illinois Administrative Code (Code) (44 Ill. Adm. Code 5010.400) requires the Department to adjust their property records within 90 days of acquisition, change, or deletion of equipment items.

Physical observation

- Seventeen of 60 (28%) items tested, totaling $8,872, were not traced to the property records. The State Property Control Act (30 ILCS 605/6.02) requires the Department to maintain a permanent record of all items of property under its jurisdiction and control.

- Six of 60 (10%) items tested, totaling $5,208, were not found at the location indicated on the Department's property listing. The Statewide Accounting Management System (SAMS) (Procedure 29.10.10) requires the Department to maintain current property records, including the location. Additionally, the Code (44 Ill. Adm. Code 5010.230) requires the Department to correctly enter each item's location code number on its property listing.

- Three of 60 (5%) items tested, totaling $7,005, were unusable or considered obsolete. The Code (44 Ill. Admin. Code 5010.620) requires the Department to regularly survey their inventories for transferable equipment and report any such equipment on proper forms to the Property Control Division of the Department of Central Management System (DCMS).

- One of 60 (2%) items tested, totaling $1,800, had a missing tag. The Code (44 Ill. Admin. Code 5010.210) requires the Department to mark each piece of State-owned equipment in their possession to indicate that it is the property of the State of Illinois. Additionally, the Code requires the Department to mark the equipment with a unique identification number to be assigned by the agency holding the property and the marking be applied using the Department's inventory decal or by indelibly marking the property.

Annual Real Property Utilization Report (ARPUR)

The Department submitted the Fiscal Year 2023 ARPUR to DCMS ten days late. The Property Control Act (30 ILCS 605/7.1(b)) requires the Department to submit by July 31 of each year, an ARPUR, or annual update of such report, on forms required by DCMS.

Agency Report of State Property (C-15 Report)

Five property additions, totaling $174,600, were not included in the Fiscal Year 2023 C-15 Report. The Statewide Accounting Management System (SAMS) (Procedure 29.10.10) requires purchased assets to be included in the C-15 Report in the quarter the assets were received.

This finding was first reported during the period ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated the issues were due to clerical errors, competing priorities, and the related position being vacant for several months.

Failure to maintain accurate property records increases the risk of equipment theft, loss, or waste occurring without detection and resulted in inaccurate property recording and reporting.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department has been working on strengthening the controls on State equipment along with recordkeeping. A review will be conducted, and changes made where the controls failed. Additionally, staff will be trained on property tracking and recording.

UPDATED RESPONSE;
Under Study
The Department agrees with the finding and the recommendation. The Department is reviewing current procedures and seeking advice from other agencies on their controls over state property. Training sessions are planned for all employees involved with property inventory.

3. The auditors recommend the Department ensure it complies with all provisions of the Act.

FINDING: *(Noncompliance with the MC/DD Act) – This finding has been repeated since 2017.*

The Illinois Department of Public Health (Department) did not comply with provisions of the MC/DD Act (Act). The Act, effective July 29, 2015, required long-term care facilities for individuals under age 22 to be known and licensed as medically complex for the developmentally disabled under the Act instead of the Intermediate Care Facility/Individual Intellectually Disabled (ID/DD) Community Care Act.

During their testing of certain provisions of the Act, the auditors noted the following:

- During testing of the inspections conducted for the State license renewals of the 10 MC/DD facilities during Fiscal Year 2022 and Fiscal Year 2023, they noted the following:
    - Three (30%) facilities were inspected by the Department 33 to 82 days after the effective date of the renewal licenses.
    - Two (20%) facilities were inspected by the Department 151 to 472 days

prior to license renewal.

- Four (40%) facilities did not provide comments or documentation within 10 days of receipt of the copy of the inspection report. The facilities submitted the comments or documentation 11 to 47 days after receipt of the report.

- Three (30%) facilities did not have documentation of comments after receipt of the report.

The Act (210 ILCS 46/3-212(a)) requires the Department to inspect, survey, and evaluate every facility to determine compliance with applicable licensure requirements and standards. The inspection should occur within 120 days prior to license renewal. The Act (210 ILCS 46/3-212(c)) requires the Department to submit a copy of the report to the licensee upon completion of each inspection, survey, and evaluation and upon exiting the facility. The licensee is required to provide within 10 days of receipt of the copy of the report, comments, or documentation which may refute findings in the report, explain extenuating circumstances that the facility could not reasonably have prevented, or which indicate methods and timetables for correction of deficiencies described in the report.

Department management attributed the conditions above to a shortage of surveyors for developmental disability facilities.

- The Department did not develop a de-identified database of residents who have injured facility staff, facility visitors, and other residents. The Act (210 ILCS 46/2-201.5(d)) requires the Department to develop and maintain a de-identified database of residents who have injured facility staff, facility visitors, or other residents, and the attendant circumstances, solely for the purposes of evaluating and improving resident pre-screening and assessment procedures and the adequacy of Department requirements concerning the provision of care and services to residents.

  Department management stated a de-identified database of residents who have injured facility staff, visitors, and other residents was not developed due to minimal technology within the Department.

- The Department did not maintain updated information on the facilities database posted on its website. Except for the inspection reports, which were current, the information posted by the Department was for the period ended December 31, 2014. The Act (210 ILCS 46/3-304.1(a)(2)) requires the Department to make available to the public in electronic form information regarding MC/DD facilities. The Act (210 ILCS 46/3-210) requires the facility to retain the following information for inspection: a complete copy of every inspection report of the facility received from the Department during the past 5 years; a copy of every order pertaining to the facility issued by the Department or a court during the past 5 years; a description of the services provided by the facility and the rates charged for those services and items

for which a resident may be separately charged; a copy of the statement of ownership; a record of personnel employed or retained by the facility who are licensed, certified or registered by the Department of Financial and Professional Regulation; and a copy of the current Consumer Choice Information Report.

Department management indicated the failure to update the information on their website was due to limited technological abilities.

This finding was first reported during the period ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

During the prior engagement period, the Department did not adopt rules to conduct on site review of large or complex construction projects; expedited process for emergency repairs or replacement of like equipment; and define the circumstances under which a ban on new admissions to a facility may be imposed. During the current engagement period, the auditors noted the Department had adopted the rules by updating the Illinois Administrative Code (Code) (77 Ill. Admin. Code 390.2610(h)(3) to (5)), (77 Ill. Admin. Code 390.2910(d)), and (77 Ill. Admin. Code 390.630), respectively. Additionally, during the prior engagement period, the Department had not updated the Code to address the requirement that each policy should include the periodic review of the use of restraints; informed consent for psychotropic medication requires a discussion with the resident's physician, a registered pharmacy, or a licensed nurse, and the use of standardized consent forms; and the facility to submit written notification of any unusual incident, abuse, or neglect within one day after the incident occurring. During the current engagement period, they noted the Department updated the Code (77 Ill. Admin. Code 390.1310, 390.1312, 390.1314, 390.1316, and 390.3210).

Failure to carry out these mandated duties does not achieve the legislative intent for the affected program, which is to provide adequate long-term care for the under age 22 MC/DD facilities.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation.

The Department is currently ensuring compliance with all provisions of the Act. The Department drafted proposed rules to bring the Department into compliance with sections of the MC/DD Act cited above. Rules are published for first notice in the January 3, 2022, issue of the Illinois Register at 46 Ill. Reg. 299 and are scheduled for review at the April 19, 2022, JCAR meeting.

Annual licensure surveys and facility comments/documentation were delayed in Fiscal Year 2020 and Fiscal Year 2021 due to the COVID-19 pandemic. The Department anticipates compliance with the applicable provisions of 210 ILCS 46/3-212(a) and (c) and will monitor scheduling so that inspections occur within the 120-day window of the applicable licensure renewal.

The Department is posting surveys and applicable plans of correction on the website pursuant to 210 ILCS 46/3-304.1(a)(2).

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. The Department does have data regarding resident to employee abuse. We have implemented a new technology system that will allow the department to track resident to employee abuse in July 2024 and should be able to use report data to develop the required data base.

The department is maintaining updated facility information on the department website as required.

4. **The auditors recommend the Department strengthen and monitor controls to ensure:**

   - **all required contract information is complete and accurate,**
   - **accurate and complete listings of contractual agreements, emergency purchases, and interagency agreements are maintained,**
   - **proper implementation of the requirements of GASB Statement No. 87, and**
   - **compliance with the requirements of the Procurement Code and State laws.**

FINDING: *(Lack of Controls over Contracts) – This finding has been repeated since 2013.*

The Illinois Department of Public Health (Department) did not have adequate controls over contracts to ensure the contracts contained the necessary provisions, were properly approved, and accurately reported.

As part of their testing, the auditors requested the Department to provide a population of contractual agreements, emergency purchases, and interagency agreements. In response to our requests, the Department provided populations for emergency purchases and interagency agreements but was not able to provide a listing of all the contractual agreements which the Department had entered into during the examination period. Additionally, the emergency purchases listing provided by the Department did not agree with the emergency purchases reported to the Office of the Auditor General and there were interagency agreements not reported in the Agency Contract Report (SC-14). Due to these conditions, they were unable to conclude the Department's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36).

During testing, the auditors noted the following:

- Six of 14 (43%) interagency agreements tested, totaling $5,706,197, were executed subsequent to the performance of services. The agreement execution dates ranged from seven to 385 days late. Additionally, the Department was not able to provide the executed agreements for two of 14 (14%) interagency agreements tested. Therefore, they are unable to test those agreements

  The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance resources are utilized efficiently and effectively and obligations and costs are in compliance with applicable laws. Good internal controls require the approval of agreements prior to their effective dates. In addition, the State Records Act (5 ILCS 160/8) requires the head of each agency to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency designed to furnish information to protect legal and financial rights of the State and of persons directly affected by the agency's activities.

- For two of eight (25%) emergency purchase contracts tested, totaling $608,380, the Department published the total actual cost of each emergency purchase in the Illinois Procurement Bulletin 40 and 390 days late. In addition, one of eight (13%) emergency purchase contracts tested, totaling $360,101, ended on June 30, 2022 but the Department had not published the actual cost as of auditors' fieldwork.

  The Illinois Procurement Code (Code) (30 ILCS 500/20-30(b)) requires the purchasing agency to publish in the Illinois Procurement Bulletin the total cost of each emergency procurement made during the previous month. When the actual total cost is determined, it shall be published before the 10th day of the next succeeding month.

- The Department was not able to provide the supporting documentation that they submitted to the Procurement Policy Board and the Commission on Equity and Inclusion the following:

  - Notice of award for seven of eight (88%) emergency purchase contracts tested, totaling $10,765,277, and

  - Notice of intent to extend an emergency contract for five of eight (63%) emergency purchase contracts tested, totaling $10,351,570.

  The Code (30 ILCS 500/20-30(b)) requires the purchasing agency to provide notice of all emergency procurements to the Procurement Policy Board and the Commission on Equity and Inclusion and publish in the online electronic Bulletin no later than 5 calendar days after the contract is awarded. The Code also requires the notice of intent to extend the emergency contract be provided to the Procurement Policy Board and the Commission on Equity and Inclusion and published in the online

electronic Bulletin at least 14 calendar days before the public hearing. Per Public Act 102-1119 effective January 23, 2023, the Code requires the notice of extension of an emergency contract be provided to the Procurement Policy Board and the Commission on Equity and Inclusion and published in the online electronic Bulletin no later than 7 calendar days after the extension was executed.

- Three of 60 (5%) contractual agreements tested, totaling $5,541,576, were filed with the Comptroller more than 30 days after their execution and were not accompanied by a Late Filing Affidavit.

  The Code (30 ILCS 500/20-80(c)) states that when a contract, purchase order, grant, or lease required to be filed by this Section has not been filed within 30 calendar days of execution, the Comptroller shall refuse to issue a warrant for payment thereunder until the agency files with the Comptroller the contract, purchase order, grant, or lease and an affidavit, signed by the chief executive officer of the agency or his or her designee, setting forth an explanation of why the contract liability was not filed within 30 calendar days of execution. A copy of this affidavit shall be filed with the Auditor General.

- Five of 60 (8%) contractual agreements tested, totaling $1,153,964, did not have the required subcontractor disclosure and utilization statements. In addition, one of 60 (2%) contractual agreements tested, totaling $471,550, did not have the conflict of interest Certification, and one (2%) contract, totaling $43, 864, did not have the Certification of Registration with the State Board of Elections.

The Code (30 ILCS 500/20-120(a)) requires any contract granted under this Code to state whether the services of a subcontractor will be used. The contract shall include the names and addresses of all known subcontractors with subcontracts with an annual value that exceeds the small purchase maximum established by Section 20-20 of the Code, the general type of work to be performed by these subcontractors, and the expected amount of money each will receive under the contract.

The Code (30 ILCS 500/50-35(a)) requires all bids and offers from responsive bidders, offerors, vendors, or contractors with an annual value that exceeds the small purchase threshold established under subsection (a) of Section 20-20 of the Code, and all submissions to a vendor portal, shall be accompanied by disclosure of the financial interests of the bidder, offeror, potential contractor, or contractor and each subcontractor to be used. The financial disclosure of each successful bidder, offeror, potential contractor, or contractor and its subcontractors should be incorporated as a material term of the contract and shall become part of the publicly available contract or procurement file.

The Code (30 ILCS 500/20-160(b)) requires all bids and offers contain (1) a certification by the bidder, offeror, vendor, or contractor that either (i) the bidder, offeror, vendor, or contractor is not required to register as a business entity with the State Board of Elections pursuant to this Section or (ii) the bidder, offeror, vendor, or contractor has registered as a business entity with the State Board of Elections and acknowledges a continuing duty to

update the registration and (2) a statement that the contract is voidable under Section 50-60 for the bidder's, offeror's, vendor's, or contractor's failure to comply with this Section.

- For 26 of 60 (43%) contracts tested, the Contract Obligation Documents (CODs) were not properly completed. The auditors noted the following:

    - Twenty CODs totaling $12,284,856, included incorrect Illinois Procurement Bulletin/Bid buy publication dates. Three of these CODs had an incorrect procurement reference number, one COD had an incorrect award code, and one COD had an incorrect appropriation code.

    - Two CODS totaling $1,555,550, had contract beginning and ending dates different from the dates reported in the SC-14 Report.

    - Four CODs did not state the correct annual contract amounts. The total annual amounts entered in the COD was $2,422,573, however, the total annual amounts reported in the SC-14 Report was $7,890,634. One of these CODs also incorrectly entered an obligation amount totaling $1,751,603, instead of the obligation amount totaling $6,314,022 in the SC-14 Report. Additionally, two of these CODS also did not state the correct maximum contract amounts. The maximum contract amounts entered in the CODs totaled $4,025,265, however, the total maximum contract amounts reported in the SC-14 Report was $9,525,184.

    - One COD totaling $72,649 had an incorrect obligation number.

    - One COD stated that subcontractors will not be utilized, however, the executed contract indicated utilization of subcontractors.

    The Statewide Accounting Management System (SAMS) (Procedure 15.20.10) requires the contract obligation document to contain the maximum contract amount, annual contract amount, beginning and ending dates of the contract, detailed description of the contract, in addition to other applicable information.

- The Department's process in implementing GASB Statement No. 87 – *Leases* (GASB 87), was not adequate. The following issues were noted:

    - For two of five (40%) GASB 87 lease contracts tested, totaling $1,251,212, the forms SCO-560 were filed with the Office of Comptroller 77 and 347 days late.

    - For three of five (60%) GASB 87 leases contracts tested, totaling $2,851,771, the forms SCO-560 were not filed with the Office of Comptroller, therefore, the Department did not record the corresponding right of use asset, lease liability, and lease payments.

- The Department did not record the right of use asset, lease liability, and lease payments for one of two (50%) forms SCO-560 the Department submitted to the Comptroller's Office, resulting in the understatement of the following accounts:
  - Right of Use Asset amounting to $1,168,683
  - Lease Liability amounting to $1,168,683
  - Lease Payments amounting to $774,306

GASB Statement No. 87 defines a lease as "a contract that conveys control of the right to use another entity's nonfinancial asset (the underlying asset) as specified in the contract for a period of time in an exchange or exchange-like transactions." GASB Statement No. 87 requires the lessee to recognize a lease liability and a lease asset at the commencement of the lease term. The lease liability should be measured at the present value of payments expected to be made during the lease term. The lease liability is reduced as payments are made. The lease asset should be measured at the amount of the initial measurement of the lease liability, plus any payments made to the lessor at or before the commencement of the lease term and certain direct costs. The lease asset is amortized in a systematic and rational manner over the shorter of the lease term or the useful life of the underlying asset.

SAMS (Procedure 27.20.60) requires all agencies who lease property complete Form SCO-560 for each multiple period lease that falls within the scope of GASB Statement No. 87. The Form SCO-560 is to be completed on a transaction-by-transaction basis as new lease agreements are initiated or when changes are made to existing lease provisions.

The finding was first reported during the period ended June 30, 2013. In the subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated the deficiencies were due to the absence of a centralized monitoring and tracking of contracts and competing priorities.

Without the Department providing a complete and accurate population of contractual agreements entered into during the examination period, the auditors were unable to adequately complete procedures to provide useful and relevant feedback to the General Assembly. Failure to fully execute a contract prior to commencement of services and contain the material terms of the contract leaves the Department exposed to liabilities and potential legal issues. Failure to publish the costs incurred for emergency purchases is noncompliance with State law. The lack of proper controls over contract obligation documents may result in inaccurate record keeping and a lack of accountability for the Department. Failure to properly implement GASB 87 reduces the reliability of Statewide financial reporting.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. The process of contract monitoring is being evaluated and will be strengthened to the standards recommended by the Auditors.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. The Department has created a Division of Procurement with the focus of being in compliant with all Procurement Codes and State laws. The Department has implemented the requirements of GASB Statement No. 87.

5. **The auditors recommend the Department strengthen its controls to ensure documentation and timely review of grantee's required quarterly and monthly reports are maintained. In addition, they recommend the Department ensure that grantees timely submit the progress reports and other required reports to comply with the provisions of the grant agreements.**

FINDING: *(Inadequate Administration and Monitoring of Awards and Grants Programs) – This finding has been repeated since 2007.*

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

During Fiscal Years 2022 and 2023, the Department expended over $701 million (44%) for awards and grants of its approximately $1.7 billion total expenditures. The auditors sampled 58 grant programs from the following offices: Health Promotion; Health Protection; Disease Control; Women's Health; Preparedness and Response; and Center for Minority Health Services. For the 58 grant programs selected for testing, they examined 60 grant agreements totaling $55,095,365.

- For 47 of 60 (78%) grant agreements tested, 426 quarterly/monthly program reports were submitted to the Department from 1 to 305 days after the deadline.

- For 25 of 60 (42%) grant agreements tested, 58 quarterly/monthly program reports were not reviewed timely. The reviews were made from 1 to 280 days after receipt.

- For 14 of 60 (23%) grant agreements tested, 26 quarterly/monthly program reports did not have evidence of a review by Department personnel.

- For 13 of 60 (22%) grant agreements tested, 65 quarterly/monthly program reports were not submitted to the Department by the grantee.

This finding was first reported during the period ended June 30, 2007. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently and effectively, and in compliance with applicable law. The grant agreements require the grantees to submit financial reports and performance reports with frequency and deadlines specified in the executed grant agreements. Additionally, the Grant Accountability and Transparency Act (30 ILCS 708/45(g)) requires each State grantmaking agency to enhance its processes to monitor and address noncompliance with reporting requirements and with program performance standards. Further, the State Records Act (5 ILCS 160/8) requires the Agency to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency to furnish information to protect the legal and financial rights of the State and of persons directly affected by the agency's activities.

Department management attributed the conditions noted above to issues including staffing capacity and vacancy, staff expertise, system technicality, inadequate policy on document retention, competing priorities, and oversight.
Failure to ensure that grantees timely submit the required reports and document the timely submission date and reviews of grantees' required reports by Department personnel decreases the Department's accountability over funds granted and increases the risk of noncompliance with the provisions of the grant agreements. Further, the untimely receipt of required reports inhibits the Department's ability to effectively track project completeness and milestones. As a result, funds could remain unspent, untimely recovered, or be utilized for activities other than the intended purpose without detection by the Department.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work with the Office of Fiscal Administration, the Office of Performance Management, Internal Audit, and the Division of Legal Services to develop clear and consistent standards on grant management across the agency, including a review of associated best practices and system improvements.

UPDATED RESPONSE:
Implemented

The Department agrees with the finding and recommendation. The Department's Office of Performance Management (OPM) has enhanced controls to support the grant manager's review and monitoring of grantee compliance with monthly grantee reports and submitting and providing deliverables in the grant agreements. The OPM has developed a comprehensive Grants Management Manual that outlines Standard Operating Procedures (SOPs) for the entire grant process. The manual, released on March 25, 2024, was developed in collaboration with experienced grant managers and was reviewed by the administrative policy team, including legal and fiscal administration. It has been disseminated to all IDPH staff and is available on the IDPH intranet.

A monthly Past Due Report- A Monthly Reminder is sent to all grant managers and the deputy directors. The reminder is a list of all grantees who are out of compliance with report submission and serves as a reminder to review progress on the provision of the grant agreement. Grant managers are encouraged to communicate openly with grantees to facilitate collaboration, regular check-ins, feedback sessions, and support mechanisms to ensure timeliness and expected program outcomes.

The OPM regularly provides training on the grant management process and issues monthly reminders to grantees about timely report submissions. Additionally, grant administrators receive monthly reminders on the importance of promptly reviewing and processing performance and fiscal reports. The manual includes specific SOPs for compliance monitoring and grant closeout.

To further support compliance, the OPM issued quarterly notifications regarding grantees reporting compliance issues on October 5, 2023. As of February 28, 2024, these notifications transitioned to monthly updates sent by the OPM Technical Assistance Group (TAG) team. This shift has resulted in a 79% improvement in grantee compliance.

These strengthened controls provide grant managers with the tools necessary to track overdue reports and ensure grantees adhere to the provisions of their grant agreements. The notifications and SOPs offer clear guidance on addressing compliance issues and maintaining grantee accountability.

6. The auditors recommend the Department ensure overtime pre-approval requests are timely submitted, properly approved in advance, and documentation of pre-approval is maintained.

FINDING: *(Inadequate Controls over Approval and Reporting of Overtime) – This finding has been repeated since 2011.*

The Illinois Department of Public Health (Department) did not exercise adequate controls over the approval and reporting of overtime to ensure employees' overtime requests were properly approved and overtime worked details were timely reported.

The Department paid $5,638,092 for 83,238 hours of overtime during Fiscal Year 2023 and $5,189,086 for 80,285 hours of overtime in Fiscal Year 2022. The auditors tested a sample of 60 pay periods and 60 employees who worked overtime during Fiscal Years 2022 and 2023. The employees in our sample incurred 483 hours of overtime during the pay periods tested. Based on our review of the overtime pre-approval requests and overtime worked details, they noted the following:

- Thirty-two of 60 (53%) employees tested worked 203 hours of overtime and did not enter the details in the timekeeping system, eTime, within two workdays of the overtime having been worked as required. The details were submitted and entered from one to 114 days after the overtime was worked.

- For 21 of 60 (35%) employees tested, overtime pre-approval requests totaling 213 hours were not timely submitted by employees. These requests were submitted from one to seven days after the overtime was worked.

- For 25 of 60 (42%) employees tested, overtime pre-approval requests totaling 315 hours were not pre-approved by the supervisors. These requests were approved from one to 43 days after the overtime was worked or the overtime was submitted, whichever is later.

- Twenty of 60 (33%) employees tested had overtime pre-approval requests that exceeded the allowed maximum of 10 hours. These requests ranged from 11 to 40 hours.

This finding was first reported during the period ended June 30, 2011. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

According to the Timekeeping Protocols of the Department's Employee Guidelines, Directive 16-02, overtime pre-approval requests must be submitted and approved in e-Time prior to the overtime being worked. Overtime pre-approval requests are limited to a maximum of ten hours. If additional time is required, a new overtime pre-approval request may be submitted for the total amount of estimated overtime hours needed. Overtime worked details must be submitted in the timekeeping system within two working days. If the need for overtime is an urgent issue and pre-approval is not possible, the Department's Employee Handbook requires the employee notify their supervisor in writing via email and request the acknowledgement and approval in the same fashion. It then must be noted in the timekeeping system Overtime Pre-approval Request and Overtime Worked comment sections. The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to ensure resources are utilized efficiently and effectively.

Department management stated competing work demands contributed to the untimely submission and approval of overtime requests.

Failure to ensure pre-approval overtime requests are submitted and properly approved in advance and overtime worked details are timely submitted undermines accountability controls and increases the risk the Department would pay unnecessary personal service expenditures.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. The Department will work to ensure that overtime pre-approval requests are timely submitted, properly approved in advance, and documentation of pre-approval is maintained by way of continually informing employees of the timekeeping Directives related to this.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department has reviewed current practices of how employees are notified and reminded staff of this directive. The Department has begun to audit and send reminders on a monthly rather than quarterly basis. The Department will continue to monitor and adjust timelines if necessary.

7. The auditors recommend the Department employ the mandated number of surveyors to ensure adequate monitoring of long-term care facilities.

FINDING: *(Failure to Employ an Adequate Number of Surveyors) – This finding has been repeated since 2013.*

The Illinois Department of Public Health (Department) failed to comply with the provision of the Department of Public Health Powers and Duties Law (Law) related to surveyors for long term care beds.

During the engagement period, the Department did not employ the required minimum number of surveyors per licensed long term care beds during Fiscal Years 2022 and 2023, which is one surveyor for every 300 beds or .33%. The auditors selected a sample of six months during the examination period to determine if the required numbers of surveyors were employed. They noted for six of the six months tested, all seven regional offices (100%) of the Department employed surveyors at the rate of .16% to .30%.

This finding was first reported during the period ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

During the prior engagement period, the Department did not have 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. During the current engagement period, Public Act 103-127 repealed the requirement effective January 1, 2024.

The Law (20 ILCS 2310/2310-130) requires the Department to employ a minimum of one surveyor for every 300 licensed long term care beds.

Department management stated they implemented several hiring strategies and allocated resources to increase the number of surveyors in all regions, however, they still were not able to fill mandated minimum surveyor/bed ratios.

Failure to hire an adequate number of surveyors could lead to inadequate monitoring of long-term care facilities.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department has developed a Long-Term Care (LTC) Re-Organization Plan to increase staffing. The Department implemented several hiring strategies to address the mandated minimum surveyor/bed ratios including immediate back filling of vacancies. Surveyor positions are being developed in each Region in LTC, Assisted Living, Immediate Care Facilities/Developmental Disabilities and Specialized Mental Health Rehabilitation Facility.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department has developed a Long-Term Care (LTC) Re-Organization Plan to increase staffing. The Department has added 3 Regions to have a comparable number of beds and alleviate some congested Regions. The Department has created a plan which includes the required number of surveyors/PSAs needed in each region to address the mandated minimum surveyor/bed ratios including immediate back filling of vacancies. Surveyor positions are being developed in each Region in LTC, Assisted Living, Immediate Care Facilities/Developmental Disabilities and Specialized Mental Health Rehabilitation Facility. The Department is working closely with the Office of Human Resources to get these positions developed and posted.

8. **The auditors recommend the Department enforce internal controls to ensure performance evaluations are conducted in a timely manner for all employees in accordance with the Code and its Directive.**

FINDING: *(Employee Performance Evaluations Not Conducted Timely) – This finding has been repeated since 2007.*

The Illinois Department of Public Health (Department) did not conduct employee performance evaluations in a timely manner.

The auditors selected 60 employees for review of performance evaluations conducted during the examination period. A total of 61 evaluations should have been completed for the applicable year tested, including first probationary new hire evaluations, four-month probationary evaluations, six-month probationary evaluations, and annual evaluations.

During testing, they noted the following:

- Thirty-two of 61 (52%) employees' performance evaluations tested were conducted from one to 459 days late.

- Eight of 60 (13%) employees tested did not have a performance evaluation completed for the evaluation period tested.

- Three of 61 (5%) employees' performance evaluations tested were not finalized timely after the supervisor conducted the performance evaluation. The delinquencies ranged from three to 71 days late.

This finding was first reported during the period ended June 30, 2007. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

The Illinois Administrative Code (Code) (80 Ill. Adm. Code 302.270(d)) requires the Department to evaluate certified employees no less often than annually. The Code (80 Ill. Admin. Code 302.270(b)) requires the Department to conduct two evaluations for any employee serving a six-month probationary period, one at the end of the third month of the employee's probationary period and another 15 days before the conclusion thereof. According to the Employee Performance Evaluations Section of the Department's Employee Guidelines, Directive 16-04 (Directive), an employee serving a probationary period is due a first probationary evaluation at the midpoint of the probationary period and a final probationary evaluation 15 days prior to the end of the probationary period. All employees are due an annual evaluation to be completed no later than 30 days of the due date.

Department management stated the untimely performance evaluations were due to competing priorities.

Performance evaluations are a systematic and uniform approach used for the development of employees and communication of performance expectations to employees. Performance evaluations should serve as foundation for recommendations of salary adjustments, promotions or demotions, discharge, layoff, recall, and reinstatement decisions.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work to enforce performance evaluations are conducted in a timely manner for all employees in accordance with the Code and its Directive.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department is reviewing current process of notification for evaluation due dates to ensure the list is being maintained and updated as new managers begin in a supervisory position, the Department has implemented new managers training of which evaluations is a piece of, and the Department is working on notification of discipline if evaluations are not completed by the required date.

The Department has set up a process in DocuSign for evaluations to be uploaded and signed electronically rather than manually to eliminate additional time in the signature process to finalize the evaluations.

9. The auditors recommend the Department strengthen its controls to ensure required reports are accurately reported and supporting documentation is maintained. They further recommend the Department file corrected Agency Workforce Reports to comply with the Illinois State Auditing Act (30 ILCS 5/3-2.2) within 30 days of the examination release.

FINDING: *(Failure to Submit and Accurately File Required Reports) – This finding has been repeated since 2003.*

The Illinois Department of Public Health (Department) did not file required reports accurately or in a timely manner.

During testing, the auditors noted the following:

- The Department did not properly report the required information in the Agency Workforce Reports. they noted the following:
    - The figures reported in the Agency Workforce Reports, filed during the examination period, did not agree to the supporting documentation provided. Discrepancies were noted on the data and statistical percentages reported for 11 of 16 (69%) employee groups in the 2021 Agency Workforce Report and 11 of 16 (69%) employee groups in the 2022 Agency Workforce Report. The Department subsequently filed the corrected 2021 and 2022 Agency Workforce Reports on May 7, 2024.
    - The Department did not provide documentation to support the position openings information reported in the Fiscal Year 2021 and Fiscal Year 2022 Agency Workforce Reports, therefore, accuracy of the reported information cannot be determined.
    - The Department did not submit the Fiscal Year 2021 Agency Workforce Report to the Office of the Secretary of State. Additionally, the Department submitted the Fiscal Year 2022 Agency Workforce Report to the Office of the Secretary of State two days late.
    - The Department filed the corrected Agency Workforce Reports covering Fiscal Years 2019 and 2020, 707 days late.

  The State Employment Records Act (Act) (5 ILCS 410 et seq.) requires the Department to collect, classify, maintain, and report certain employment statistics for women, disabled, and minority groups. In addition, the Act requires the Department to report on the number of position openings and persons employed as professionals and contractual employees. The Act requires the Department to report all information required by the Act as public information by January 1 each year with the Office of the Secretary of State and the Governor.

The Illinois State Auditing Act (30 ILCS 5/3-2.2) requires the State agency that has materially failed to comply with the requirements of the State Employment Records Act, within 30 days after release of the audit by the Auditor General, to prepare and file with the Governor and the Office of the Secretary of State corrected reports covering the periods affected by the noncompliance.

- For eight funds, the Department did not provide the degree to which program goals were met in its Fiscal Year 2022 and 2023 Agency Fee Imposition Report Forms.

  The Illinois State Auditing Act (30 ILCS 5/3-8.5) requires the Department to submit the Agency Fee Imposition Report Form containing the following information: (1) a list and description of fees imposed by the agency, (2) the purpose of the fees, (3) the statutory or other authority for the imposition of the fees, (4) the amount of revenue generated, (5) the general population affected by the fee, (6) the funds into which the fees are deposited, (7) the use of the funds, if earmarked, and (8) the cost of administration and degree to which the goals of the program are met.

- The Department did not report to the Department of Central Management Services (DCMS) and the Department of Human Rights (DHR), on forms prescribed by DCMS, all of the Department's activities in implementing the State's African American, Hispanic, Asian-American, Native Americans Employment Plans, and Bilingual Needs and Bilingual Pay Reports in Fiscal Year 2022.

  The Civil Administrative Code of Illinois (Code) (20 ILCS 405/405-120 and 125) requires each State agency to report annually to DCMS and DHR, in a format prescribed by DCMS, all of its activities in implementing the State Hispanic, Asian American, Native Americans Employment Plans and bilingual employment strategies and programs. Additionally, the African American Employment Plan Act (Act) (20 ILCS 30/20) requires each State agency to report annually to DCMS and DHR, in a format prescribed by DCMS, all of its activities in implementing the African American Employment Plan.

This finding was first reported during the period ended June 30, 2003. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

During the prior engagement period, the Department did not prepare the Fiscal Year 2019 Food Desert Annual Report and did not contain information about health issues associated with food deserts in its Fiscal Year 2020 Food Desert Annual Report. During the current engagement period, the Food Deserts Annual Reports were timely submitted to the General Assembly and contained the required information about health issues associated with food deserts.

Department management stated, as they did during the prior engagement period, the failure to comply with reporting timelines and requirements was due to lack of staff available to work on the reports and oversight.

Failure to submit and accurately report information on statutorily required reports prevents the appropriate oversight authorities from receiving relevant feedback and monitoring of programs and can decrease effectiveness of future decisions when accurate information is not available.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will strengthen its controls to ensure required reports are accurately reported and supporting documentation is maintained.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and recommendation. The EEO Officer has maintained regular communication with the Deputy Director of Diversity and Inclusion at the Department of Central Management Services (DCMS) to ensure all required reports are submitted promptly and that supporting documentation is accurately maintained. Additionally, the EEO Officer actively participates in all CMS DEI Council meetings to stay informed of reporting deadlines and ensure the department remains up to date on all reporting obligations.

The Fiscal Year 2024 Fee Imposition Report provides information regarding the degree to which program goals were met for each program.

The Department filed corrected Agency Workforce Reports on May 7, 2024 per recommendation.

10. The auditors recommend the Department continue to work diligently to ensure it complies with all aspects of the distressed facility requirements of the Nursing Home Care Act.

FINDING: *(Noncompliance with Distressed Facilities Provisions of the Nursing Home Care Act) – This finding has been repeated since 2015.*

The Illinois Department of Public Health (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 their testing, the auditors 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 regarding creating criteria for mandatory license revocations of distressed facilities and making recommendations regarding statutory changes.

The Nursing Home Care Act (Act) (210 ILCS 45/3-304.2(c) through (h) include the following:

- The Department is required, by rule, to adopt criteria to identify non-Medicaid-certified facilities that are distressed and publish this list quarterly. The Department must notify each facility of its distressed designation and the calculation on which it is based.

- The Department is required by rule, to establish a mentor program for owners of distressed facilities and also establish sanctions against distressed facilities that are not in compliance with this Act and, if applicable, with federal certification requirements.

- The Department is required to report to the General Assembly on the results of negotiations about creating criteria for mandatory license revocations of distressed facilities and make recommendations about any statutory changes it believes are appropriate to protect the health, safety, and welfare of nursing home residents.

These provisions of the Act were first effective on July 29, 2010.

This finding was first reported during the period ended June 30, 2015. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated their internal rulemaking process began with the enactment of Public Act 103-139, effective January 1, 2024, which removed the problematic provision in the Act requiring the inclusion in the criteria for determining distressed facilities with the outdated methodology used by the U.S. General Accounting Office (GAO) Report 9-689.

Failure to timely and completely carry out mandated duties of the Act does not achieve the legislative intent for the affected program. Noncompliance limits the Department's ability to identify, encourage and assist a facility designated as a distressed facility to develop a plan for improvement to bring and keep the facility in compliance with the Act. Failure to establish sanctions, negotiate criteria for license revocations, and make recommendations for statutory changes prevents potential actions which could better protect the health, safety, and welfare of nursing home residents.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. The Department will work with the Long-Term Care Facilities Advisory Board and the Joint Committee on Administrative Rules as necessary to adopt rules to carry out the requirements of Section 3-304.2(c)-(h) of the Nursing Home Care Act (210 ILCS 3-304.2(c)-(h)). The internal rulemaking process began with the enactment of Public Act 103-139, effective January 1, 2024, which removed a problematic provision in the Act. Draft rules have been prepared and are under review by Office of Healthcare Regulation management and staff.

UPDATED RESPONSE:
Under Study
The Department agrees with the finding and the recommendation. The Department has prepared draft amendments implementing Section 3-304.2 of the Act. The amendments are pending review at the October 17, 2024, Long-Term Care Facilities Advisory Board and should be filed for First Notice before end of this calendar year.

The Department's draft amendments implementing the distressed facilities provisions in Section 3-304.2 of the Act do not include references to a mentor program per Section 3-304.2(g) as the Department does not yet have a program in place. Once a program is in place, the Department will amend the rules accordingly.

The Department's draft amendments implementing the distressed facilities provisions in Section 3-304.2 of the Act also include provisions from Section 3-304.2(h) of the Act.

11. The auditors recommend the Department ensure reconciliations of its obligations, expenditures, and appropriations are timely performed.

FINDING: *(Lack of Controls over Monthly Reconciliations) – This finding has been repeated since 2017.*

The Illinois Department of Public Health (Department) did not maintain adequate controls over its monthly obligations, expenditures, and appropriation reconciliations.

During our testing of monthly reconciliations between the Office of Comptroller (Comptroller) records and Department records, the auditors noted the Department did not perform the required monthly reconciliations of its internal records to the Monthly Appropriation Status Report (SB01) and Monthly Agency Contract Report (SC14) or Obligation Activity Report (SC15) during Fiscal Years 2022 and 2023.

This finding was first reported during the period ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

The Statewide Accounting Management System (SAMS) (Procedure 07.30.20) requires the Department to reconcile its records to the SAMS system on a monthly basis. This reconciliation must be completed within 60 days of the month end. Discrepancies must be reported to the Comptroller's Office immediately for corrections.

Department management stated staff shortages and competing priorities resulted in the failure to prepare the reconciliations.

Failure to perform the monthly reconciliations increases the risk of undetected loss or theft and could lead to unresolved discrepancies between Department and Comptroller records, or inaccurate financial reporting.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The reconciliations of the obligations, expenditures, and appropriations are being done and procedures in place to ensure that they are timely performed.

UPDATED RESPONSE:
Partially Implemented
No change.

12. The auditors recommend the Department either comply with the mandate or seek legislative changes.

FINDING: *(Failure to Establish Policies and Procedures on Alzheimer's Disease and Related Disorders) – This finding has been repeated since 2015.*

The Illinois Department of Public Health (Department) failed to establish policies and procedures for data gathering on victims of Alzheimer's disease and related disorders.

During testing, the auditors noted 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.

This finding was first reported during the period ended June 30, 2015. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

The Civil Administrative Code of Illinois (Code) (20 ILCS 2310/2310-335) requires the Department 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 and for the conduct of consultation, referral, and treatment through personal physicians, primary Alzheimer's centers, and regional Alzheimer's assistance centers provided for in the Alzheimer's Disease Assistance Act. Further, the requirements shall include procedures for obtaining the necessary consent of a patient or guardian to the disclosure and exchange of that information among providers of services within an Alzheimer's disease assistance network and for the maintenance of the information in a centralized medical information system administered by a regional Alzheimer's center. Any person identified as a victim of Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act must be provided information regarding 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 person, or the spouse or guardian of the person, shall be encouraged to consent to an autopsy upon the person's death.

Department management stated the delay was due to challenges in putting procedures, policies, and standards in place such as the Regional Alzheimer's Disease Centers' use of different electronic health records, research data systems, and metrics; the private nature

of sharing personal health information; and the costs associated with the Department internally developing a new data dashboard, data use agreements, data purchase, and data staff to manage the system, among others.

In addition, management stated legislative changes to 410 ILCS 410, 410 ILCS 405, and potential changes to Rule 77-710 have been analyzed, but do not appear to offer resolution to this finding. Nationally, few best practices have been identified for dementia registries, so this would require considerable time to determine an efficient and effective route forward in Illinois. Failure to carry out the mandated duty does not achieve the legislative intent for the affected program and results in noncompliance with the Code.

DEPARTMENT RESPONSE:
The Department agrees with this recommendation and will seek legislative changes. A meeting was held with the Dementia Coordinator, management and legislative affairs to initiate this process.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department began the internal process to seek legislative changes. On 6/4/24, the Dementia Coordinator, IDPH Office of Health Promotion leadership, and the IDPH Legislative team met to discuss **Civil Administrative Code of Illinois (Department of Public Health Powers and Duties Law)--20 ILCS 2310/2310-335.** It was concluded that the Dementia Coordinator complete a mandate review form, which was submitted to legislative on 6/7/24. The IDPH Legislative team is now working on the statutory language changes.

13. The auditors recommend the Department strengthen controls to ensure employees' time records and leave requests are submitted and approved in a timely manner. Additionally, they recommend the Department periodically review and update its written policies to reflect current operations.

FINDING: *(Inadequate Controls over Employee Time Reporting) – This finding has been repeated since 2015.*

The Illinois Department of Public Health (Department) did not exercise adequate controls over employee time reporting to ensure employees' work hours were timely reported and did not update its Employee Handbook in relation to paid parental leave.

The Department expended $171,028,829 and $168,439,737 for payroll and had an average of 1,180 employees during Fiscal Years 2022 and 2023, respectively.

The Department utilizes the eTime system, which is an automated system for reporting and summarizing the employees' work hours and time off. Each employee is expected to submit a weekly Daily Time Report (DTR) in the eTime system for approval by the supervisor.

The auditors selected 60 employees and reviewed the DTRs for the pay period. During testing, they noted the following:

- Fifteen (25%) DTRs tested were not timely completed. The employees completed their DTRs from one to 17 days late.

- Two (3%) DTRs required to be completed were not submitted, and the employees were still paid despite the lack of required time reports.

- One (2%) DTR tested was not completed by the employee but instead was completed by the timekeeper.

- For three (5%) DTRs tested, the leave requests were not timely approved by the Supervisor. The leave requests were approved one to five days late.

This finding was first reported during the period ended June 30, 2015. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Additionally, the Department did not update its Employee Handbook to reflect the change in eligible paid parental leave from 4 weeks (20 days) to 10 weeks (50 workdays) effective July 26, 2019.

The State Officials and Employees Ethics Act (5 ILCS 430/5-5(c)) requires State employees to periodically submit time sheets documenting the time spent each day on official State business to the nearest quarter hour. According to the Timekeeping Protocols of the Department's Employee Guidelines, Directive 16-02, all employees are required to submit a complete and accurate weekly timesheet to the supervisor within two days of the start of the following workweek.

The Illinois Administrative Code (Code) (80 Ill. Admin. Code 303.130) states all employees are eligible for 10 weeks (50 workdays) of paid parental leave per twelve (12) month period which begins upon birth, for each pregnancy resulting in births or multiple births.

Department management stated competing work demands and oversight were the reasons for the untimely submission and approval of DTRs and the failure to update the Employee Handbook on parental leave.

Failure to maintain adequate controls over employee time reporting increases the risk of the Department paying for services not rendered by employees. Failure to review and update the Employee Handbook could result in inconsistencies between Department policies and actual Department operations. In addition, the existence of an outdated policy increases the risk employees will be misguided.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work to ensure employees' time records and leave requests are submitted and approved in a timely manner. The Department is currently reviewing policies and directives in relation to timekeeping.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department has reviewed current practices of how employees are notified and reminded of time keeping and leave requests related directives. The Department has begun to audit and send reminders on a monthly rather than quarterly basis. We will continue to monitor and adjust timelines if necessary.

The Department has formed a policies and procedures committee that is currently reviewing all directives and policies for updates. Expected implementation date will be first quarter of CY2025.

14. The auditors recommend the Department strengthen its internal controls over commodities to ensure its physical year-end inventory balance is accurate.

FINDING: *(Inadequate Internal Controls over Commodities) – This finding has been repeated since 2013.*

The Illinois Department of Public Health (Department) did not ensure the accuracy of its fiscal year-end commodities inventory balance.

During testing of the Department's June 30, 2023 year-end commodities inventory balance, auditors noted for five of 60 (8%) commodity items inspected, the count per Department inventory list did not agree with the auditor's physical count. The discrepancies resulted in an overstatement of inventory by $133,698.

The Department reported a commodities inventory balance totaling $5.9 million at June 30, 2023 to the Office of Comptroller (Comptroller) in its year-end financial reporting packages.

The Statewide Accounting Management System (SAMS) (Procedure 03.60.20) requires State agencies to perform an annual physical inventory count to ensure the completeness and accuracy of inventory records. Significant inventory balances are required to be reported to the State Comptroller on form SCO-577 as part of the financial reporting process. In addition, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance the accounting and recording of financial data permits the preparation of reliable financial reports. This would include procedures to ensure inventory balances are accurately counted and undergo a thorough supervisory review prior to reporting the balances.

Department management stated the overstatement was due to employee oversight regarding proper completion of the commodity disposal transaction and completion of the Inventory Discard Report.

This finding was first reported during the period ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Failure to ensure accuracy of commodities inventory balance at fiscal year-end results in inaccurate financial reporting.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will strengthen its internal controls over commodities to ensure its physical year-end inventory balance is accurate.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and recommendation. The Division of Laboratories has implemented an Inventory Tracking system for the accurate control and inventory of commodities used within each Laboratory and section. Administrative SOP "DAA039 Reagent and Consumable Inventory and Accountability" to establish standardized processes for reagent and consumable accountability and fiscal tracking.

15. The auditors recommend the Department timely fill the vacancies on the Committee and Advisory Board as required.

FINDING: *(Statutory Committee and Board Requirements) – This finding has been repeated since 2011.*

The Illinois Department of Public Health (Department) did not comply with committee and board requirements mandated by State law.

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

- The Home Health, Home Services, and Home Nursing Agency Licensing Act (210 ILCS 55/7(a)) (Act) requires the Director of the Department to 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. The Act establishes the membership composition of the Committee. As of June 30, 2023, the Committee was comprised of 11 members. The Committee lacked a representative from the private not-for-profit home health agencies, a representative from the general public representing consumer of home services or a family member

of a consumer home services, a representative from the general public representing home services worker, and an Illinois licensed physician.

- The Nursing Home Care Act (210 ILCS 45/2-204) requires the Director of the Department to appoint a Long-Term Care Facility Advisory Board (Advisory Board) composed of 16 persons to advise and consult with the Department in the administration of the Act, including on the format and content of any rules promulgated by the Department. In addition, the Act requires the Advisory Board to meet as frequently as the chairman deems necessary, but not less than four times each year. As of June 30, 2023, the Advisory Board was comprised of 9 members and lacked a representative from the Department of Healthcare and Family Services, a representative from the Department of Human Services, a representative from the Office of the State Fire Marshal, a representative from local health departments who is a nonvoting member, two members representing the general public who are not members of a residents' advisory council who have no responsibility for management or formation of policy or financial interest in a facility, and one member who is a member of a residents' advisory council who is capable of actively participating on the Board.

This finding was first reported during the period ended June 30, 2011. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated it has been difficult to obtain board members who are interested in serving the Committee and Advisory Board.

The existence of vacancies and not appointing representatives to statutorily required positions lessens governmental oversight and limits the input of all members that were intended by the General Assembly.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department continues to actively seek new members on the Committee and the Advisory Board and is considering several nominee applications.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department submitted a recommendation for the Physician Member to the Home Health, Home Services and Home Nursing advisory Board for consideration in August 2024.

The Long -Term Care Advisory Board currently has 4 non-voting positions, all of which are filled. The board has 10 voting positions, 8 of which are filled and within their term expiration. The department is working to fill the remaining 2 vacant positions within the next 2-3 months.

16. The auditors recommend the Department ensure required reports are timely submitted to the General Assembly.

FINDING: *(Noncompliance with the Breast Cancer Patient Education Program) – This finding has been repeated since 2017.*

The Illinois Department of Public Health (Department) did not timely submit a required report to the General Assembly regarding the Breast Cancer Patient Education Program.

During their testing, the auditors noted the Department submitted the report to the General Assembly on January 29, 2024, 2 years late. The report described activities carried out during Fiscal Years 2020 and 2021 and contained an evaluation of the extent to which activities have been effective in improving the health of racial and ethnic minority groups.

This finding was first reported during the period ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

The Civil Administrative Code of Illinois (Code) (20 ILCS 2310/2310-670(e)) requires, beginning no later than January 1, 2016 (two years after the effective date of Public Act 98-479) and continuing each second year thereafter, the Director to submit to the General Assembly a report describing the activities carried out under this section during the preceding two fiscal years, including evaluating the extent to which the activities have been effective in improving the health of racial and ethnic minority groups.

During the prior engagement period, the Department's educational campaign brochure "Your Right to Know" was not updated for the required information for breast cancer patients. Additionally, special emphasis on African-American and Hispanic populations' breast reconstructive surgery and breast prosthesis were not noted in the Department's consultation with appropriate medical societies and patient advocates related to breast cancer. During the current engagement period, auditors noted the brochure "Your Right to Know" was updated to contain the information required by the Code (20 ILCS 2310/2310-670(c)). Further, the Department hired a Medical Director for Women's Health Services who worked with the Illinois Breast and Cervical Cancer Program, medical societies, and advocacy organizations for the update of the brochure to comply with the Code.

Department management stated they drafted the report in December 2021, but it has undergone multiple rounds of reviews from Department and Office leaders requiring significant revisions.

Failure to timely submit the report is noncompliance with the Code and inhibits General Assembly oversight of the Breast Cancer Patient Education Program.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. To meet this requirement, the Department will work with the program team to devise a reasonable timeline for drafting and reviewing the report to ensure more timely submission.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The IBCCP team has completed the initial draft of the January 2024 report for Deputy Director review. Upon Deputy Director review and completion of edits the report will be submitted for Communications review. After Communications review and completion of edits the report will be forwarded to Legislative Affairs in the Director's Office for final review and signature prior to submission to the General Assembly.

17. **The auditors recommend the Department design and maintain internal controls to provide assurance its data entry of key attributes into ERP is complete and accurate. Further, they recommend the Department process proper bills within 30 days of receipt, approve vouchers for payment of interest due to vendors, submit travel vouchers and related travel request forms in a timely manner, and ensure vouchers are properly supported and recorded.**

FINDING: *(Voucher Processing Internal Controls Not Operating Effectively) – This finding has been repeated since 2017.*

The Illinois Department of Public Health's (Department) internal controls over its voucher processing function were not operating effectively during the examination period.

Due to the auditor's ability to rely upon the processing integrity of the Enterprise Resource Planning System (ERP) operated by the Department of Innovation and Technology (DoIT), they were able to limit our voucher testing at the Department to determine whether certain key attributes were properly entered by the Department's staff into the ERP. In order to determine the operating effectiveness of the Department's internal controls related to voucher processing and subsequent payment of interest, they selected a sample of key attributes (attributes) to determine if the attributes were properly entered into the State's ERP System based on supporting documentation. The attributes tested were 1) vendor information, 2) expenditure amount, 3) object(s) of expenditure, and 4) the later of the receipt date of the proper bill or the receipt date of the goods and/or services.

Our testing noted 4 of 140 (3%) attributes were not properly entered into the ERP System. Therefore, the Department's internal controls over voucher processing **were not operating effectively**.

The Statewide Accounting Management System (SAMS) (Procedure 17.20.20) requires the Department to, after receipt of goods or services, verify the goods or services received met the stated specifications and prepare a voucher for submission to the Office of Comptroller to pay the vendor, including providing vendor information, the amount expended, and object(s) of expenditure. Further, the Illinois Administrative Code (Code) (74 Ill. Admin.

Code 900.30) requires the Department maintain records which reflect the date goods were received and accepted, the date services were rendered, and the proper bill date. Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance expenditures are properly recorded and accounted for to maintain accountability over the State's resources.

Due to this condition, the auditors qualified their opinion because they determined the Department had not complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

Even given the limitations noted above, they auditors conducted an analysis of the Department's expenditures data for fiscal years 2022 and 2023 to determine compliance with the State Prompt Payment Act (Act) (30 ILCS 540) and the Code (74 Ill. Admin. Code 900.70). They noted the following noncompliance:

- The Department owed 113 vendors interest totaling $84,095 in fiscal years 2022 and 2023; however, the Department had not approved these vouchers for payment to the vendors.

  The Act (30 ILCS 540) requires agencies to pay vendors who had not been paid within 90 days of receipt of a proper bill or invoice interest.

- The Department did not timely approve 12,555 of 56,089 (22%) vouchers processed during the examination period, totaling $332,286,151. They noted these late vouchers were approved between 1 and 375 days late.

  The Code (74 Ill. Admin. Code 900.70) requires the Department to timely review each vendor's invoice and approve proper bills within 30 days after receipt.

- Six of 35 (17%) vouchers tested, totaling $206,122, were not supported by a purchase requisition or purchase order.

  The State Records Act (5 ILCS 160/8) requires the Department make and preserve adequate and proper documentation of the essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

- Four of 115 (3%) vouchers tested, totaling $2,005,235, were not coded with proper detail object codes.

  SAMS (Procedure 11.10.50) states that the purpose of assigning a correct detail object code is to report expenditure information at a more refined level with common object.

- One of 115 (1%) vouchers tested, totaling $620, did not agree with amount per vendor invoice. The amount paid was overstated by $5.

  The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. Good internal controls over voucher processing include ensuring procedures are in place and functioning to ensure the amount paid agrees to the related invoice.

- Two of 40 (5%) travel vouchers tested, totaling $2,146, were submitted 79 and 82 days after the last day of travel. Additionally, one of 40 (3%) travel vouchers tested, the out-of-state travel request form was not submitted 30 days in advance of the departure date to the Governor's Office of Management and Budget.

  The Internal Revenue Service (IRS) Publication 535, Business Expenses, notes employees receiving travel reimbursements must have paid or incurred deductible expenses while performing employment services, adequately accounted for the expenses within a reasonable period of time generally defined by Publication 535 as within 60 days after the expenses were paid or incurred and returned any excess reimbursements within a reasonable period of time.

  The Code (80 Ill. Adm. Code 2800.700) states travel outside of Illinois (including travel outside the contiguous United States) requires the approval of the Governor's Office of Management Budget prior to the travel. All requests are to be submitted to the Governor's Office of Management and Budget's on-line travel system (eTravel) at least 30 days in advance of the departure date.

This finding was first reported during the period ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures to remedy this deficiency.

Department management stated the issues were due to the delay of other offices in submitting the invoices to the Office of Finance and Administration. Department management also stated the other issues were due to oversight.

Failure to properly enter the key attributes into the State's ERP when processing a voucher for payment hinders the reliability and usefulness of data extracted from the ERP, which can result in improper interest calculations and expenditures. Further, failure to timely process proper bills, approve vouchers for payment of interest due, submit travel vouchers and related travel request forms, and ensure vouchers are properly supported and recorded represent noncompliance with laws and regulations and increases the likelihood that errors or irregularities could occur.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. The Department will design and maintain internal controls to provide assurance its data entry of key attributes into ERP is complete and accurate. The Department has begun work to evaluate and strengthen the process of paying all types of vouchers in a timely manner and maintaining supporting documents.

UPDATED RESPONSE:
Under Study
The Department agrees with the finding and the recommendation. The Department has contracted with a vendor to implement this recommendation. The discovery process is completed, and implementation will start in October.

18. The auditors recommend the Department adopt rules required by the State laws or seek legislative remedy.

FINDING: *(Formal Department Rules Not Adopted) – This finding has been repeated since 2017.*

The Illinois Department of Public Health (Department) has not adopted rules required by State laws.

During the auditors testing of statutory mandates, they noted the following:

- The Department has not adopted the rules required by the Specialized Mental Health Rehabilitation Act of 2013 (210 ILCS 49/3-106(b-5)). The Specialized Mental Health Rehabilitation Act of 2013, effective June 5, 2019, requires the Department adopt, by rule, a protocol specifying how informed consent for psychotropic medication may be obtained or refused. The protocol shall require, at a minimum, a discussion between the consumer or the consumer's authorized representative and the consumer's physician, a registered pharmacist who is not a dispensing pharmacist for the facility where the consumer lives, or a licensed nurse about the possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department.

  Department management stated the draft amendments are still under review.

- The Department has not adopted the rules required by the Equitable Restrooms Act (410 ILCS 35/25). The Equitable Restrooms Act, effective January 1, 2020, requires the Department adopt rules to implement that every single-occupancy restroom in a place of public building be identified as all-gender and designated for use by no more than one person at a time or for family or assisted use. Additionally, each single-occupancy restroom shall be outfitted with exterior signage that marks the single-occupancy restroom as restroom and does not indicate any specific gender.

  Department management stated rules have not been adopted due to competing priorities.

- The Department did not adopt the rules required by the Health Maintenance Organization Act (215 ILCS 125/5-5(d)). The Health Maintenance Organization Act states that a certificate of authority issued to a health maintenance organization may be suspended, revoked, or denied if the Department has certified to the Department of Insurance that (1) the health maintenance organization does not meet the requirements for the issuance of a certificate of authority listed in Section 2-2 or (2) the health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan. In relation to this certification, the Health Maintenance Organization Act, effective June 5, 2019, requires the Department promulgate by rule, pursuant to the Illinois Administrative Procedure Act, the precise standards used for determining what constitutes a material misrepresentation, what constitutes a material violation of a contract or evidence of coverage, or what constitutes good faith.

  Department management stated they were unaware of the statutory requirement.

During the prior engagement period, the Department did not adopt rules on reporting by the coroner or medical examiner to the Department of death due to drug overdose as required by the Counties Code. Further, the Department did not adopt rules requiring age-appropriate developmental screening and age-appropriate social and emotional screening mandated by the School Code. During the current engagement period, the rules necessary to administer and enforce the Counties Code and the School Code were adopted.

Formal administrative rules provide a basis for proper implementation and enforcement of State laws, protect the Department from legal challenges, and give additional legitimacy to Department actions. Failure to adopt the required rules is noncompliance with State laws.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. In regard to the finding concerning the requirements in Section 3-106(b-5) of the Specialized Mental Health Rehabilitation Act of 2013 (210 ILCS 49/3-106(b-5)), the Department will work with the Long-Term Care Facilities Advisory Board and the Joint Committee on Administrative Rules, as necessary, to adopt rules specifying how informed consent for psychotropic medication may be obtained or refused. The internal rulemaking process has begun, and draft rules have been prepared and are under review by Office of Healthcare Regulation management and staff. The Department will work with the Department of Insurance and adopt the rules required by the Health Maintenance Organization Act (215 ILCS 125/5-5(d)).

The Department will work with the Plumbing Code Advisory Council, the State Board of Health, and the Joint Committee on Administrative Rules as necessary to adopt rules for implementation of the Equitable Restrooms Act (410 ILCS 35/25).

UPDATED RESPONSE:

Under Study

The Department agrees with the finding and recommendation. The Department has drafted amendments that are currently pending DHS legal review prior to submittal for Director's and Governor's Office reviews.

With regard to the Equitable Restrooms Act, the Department Plumbing Program has recently filled the vacant membership of the Advisory Council and will begin working with the Plumbing Code Advisory Council to develop the rules for implementation.

19. The auditors recommend the Department pursue all reasonable and appropriate procedures to collect on outstanding debts as required by State laws and regulations.

FINDING: *(Inadequate Controls over Accounts Receivable) – This finding has been repeated since 2019.*

The Illinois Department of Public Health (Department) did not have adequate controls over the administration of its accounts receivable.

The Department reported $26.8 million in accounts receivable, of which $11.2 million was over one year past due, as of June 30, 2023, and $19.8 million, of which $8.5 million was over one year past due, as of June 30, 2022. During their testing, the auditors noted the following:

- For 16 of 40 (40%) accounts receivable tested, totaling $215,935, that were over 90 days to one year past due, the Department had not made active collection efforts during the examination period on the account or referred the account to the Office of Comptroller's (Comptroller) Offset System, Department of Revenue's Debt Collection Bureau, or the Attorney General.

- For two of 40 (5%) accounts receivable tested, totaling $75,000, the Department did not timely refer the accounts to the Comptroller's Offset System. The accounts were placed in the Comptroller's Offset System from 60 to 137 days after the due dates.

The finding was first reported during the period ended June 30, 2019. In the subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

The Illinois State Collection Act of 1986 (Act) (30 ILCS 210/3) and the Statewide Accounting Management System (SAMS) (Procedure 26.40.10) require the Department to pursue the collection of accounts or claims due and payable to the State of Illinois through all reasonable and appropriate procedures. The Act (30 ILCS 210/5(c-1)) and SAMS (Procedure 26.40.20) require the Department to place all debts over $250 and more than 90 days past due in the Comptroller's Offset System. The Act (30 ILCS 210/5(g)) requires the Department to refer qualifying delinquent debt to the Department of Revenue's Debt Collection Bureau. The Uncollected State Claims Act (30 ILCS 205/2(a)) requires the Department, when it is unable to collect any claim or account receivable of $1,000 or more

due, request the Attorney General to certify the claim or account receivable to be uncollectible.

Department management stated that for 15 of 16 exceptions noted, the delay in referring the accounts for collection was due to the difficulty in obtaining the necessary information such as federal identification numbers to pursue collections or write-off. In the remaining instance, there was a dispute over ownership of the fine.

Regarding the two accounts totaling $75,000, Department management stated the accounts receivable section was short-staffed during the examination period causing these collection efforts to be delayed.

Failure to timely refer receivables to the Comptroller's Offset System and to the Department of Revenue's Debt Collection Bureau increases the likelihood that past due amounts owed to the Department will not be collected or the collection will be further delayed. Failure to report uncollectible accounts to the Attorney General results in the Department not writing off accounts receivable balances and the corresponding allowance for doubtful accounts, resulting in an overstatement of these balances in the Department's accounts receivable reports.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will pursue all reasonable and appropriate procedures to collect on outstanding debts as required by State laws and regulations.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. The Department has made collection attempts on 70% of the exceptions noted in the audit. Collection efforts are on-going. A procedure has been implemented to place accounts with the Comptroller's Offset System when they become 30 days past due.

20. The auditors recommend the Department make reasonable efforts to promote the Alzheimer's Disease Research, Care, and Support Fund to comply with the Act.

FINDING: *(Noncompliance with the Alzheimer's Disease Assistance Act) – This finding has been repeated since 2021.*

The Illinois Department of Public Health (Department) did not promote the Alzheimer's Disease Research, Care, and Support Fund.

During testing, the auditors noted the Department has not made reasonable efforts to promote the Alzheimer's Disease Research, Care, and Support Fund. The Alzheimer's Disease Assistance Act (410 ILCS 405/8), effective January 1, 2020, requires the Department, in coordination with the members of the Alzheimer's Disease Advisory

Committee, to make reasonable efforts to promote the Alzheimer's Disease Research, Care, and Support Fund during relevant times.

During the prior engagement period, the Department did not pay the salary and benefits of its Dementia Coordinator from the Alzheimer's Disease Research, Care, and Support Fund (Fund) and did not utilize the moneys in the Fund as required. During the current engagement period, the auditors noted the Department paid the salary and benefits of its Dementia Coordinator from the Fund and has properly utilized the Fund as mandated.

Department management stated they were still developing a social media kit to promote the Fund during the examination period

Failure to carry out the mandated duty is noncompliance with the Act and does not achieve the legislative intent to increase public awareness of the program for the conduct of research regarding the cause, cure and treatment of Alzheimer's disease and related disorders.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation for this reporting period. The issue has since been resolved. The IDPH social media kit was approved, and social media posts began in March 2024. The social media posts will be monthly, including educational content about the disease in general, and also information about the Alzheimer's Disease Research, Care, and Support Fund, how, and where to donate via tax returns. In addition, IDPH published an Alzheimer's Fund subpage on the IDPH website with all of the information, including a link to the Schedule G tax form where the public can donate during tax season. All components of this finding should now be resolved.

UPDATED RESPONSE:
Implemented
No change.

21. **The Department has the responsibility to ensure that confidential and personal information is adequately protected. Specifically, the auditors recommend the Department:**

    - **Maintain policies and procedures over Configuration Management, Acceptable Use, Access Control, Change Management, Personnel Security, Security Planning, and Program Management;**
    - **Maintain documentation of the annual review of policies and procedures;**
    - **Establish policies and procedures for controls over data retention, maintenance, and destruction; the creation, storage, and testing of backups; and project management;**
    - **Establish a cybersecurity plan;**
    - **Establish a risk methodology;**
    - **Establish a disaster recovery plan for the primary Department functions and network; and,**

- **Ensure adequate documentation is developed, retained, and provided to auditors.**

FINDING: *(Weaknesses in Cybersecurity Programs and Practices) – This finding has been repeated since 2021.*

The Illinois Department of Public Health (Department) had not implemented adequate internal controls related to cybersecurity programs, practices, and control of confidential information.

The mission of the Department is to promote health through the prevention and control of disease and injury. IDPH assures the quality of food, sets standards for hospitals and nursing homes, investigates disease outbreaks, maintains the state's vital records, screens newborns, and many other programs.

To carry out its mission, the Department utilizes the Department of Innovation and Technology (DoIT) to perform cybersecurity tasks, including collaborating on the maintenance of the Department's Cybersecurity program. The majority of network and security functions are performed by DoIT.

The Illinois State Auditing Act (30 ILCS 5/3-2.4) requires the Auditor General to review State agencies and their cybersecurity programs and practices. During the examination of the Department's cybersecurity program, practices, and control of confidential information, the auditors noted the Department had not:

- Maintained its own policies and procedures to fulfill the compliance requirements of the DoIT policies in use for the following policies: Configuration Management, Acceptable Use, Access Control, Change Management, Personnel Security, Security Planning, and Program Management.
- Maintained documentation for the annual review of all policies and procedures to ensure compatibility with DoIT's policies.
- Established policies and procedures for controls over the following: data retention, maintenance, and destruction; the creation, storage, and testing of backups; and project management.
- Established a cybersecurity plan.
- Established a risk methodology.
- Established a disaster recovery plan for the primary Department functions and network.

Additionally, the auditors noted the following exceptions:

- Testing could not be completed for developments. The Department did not provide a complete and accurate population of developments for the period.
- Auditors are unable to perform testing of security event remediation due to the lack of event remediation documentation for the events sampled. 40 of 40 (100%) of sampled security events did not have any documentation of remediation or response provided.

- Auditors are unable to determine if the Department's users with access to critical applications is based upon job functions due to the lack of Department response for request of users with access to sampled critical applications.
- Eight of 30 (27%) and 9 of 30 (30%) staff tested for Fiscal Years 2022 and 2023, respectively, did not have a policy attestation signed for the respective period. Additionally, personal services contracts did not have a requirement for contractors to review and attest to the Department's policies.

The prior finding noted issues with cybersecurity training. For the current examination, any training issues noted are reported in finding 2023-031.

The Framework for Improving Critical Infrastructure and the Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST) requires entities to consider risk management practices, threat environments, legal and regulatory requirements, mission objectives and constraints in order to ensure the security of their applications, data, and continued business mission.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires IDOA to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

Department management indicated competing priorities and employee turnover contributed to the inability to establish a cybersecurity plan and provide documentation.

The lack of adequate cybersecurity programs and practices could result in unidentified risk and vulnerabilities and ultimately lead to the Department's confidential and personal information being susceptible to cyber-attacks and unauthorized disclosure.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. The Department is in the process of reviewing all information technology policies and procedures and will document the annual review by 12/31/24. The Department began a Risk Assessment in July 2024 that will help inform risk methodology and is working with the Department of Innovation and Technology on disaster recovery plans for critical agency applications. The Department will establish a cybersecurity plan for the agency.

UPDATED RESPONSE:

Under Study

The Department agrees with the finding and recommendation. The Department is now completing annual reviews of policies and procedures, is currently on track to establish a cybersecurity plan by the end of calendar year 2024, is in the process of completing a Risk Assessment with DoIT, and is working towards creating Information Systems Contingency Plans for critical Department applications.

22. The auditors recommend the Department ensure license renewal notices are sent to all Emergency Medical Services licensees at least 60 days prior to the expiration date of the license and issue stretcher van provider licenses that are valid for only one year to comply with the Act and the Code.

FINDING: *(Noncompliance with the Emergency Medical Services Systems Act) - This finding has been repeated since 2021.*

The Illinois Department of Public Health (Department) did not send Emergency Medical Services license renewal notices timely and did not issue stretcher van provider licenses that are valid for one year as required by the Emergency Medical Services Systems Act.

During testing, the auditors noted the following:

- For four of 40 (10%) Emergency Medical Services license renewal notices tested, the Department did not send the notices to the licensee at least 60 days prior to the expiration date of the license.

- For three of four (75%) stretcher van provider licenses tested, the Department issued licenses valid for more than one year. The licenses issued were valid for four to five years.

The Emergency Medical Services Systems Act (Act) (210 ILCS 50/3.50(f)) requires the Department to send license renewal notices electronically and by mail to all Emergency Medical Services licensees who provide the Department with his or her email address, at least 60 days prior to the expiration date of the license.

The Act (210 ILCS 50/3.86(b)(2) to (4)) requires the Department establish licensing and safety standards and requirements for stretcher van providers, through rules adopted pursuant to this Act, including but not limited to: (a) vehicle design, specification, operation, and maintenance standards; (b) safety equipment requirements and standards; (c) staffing requirements, and (d) annual license renewal. Additionally, the Act requires the Department to annually inspect all licensed stretcher van providers and relicense providers that have met the Department's requirements for license renewal. Further, the Illinois Administrative Code (Code) (77 Ill. Admin. Code 515.835(d)) requires the Department issue a license that is valid for one year if, after inspection, the Department finds that the stretcher van provider and each vehicle identified in the application are in compliance with the Act and the Code.

Department management stated the issues were due to oversight and human error.

Failure to send Emergency Medical Services license renewal notices timely is noncompliance with the Act and could result in Emergency Medical Services personnel failing to renew their licenses timely. Failure to issue stretcher van provider licenses that are valid for one year is noncompliance with the Act and the Code and lessens the Department's oversight over stretcher van providers.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. For the Division of EMS and Highway Safety, this issue is multifaceted. First, this could be related to software vendor downtime preventing the ability to complete renewal notices. Second, continued work has been completed with the software vendor to ensure all renewals are being captured appropriately and that auditors are able to provide notice 60 days in advance. Finally, staffing challenges have played a role in this as well. The EMS licensing section has not been fully staffed for more than one year. They have worked to address the staffing challenge by following up with Human Resources and authorizing overtime in advance when there is likely to be a delay of any kind. Regarding the stretcher van provider licenses, this was an error and has been reviewed. Prospectively, the Division of EMS and Highway Safety plans for compliance.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and recommendation. The licensing section has been educated on required compliance with sending EMS licenses as least 60 days prior to the expiration date and to report any issues with completing renewal notices in a timely manner to include any issues with staffing or software systems so they may be resolved swiftly.

Licensing staff have been educated on the need to only issue stretch van provider licenses that are only valid for one year and have committed to reviewing stretcher van provider licenses to ensure compliance.

23. The auditors recommend the Department establish a nursing home labor force program, approved by the Centers for Medicare and Medicaid Services, and submit the required reports to the General Assembly to comply with the Act.

FINDING: *(Noncompliance with the Equity in Long-term Care Quality Act) – This finding has been repeated since 2021.*

The Illinois Department of Public Health (Department) did not establish the nursing home labor force program required by the Equity in Long-term Care Quality Act.

The Department did not establish a nursing home labor force promotion, expansion, and retention program by January 1, 2020.

The Equity in Long-term Care Quality Act (Act) (30 ILCS 772/25) requires the Department, contingent upon approval by the Centers for Medicare and Medicaid Services (CMS), to establish a nursing home labor promotion, expansion, and retention program no later than January 1, 2020, using moneys appropriated from the Equity in Long-term Care Quality Fund. The Act requires the program to include, but not limited to: (1) a public relations campaign to encourage people to become nursing home workers; (2) scholarships for certified nursing assistants, licensed practical nurses, and registered nurses; and (3) retention incentives for nursing home workers. The Act also requires the Department

establish partnerships with one or more community colleges or universities to execute the program. Additionally, the Act requires the Department to report to the General Assembly: (1) no later than January 30, 2020, the status of the establishment of the program, and (2) no later than January 1, 2021, and each January 1 thereafter, the number of scholarships awarded during the preceding year and the demographics of the awardees.

Department management stated they are still in the process of obtaining approval from CMS to establish a nursing home labor force program and use funding from the Equity in Long-term Care Quality Fund as required by the Act.

Failure to establish a nursing home labor force program is noncompliance with the Act and does not achieve the legislative intent of the program to provide high-quality nursing home care to residents of nursing home facilities.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Office of Health Care Regulation (OHCR) lost several leadership positions in 2021 and 2022. The Department developed a long-term staffing strategy and is working within the Agency and with other agencies to execute this strategy.

UPDATED RESPONSE:
Partially Implemented
No change.

24. The auditors recommend the Department adopt rules and require tobacco products manufacturer to submit the required annual written compliance certifications to the Department to comply with the Act or continue to seek legislative remedy.

FINDING: *(Noncompliance with the Tobacco Products Compliance Act) – This finding has been repeated since2021.*

The Illinois Department of Public Health (Department) did not require tobacco manufacturers to submit the annual written compliance reports and did not adopt rules required by the Tobacco Products Compliance Act.

During testing, the auditors noted the following:

- The Department did not receive annual written certifications from manufactures of tobacco products in the State and who distribute or sell the tobacco products in the United States. The Tobacco Products Compliance Act (Act) (410 ILCS 76/10) requires any person who manufactures any tobacco product in the State for distribution or sale in the United States to provide annually to the Department by June 1 of each year thereafter, a written certification, including supporting evidence and documentation, of such person's compliance with provisions of the federal Family Smoking Prevention and Tobacco Control Act.

- The Department did not draft and adopt rules required by the Act. The Act (410 ILCS 76/20), effective August 26, 2019, requires the Department to adopt rules for the administration and enforcement of the Act.

Department management stated they submitted a legislative proposal to transfer authority and the requirements of the statute to the Tobacco Enforcement Bureau of the Illinois Attorney General's Office which the Governor's Office has approved but was not accepted by the Attorney General's Office. Department management also stated they have not taken or proposed further legislative action, however, they inquired about other options for relieving the Department of oversight of tobacco manufacturers.

Formal administrative rules provide the basis for proper implementation and, therefore, would enforce manufacturers to comply with the requirement to submit the annual written compliance certifications to the Department.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. To meet the recommendation, the Department will adopt administrative rules to require tobacco products manufacturers to submit required annual written compliance certifications to the Department to comply with the Act. The Department will also continue to seek a legislative remedy.

UPDATED RESPONSE:
Under Study
The Department agrees with the finding and the recommendation. The Department's senior leadership and tobacco control program staff held a meeting on July 8, 2024, to discuss the feasibility of seeking a legislative remedy to remove authority for this Act from the Department. Concerns with the Act continue to be the lack of specificity regarding the Department's responsibility if a tobacco producer fails to comply with the Act, and the private right of action section of the Act, which allows any interested party to file suit in circuit court for alleged violations of the Act. The conclusion was that the Department may need to adopt the required rules and simply collect tobacco product compliance reports with no enforcement authority.

25. The auditors recommend the Department:

- **Complete the appropriate SAQ(s) and AOC for its environment and maintain documentation supporting its validation efforts, and**

- **Ensure quarterly vulnerability scans are completed by an approved scanning vendor for all environments.**

FINDING: *(Weaknesses with Payment Card Industry Data Security Standards) – This finding has been repeated since 2015.*

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

The Department agreed to use the Illinois State Treasurer's ePAY program to accept credit card payments. In Fiscal Years 2022 and 2023, the Department handled 91,407 transactions totaling approximately $8.98 million and 78,070 transactions totaling approximately $8.26 million, respectively.

The auditors reviewed the efforts of four Department's Divisions to ensure compliance with PCI DSS. During their testing, they noted the Department had not:

- Completed and certified a SAQ and Attestation of Compliance (AOC) for all programs accepting credit card payments for three (75%) Divisions tested; and

- Completed quarterly vulnerability scan by an approved scanning vendor (ASV) of the servers that provide a path to the cardholder data environment for four (100%) Divisions tested.

This finding was first reported in Fiscal Year 2015. In subsequent years, the Department has been unsuccessful in implementing appropriate procedures to ensure compliance with the PCI DDS.

To assist merchants in the assessments of their environment, the PCI Council has established SAQ for validating compliance with PCI's core requirements. At a minimum, PCI DSS required completion of SAQ A; which highlights specific requirements to restrict access to paper and electronic media containing cardholder data, destruction of such media when it is no longer needed, and requirements for managing service providers. As additional elements, such as face-to face acceptance of credit cards and point-of-sale solutions, are introduced into the credit card environment being assessed, additional PCI DSS requirements apply.

Department management indicated the issue was due to competing priorities.

Cardholder's data or personal information collected by the Department should be adequately secured at all times. Failure to establish and maintain adequate procedures to handle and protect such information could result in identity theft or other unintended use.

DEPARTMENT RESPONSE:
The Department agrees with the finding and will implement the auditor's recommendations.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. Three of four of the Agency's Divisions responsible for completing Self-Assessment Questionnaires and Attestation of Compliance are in compliance. The remaining Division is working with the State Treasurer's Office to achieve compliance.

Due to the installation of new Payment Card Industry software, the Department is in the process of working with the State Treasurer's Office to determine what level of access requires quarterly vulnerability scans.

26. **The auditors recommend the Department identify all third-party service providers and determine and document if a review of controls is required. If required, the Department should:**

    - **Obtain SOC reports or (perform independent reviews) of internal controls associated with outsourced systems at least annually.**
    - **Monitor and document the operation of the CUECs relevant to the Department's operations.**
    - **Either obtain and review SOC reports for subservice organizations or perform alternative procedures to satisfy itself that the existence of the subservice organization would not impact its internal control environment.**
    - **Document its review of the SOC reports and review all significant issues with subservice organizations to ascertain if a corrective action plan exists and when it will be implemented, any impacts to the Office, and any compensating controls.**
    - **Establish a regular review process to monitor specified performance measures, problems encountered, and compliance with contractual terms with the service providers.**
    - **Establish policy and procedures to ensure information assets and resources at the service provider were adequately protected from unauthorized or accidental disclosure, modification, or destruction.**
    - **Review contracts with service providers to ensure applicable requirements over the independent review of internal controls are included.**

FINDING: *(Lack of Adequate Controls over Review of Internal Controls over Service Providers) – This finding has been repeated since 2021.*

The Illinois Department of Public Health (Department) did not document independent internal control reviews over service providers.

The Department entered into agreements with various service providers to assist with significant processes such as information technology hosting and shared service, and hosting its Enterprise Resource Planning System.

The auditors requested the Department to provide a population of service providers. In response to this request, the Department did not provide a listing of service providers. Due to this deficiency, they were unable to conclude the Department's records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36) to test the Department's controls over external service providers.

In addition, the auditors noted the Department had not:

- Obtained and documented its review of the System and Organization Control (SOC) reports;
- Monitored and documented the operation of the Complementary User Entity Controls (CUECs) relevant to the Department's operations;
- Obtained and reviewed SOC reports for subservice organizations or performed alternative procedures to determine the impact on its internal controls;
- Established a regular review process to monitor specified performance measures, problems encountered, and compliance with contractual terms with the service providers; and
- Established policy and procedures to ensure information assets and resources at the service provider were adequately protected from unauthorized or accidental disclosure, modification, or destruction.

The Department is responsible for the design, implementation, and maintenance of internal controls related to information systems and operations to ensure resources and data are adequately protected from unauthorized or accidental disclosure, modifications, or destruction. This responsibility is not limited due to the process being outsourced.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST), Maintenance and System and Service Acquisition sections, requires entities outsourcing their IT environment or operations to obtain assurance over the entities internal controls related to the services provided. Such assurance may be obtained via System and Organization Control reports or independent reviews.

In addition, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Department management indicated the issues were due to a lack of dedicated staff to obtain and review SOC reports.

Without maintaining a complete list of service providers, obtaining SOC reports, and proper documentation of its review of the SOC reports and CUECs relevant to the Department, the Department does not have assurance the service providers' internal controls are adequate. Failure to include a requirement in the contracts with service providers for independent review and monitor specified performance, problems encountered, and compliance with contractual terms may result in obligations and services not met and not timely detected and corrected.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will identify all third-party service providers and document if a review of controls is required. The Department will perform the reviews as required.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and the recommendation. The Department has implemented the recommendations.

27. The auditors recommend the Department strengthen its controls to ensure proper completion of I-9 forms. They also recommend the Department ensure personnel files are complete and employee application documents are properly maintained. Further, they recommend the Department ensure the list of persons required to file statements of economic interests are complete.

FINDING: *(Inadequate Controls over Personnel Files) – This finding has been repeated since 2021.*

The Illinois Department of Public Health (Department) did not exercise adequate internal controls over the personnel files.

As part of their testing, the auditors requested the Department to provide a population of new hires, active, and terminated employees. In response to our requests, the Department provided populations for new hires, active, and terminated employees, however, there were terminated employees during the engagement period who were not included in the listing of terminated employees provided by the Department. Due to these conditions, they were unable to conclude the Department's population records of terminated employees were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36).

Even given the population limitations noted above, the auditors performed their testing.

During their testing, the auditors noted;

- Two of 60 (3%) I-9 forms were not properly completed. Section 1 of one I-9 form was not signed and one I-9 form had missing information.

- For 32 of 60 (53%) employees tested, the required application documents were not maintained in the personnel files.

Additionally, they obtained from the Department the lists of employees who are required to file Statement of Economic Interest during the Fiscal Year 2022 and Fiscal Year 2023 and noted the following:

- Twelve employees and a member of the State Board of Health were not included in the Department's Fiscal Year 2022 listing who are required to file Statement of Economic Interest, but these employees were included in the Office of the Secretary of State (SOS) listing. In addition, 27 employees and a member of the State Board of Health were listed in the Department's Fiscal Year 2022 listing, but these employees were not included in the SOS listing.

- Seventy-nine employees and four State Board of Health members were not included in the Department's Fiscal Year 2023 listing, but these employees were included in the SOS listing. In addition, 18 employees and one State Board of Health member were listed in the Department's Fiscal Year 2023 listing, but these employees were not included in the SOS listing.

Federal law (8 U.S.C. § 1324a) requires an employer to complete I-9 form to verify an individual's eligibility for employment in the United States. Also, Federal Law (8 CFR §274a.2(b)(1)) requires a hiring entity to attest it has verified an individual it employs is a citizen or otherwise authorized to work in the United States by (a) ensuring the individuals it hires properly complete Section 1 of Form I-9 at the time of hire, and (b) sign Section 2 of Form I-9 within three business days of hire.

The State Records Act (5 ILCS 160/8) requires the head of each agency to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency designed to furnish information to protect legal and financial rights of the State and of persons directly affected by the agency's activities.

The Illinois Governmental Ethics Act (Act) (5 ILCS 420/4A-106) requires the chief administrative officer of a state agency, on or before February 1 annually, to certify to the Secretary of State the names and mailing addresses of persons required to file statements of economic interests.

Department management stated the issues were due to oversight.

Failure to properly complete I-9 forms is a violation of federal laws. Failure to maintain complete personnel files limits the Department's ability to verify and document qualifications

and the propriety of the hiring process. Failure to provide complete and accurate list of persons required to file statements of economic interests in noncompliance with the Act.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work to ensure proper completion of I-9 forms. The Department will also ensure that personnel files are properly maintained, including the I-9 form. The Department agrees that there is inconsistency between its employee listing and Illinois Secretary of State's (SOS) list of employees for the statements of economic interest. The Department will develop a more accurate way of verifying employees who are required to file the statement of economic interest. During the two-month period before the filing period (March-April), the SOS requires each agency to verify lists of employees required to file. This process creates room for error as the exchange of information between the Department and SOS occurs at least three different times. A proposed approach is to use different data sources (perhaps payroll lists) to cross-reference with the SOS list to ensure that the list of employees is current. While payroll lists may be overinclusive, they provide a comprehensive listing of all employees. That list could be further used to reevaluate who is required to file a statement of economic interest. Revolving door lists (c-list employees) may also be used as a basis to verify correct listings.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. The Department's Office of Human Resources has reviewed and updated onboarding checklist to highlight importance of I-9 form being accurate with all signatures and completion on time. I-9 form was reviewed in a meeting so that staff have a better understanding of the importance of the form.

Employee applications are all electronic now through Success Factors. This will ensure complete personnel files and that all documentation is maintained.

The Department's Division of Legal is reviewing the current process of tracking employees new and old that are required to submit a Statement of Economic Interest and continues to work with the Office of Human Resources to determine the best way to update the listing of employees required to complete to ensure an accurate listing of employees each year.

28. The auditors recommend the Department designate a member of its staff to handle men's health issues and create a Division of Men's Health to comply with the Law.

FINDING: *(Failure to Designate a Staff to Handle Men's Health Issues and Create Men's Health Division) - New*

REVIEW #4595 DEPARTMENT OF PUBLIC HEALTH FY22-23 COMPLIANCE

The Illinois Department of Public Health (Department) failed to designate a member of its staff to handle men's health issues and create a Division of Men's Health required by the Department of Public Health Powers and Duties Law (Law).

During their testing, the auditors noted the following:

- The Department did not designate a member of its staff to handle men's health issues not currently or adequately addressed by the Department. The Law (20 ILCS 2310/2310-424) requires the Department designate a member of its staff to handle men's health issues not currently or adequately addressed by the Department and whose duties shall include, but not limited to the following: (1) assist in the assessment of the health needs of men in Illinois; (2) recommend treatment methods and programs that are sensitive and reference materials to service providers, organizations, and other agencies; (3) promote awareness of men's health concerns and encourage, promote, and aid the establishment of men's services; and (4) provide adequate and effective opportunities for men to express their views on Department policy development, program implementation, and interdepartmental coordination of men's services.

  Department management stated they filled the position to lead Men's Health efforts in February 2023 but the individual left the position shortly thereafter.

- The Department did not create the Division of Men's Health. The Law (20 ILCS 2310/2310-424.5) requires the Department to create the Division of Men's Health. The Division of Men's Health should concentrate on raising awareness of health issues specific to men, including, but not limited to prostate cancer, testicular cancer, heart disease, smoking cessation, respiratory illness, unintentional injuries, health equity, and cultural competency. The Law also required the Division of Men's Health to work with mental health providers to raise awareness of the mental health of men and address developmental issues of boys, violence prevention, self-esteem, and communication; complete an annual assessment in collaboration with the schools of public health in Illinois of the status of men's health and recommend policy developments to address those needs and identify the services needed; and make recommendations to the General Assembly to address health disparities among men.

  Department management stated the issue was due to lack of staff and appropriation.

Failure to carry out the mandated duties is noncompliance with the Law and does not achieve the legislative intent for the affected program, which is to raise awareness of men's health issues.

DEPARTMENT RESPONSE:

The Department agrees with the finding and recommendation. The Department filled a position to lead a Division of Men's Health in February 2023. The person vacated the position. Interviews to refill this Division Chief role were completed in May 2024.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and recommendation. A candidate has been selected to lead the Men's Health Division and began employment in September 2024 and will work towards developing our Men's Health Division.

29. **The auditors recommend the Department strengthen its enforcement mechanisms to ensure application and payment of the annual renewal of certificates of registration are received in a timely manner and ensure penalties for violations of the Act are assessed and collected.**

FINDING: *(Noncompliance with the Tattoo and Body Piercing Establishment Registration Act) - New*

The Illinois Department of Public Health (Department) did not receive application and payment of the annual renewal of certificates of registration of tattoo and body piercing establishments in a timely manner and did not assess penalties.

During their testing, the auditors noted for 24 of 28 (86%) annual renewal of certificates of registration tested, the Department received the application and payment of fees one month to four years late, and the Department did not assess penalties for late application and payment of the fees.

The Tattoo and Body Piercing Establishment Registration Act (Act) (410 ILCS 54/35) states the certificate of registration expires annually and may be renewed. The Act further states the Department may assess a late fee if the renewal application and renewal fee are not submitted on or before the registration expiration date and the Department, by rule, determines the amount of the fee assessed. Additionally, the Illinois Administrative Code (Code) (77 Ill. Admin. Code 797.1700(b)) states a fine not to exceed $1,000 per day for each day the registrant remains in violation shall be issued for any violation of the Act. The Code (77 Ill. Admin. Code 797.1700(c)(17)) listed the failure to renew a certificate of registration in accordance with Section 35 of the Act, as a violation of the Act.

Department management stated the issue was due to competing priorities and oversight.

Failure to receive application and payment of the annual renewal of certificates of registration timely is noncompliance with the Act and could result in the tattoo and body piercing establishment operating with an expired registration. Failure to accrue and collect penalty is noncompliance with the Code and will result in a loss of revenue.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department is working with the software vendor to correct the issues that are preventing the past due permits from being issued correctly, with the appropriate late fees included.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. The Department has sent all renewals and second notices. The Department has escalated an issue with USA Food Safety the vendor, to send late notices with correct penalties. Currently the fines do not calculate correctly on the notices. The vendor anticipates completion by 9/30/24. The program will beta test and if the correct totals are assessed, the program will send late notices in accordance with the updated SOP.

30. **The auditors recommend the Department design and maintain internal controls to provide assurance its data entry of key attributes into ERP is complete and accurate. Further, they recommend the Department timely deposit receipts into the State's treasury and promptly pursue payment for all returned checks, including revoking licenses.**

FINDING: *(Receipt Processing Internal Controls Not Operating Effectively) - New*

The Illinois Department of Public Health (Department) internal controls over its receipt processing function were not operating effectively during the examination period.

Due to the auditor's ability to rely upon the processing integrity of the Enterprise Resource Planning System (ERP) operated by the Department of Innovation and Technology (DoIT), they were able to limit our receipt and refund testing at the Department to determine whether certain key attributes were properly entered by the Department's staff into the ERP. In order to determine the operating effectiveness of the Department's internal controls related to receipt processing, they selected a sample of key attributes (attributes) to determine if the attributes were properly entered into the ERP System based on supporting documentation. The attributes tested for receipts testing were (1) amount, (2) fund being deposited into, (3) date of receipt, (4) date deposited, and (5) SAMS Source Code. The attributes tested for refunds testing were (1) amount, (2) date of receipt, (3) date deposited, and (4) offset against the correct appropriation code.

Our testing noted:

- Fifty-two of 140 (37%) attributes were not properly entered into the ERP System. Therefore, the Department's internal controls over receipts processing **were not operating effectively**.

- Seventy of 140 (50%) attributes were not properly entered into the ERP System. Therefore, the Department's internal controls over refund receipt processing **were not operating effectively**.

The State Officers and Employees Money Disposition Act (Act) (30 ILCS 230/2(a)) requires the Department to maintain a detailed record of all moneys received, which is to include date of receipt, the payor, purpose and amount, and the date and manner of disbursement. Additionally, Statewide Accounting Management System (Manual)

(Procedure 25.10.10) requires the Department to segregate the moneys into funds and document the source of the moneys. Further, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance revenues, expenditures, and transfers of assets, resources, or funds applicable to the operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Due to this condition, the auditors qualified our opinion because they determined the Department had not complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

Even given the limitations noted above, they conducted an analysis of the Department's receipts, refunds, and returned checks data for fiscal years 2022 and 2023 to determine compliance with the Act. The auditors noted:

- The Department did not deposit 1,506 receipts items, each exceeding $10,000, on the same day as received.

- The Department did not deposit 21,087 receipt items, $10,000 or more in totality, within 24 hours.

- For five of 40 (13%) returned checks tested, totaling $190, the Department had already issued the certifications, screening results, and licenses but failed to obtain replacement payments and revoke licenses upon notification of the check being returned. The receivables from these returned checks were written off.

The Act (30 ILCS 230/2(b)) requires the Department to pay into the State treasury any single item of receipt exceeding $10,000 on the day received. Additionally, receipt items totaling $10,000 or more are to be deposited within 24 hours. The Illinois State Collection Act of 1986 (30 ILCS 210/3) and Statewide Accounting Management System (Procedure 26.40.10) require the Department to pursue the collection of accounts or claims due and payable to the State of Illinois through all reasonable and appropriate procedures. The Department's collection letter stated if payment is not received, collection and/or legal procedures will be initiated including but not limited to revocation of license or registration and the licensee is not licensed until the matter is resolved.

Department management stated the issues on internal controls and late deposits were due to data entry errors which resulted from mismatches in the ERP fields used by Department staff. Department management stated the licenses were not revoked due to oversight.

Failure to properly enter the key attributes into the State's ERP when processing a receipt hinders the reliability and usefulness of data extracted from the ERP, which can result in improper recording of revenues and accounts receivable. The failure to deposit receipts

in a timely manner could result in loss of interest revenue and increases the risk of misappropriation of assets. The Department's failure to revoke issued licenses could result in unauthorized use of licenses and increases the risk that payments will not be received.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will design and maintain internal controls to provide assurance its data entry of key attributes into ERP is complete and accurate. The Department will timely deposit receipts into the State's treasury and promptly pursue payment for all returned checks, including revoking licenses.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and the recommendation. Accounting staff consulted with DoIT subject matter experts and implemented a procedure to ensure receipts are recorded timely and accurately in the SAP system.

Receipts are being deposited in a timely manner. After consultation with DoIT subject matter experts, a new procedure has been implemented by which the SAP system is accurately reflecting the timely deposit of receipts.

A procedure has been implemented whereby Division of Accounting Services accounting staff issue a memo to accounting staff in the various divisions when a check is returned by the Illinois State Treasurer's Office. The various division accounting staff then follow-up to ensure a license is not issued in that instance.

31. The auditors recommend the Department strengthen its internal controls to monitor employees to ensure all employees complete the required training in a timely manner and documentation of completion of trainings is maintained.

FINDING: *(Trainings Not Completed Within the Required Timeframe) - New*

The Illinois Department of Public Health's (Department) employees did not complete all mandatory trainings within the required timeframes.

During their testing of the Department's compliance with training requirements, the auditors noted the following:

Ethics Training:

- Thirty-five new hires did not complete the initial ethics training within 30 days after commencement of employment. These employees completed the initial training from one to 159 days late.

- Five employees did not complete the annual ethics training during calendar years 2021 and 2022 training periods.

- The Department did not maintain documentation to support completion of the ethics training for 70 employees who were separated from the Department during the engagement period. Therefore, the auditors were unable to determine if the separated employees completed the ethics training during the required training periods.

The State Officials and Employees Ethics Act (5 ILCS 430/5-10(c)) requires new employees entering a position requiring ethics training to complete an initial ethics training course within 30 days after commencement of employment. The State Officials and Employees Ethics Act (5 ILCS 430/5-10(a)) requires each officer, member, and employee to complete an ethics training annually.

Sexual Harassment Prevention Training:

- Thirty-three new hires did not complete the initial sexual harassment prevention training within 30 days after commencement of employment. These employees completed the initial training from two to 307 days late. Additionally, four new hires did not complete the initial sexual harassment prevention training.

- Sixty-three employees did not complete the annual sexual harassment prevention training during calendar year 2021 and 2022 training periods.

- The Department did not maintain documentation to support completion of the sexual harassment prevention training for 71 employees who were separated from the Department during the engagement period. Therefore, the auditors were unable to determine if the separated employees completed the sexual harassment prevention training during the required training periods.

The Illinois Human Rights Act (775 ILCS 5/2-105(B)(5)(c)) requires the Department to provide training on sexual harassment prevention and the Department's sexual harassment policy as a component of all ongoing or new employee training programs. Additionally, the State Officials and Employees Ethics Act (5 ILCS 430/5-10.5(a)) requires all new employees entering a position requiring sexual harassment training complete their initial training within 30 days after commencement of employment. It also requires each officer, member, and employee to complete, at least annually, a harassment and discrimination prevention training.

Health Insurance Portability and Accountability Act (HIPAA) Training:

- Twenty-one new hires did not complete the initial HIPAA training within 60 days after commencement of employment. These employees completed the initial training from four to 217 days late. Additionally, four new hires did not complete the initial HIPAA training.

- Four employees did not complete the annual HIPAA training during the training period.

- The Department did not maintain documentation to support completion of the HIPAA training for 13 employees who were separated from the Department during the engagement period. Therefore, the auditors were unable to determine if the separated employees completed the HIPAA training during the required training periods.

The Department's Employee Handbook requires HIPAA training be done annually. All employees receive instructions for registering for and completing the mandatory training course. Additionally, the New Employee Onboarding Checklist provides instructions to new employees to complete the HIPAA training within 60 days after commencement of employment.

Cybersecurity Awareness Training:

- Sixteen new hires tested did not complete the initial Cybersecurity Awareness training within 60 days after commencement of employment. These employees completed the initial training from four to 217 days late. Additionally, three new hires tested did not complete the initial Cybersecurity Awareness training.

- Five employees did not complete the annual Cybersecurity Awareness training during the training period.

- The Department did not maintain documentation to support completion of the Cybersecurity Awareness for 17 employees who were separated from the Department during the engagement period. Therefore, the auditors were unable to determine if the separated employees completed the Cybersecurity Awareness training during the required training periods.

- Twenty-two of 25 (88%) Department contractors tested did not complete the Cybersecurity Awareness training during the training period.

The Data Security on State Computers Act (20 ILCS 450/25(b)) requires employees to undergo an annual training by the Department of Innovation and Technology concerning cybersecurity. Additionally, the New Employee Onboarding Checklist provides instructions to new employees to complete the Cybersecurity Awareness training within 60 days after commencement of employment.

The State Records Act (5 ILCS 160/8) requires the head of each agency to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency designed to furnish information to protect legal and financial rights of the State and of persons directly affected by the agency's activities.

Department management stated competing priorities and shortage of staff contributed to inconsistent monitoring of trainings completions and timeliness of completions. Department management also stated the issue of the Department's failure to maintain documentation of employee completion of the trainings was due to limitations of the training system after employees have separated from the agency.

Failure to complete trainings within the required timeframe may lead to employees being unaware of specific requirements for State employees and Department and State policies regarding ethics, sexual harassment, HIPAA, and Cybersecurity Awareness training. As a result, there is an increased risk that new employees could unknowingly commit ethics violations. Further, there is a greater likelihood the Department could be exposed to legal and financial risks due to noncompliance.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. The Department has formed a committee between the Office of Human Resources and the Division of Legal to ensure that required trainings are being tracked in the same manner and notices will begin to be sent to employee and supervisor on a more routine basis reminding of the trainings.

The Department has created a Smartsheet to track new employee trainings and the annual required trainings by all employees. Once this sheet is complete all trainings will be tracked on one location outside of OneNet for easier ability to create proper reports.

32. The auditors recommend the Department ensure initial inspections are timely conducted and annual inspections are performed as required by the Act.

FINDING: *(Noncompliance with the Tanning Facility Permit Act) - New*

The Illinois Department of Public Health (Department) did not perform inspections of the tanning facilities in a timely manner as required by the Tanning Facility Permit Act (Act).

During the current engagement period, 121 tanning facilities applied for permits during Fiscal Years 2022 and 2023. The auditors noted the following:

- Five of 20 (25%) tanning facilities tested were not inspected during Fiscal Year 2023.
- For three of 20 (15%) tanning facilities tested, the Department performed an initial inspection of the facilities 98 to 139 days after the receipt of the application for a permit.

The Act (210 ILCS 145/10(d)) requires the Department to complete the initial inspection of the premises of the tanning facility within 90 days of receipt of an application and ensure the premises and the tanning facilities are installed and will be operated in accordance with the Act. Additionally, the Act (210 ILCS 145/15(c)) requires each tanning facility be inspected at least once each year after the initial year in which the facility was granted a permit.

Department management indicated the issues were due to competing priorities and oversight.

Failure to perform annual inspections and conduct initial inspections timely is noncompliance with the Act.

DEPARTMENT RESPONSE:
The Department is in partial agreement with the finding. The Department will work to ensure that initial inspections are conducted timely. Initial inspections are scheduled with the Tanning Establishment owners, as the establishments are not in operation prior to receipt of their permit.

UPDATED RESPONSE:
Implemented
The program now has an acting program manager, who along with administrative staff are able to assign establishments for inspection after payment has been received from validation.

The program has begun reviewing all establishments that have not been inspected for jurisdictions that have not chosen to accept the grant. An annual inspection has been added to the inspection schedule for those tanning establishments.

33. The auditors recommend the Department conduct continuing education and training programs for the prevention, identification, and treatment of resident abuse and neglect. They further recommend the Department timely initiate investigation of all reports of neglect and abuse to comply with the Act and Code.

FINDING: *(Noncompliance with the Abused and Neglected Long Term Care Facility Residents Reporting Act) - New*

The Illinois Department of Public Health (Department) did not fully comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act).

During testing, the auditors noted the Department did not initiate investigations of each report of resident abuse and neglect in Specialized Mental Health Rehabilitation Facilities in a timely manner. For 16 of 40 (40%) reports of resident abuse and neglect tested, the Department initiated the investigations 34 to 216 days after receipt of the report. Additionally,

the Department did not conduct a continuing education and training program for the prevention, identification, and treatment of resident abuse and neglect.

The Act (210 ILCS 30/6) requires the Department to be capable to receive reports of suspected abuse and neglect 24 hours a day, 7 days a week. All reports received by the Department are forwarded to the central register, in the manner and form described by the Department. Additionally, the Act requires the Department to initiate an investigation of each report of resident abuse and neglect. The Illinois Administrative Code (Code) (77 Ill. Adm. Code 400.120(a)) requires all complaint investigations be initiated within 30 days of the receipt of the complaint by the Central Complaint Registry except for reports of abuse or neglect which indicate that a resident's life or safety is in imminent danger shall be investigated within 24 hours of such report. The Act (210 ILCS 30/16) requires the Department to conduct a continuing education and training program for State and local staff, persons and officials required to report, the general public, and other persons engaged in or intending to engage in the prevention, identification, and treatment of resident abuse and neglect. The program shall be designed to encourage the fullest degree of reporting of known and suspected resident abuse and neglect, and to improve communication, cooperation, and coordination among all agencies in the identification, prevention, and treatment of resident abuse and neglect. Further, the program shall inform the general public and professionals of the nature and extent of abuse and neglect and their responsibilities, obligations, powers and immunity from liability under this Act.

Department management stated instances of abuse or neglect reported to the program were not timely investigated and their failure to start a continuing education and training program for the prevention, identification, and treatment of resident abuse and neglect were due to being understaffed.

Failure to conduct continuing education program and timely initiate investigation of reports of abuse and neglect in all facilities are noncompliance with the Act and does not achieve the legislative intent of the program to protect residents in the facility and prevent further harm to residents who are subjects of the reports of abuse and neglect.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

UPDATED RESPONSE:
Partially Implemented
The Department agrees with the finding and the recommendation. The Department's Training and Technical program provides education to new surveyors on abuse, neglect, theft, misappropriation federal citations and state violations. Current staff is provided ongoing training and education on abuse and neglect as well as needed information required for investigation.

The Department had developed reporting to track all complaints of abuse and neglect. The Office of Health Care Regulation (OHCR) reviews compliance with

investigations on a regular basis. The OHCR has a 98% compliance rate with 24-hour complaints and 30-day complaints. The OHCR has a 90% compliance rate with 7-day complaints. The OHCR is currently in the process of increasing the number of surveyors in order to ensure our compliance rate is improved to 98% and above timely investigation rate into all complaints.

34. The auditors recommend the Department conduct the program to promote awareness of firearms restraining orders to comply with the Law.

FINDING: *(Failure to Conduct Firearms Restraining Orders Awareness Program) – New*

The Illinois Department of Public Health (Department) did not conduct a program to promote awareness of firearms restraining orders to the general public as required by the Department of Public Health Powers and Duties Law (Law).

During Fiscal Year 2023, the Department was appropriated $1,000,000, or so much as may be necessary, for costs associated with the firearms restraining order awareness. During testing, the auditors noted the Department has not conducted a program to promote awareness of firearms restraining orders to the general public.

The Law (20 ILCS 2310/2310-705) requires the Department, subject to appropriation or other available funding, to conduct a program to promote awareness of firearms restraining orders to the general public. The program must include development and dissemination, through print, digital, and broadcast media, of public service announcements that publicize the firearms restraining order.
Department management stated they are still working with the stakeholders on a campaign to implement the Act. Department management also stated the materials for the campaign are still under review and subject to changes.

Failure to carry out the mandated duties is noncompliance with State laws and does not achieve the legislative intent for the affected program, which is to promote awareness of firearms restraining orders to the general public.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department is working with external partners to launch the program to promote awareness of firearms restraining orders to the general public. Launch is scheduled for July 2024 and will involve print, digital and broadcast media of public service announcements that publicize the firearms restraining order.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and recommendation. The Department worked with external partners to launch the program to promote awareness of firearms restraining orders to the general public in July 2024. The program involved print, digital and broadcast media of public service announcements that publicize firearms restraining orders (FROs).

35. The auditors recommend the Department work with the Department of Human Services to conduct the study and submit the report to the General Assembly to comply with the Act or seek legislative changes.

FINDING: *(Noncompliance with the Underlying Causes of Crime and Violence Study Act) – New*

The Illinois Department of Public Health (Department) did not comply with the requirements of the Underlying Causes of Crime and Violence Study Act (Act).

During testing, the Department and the Department of Human Services did not conduct a study and create a process to identify high violence communities, also known as R3 (Restore, Reinvest, and Renew) areas, and to prioritize funding of programs and economic development projects to these communities that would address the underlying causes of crime and violence. Additionally, the Department and the Department of Human Services did not prepare a report of their findings required to be submitted to the General Assembly by December 31, 2022.

The Act (410 ILCS 165/72-10) requires the Department and the Department of Human Services to study how to create a process to identify high violence communities, also known as R3 (Restore, Reinvest, and Renew) areas, and to prioritize State dollars to go to these communities to fund programs as well as community and economic development projects that would address the underlying causes of crime and violence. The Act (410 ILCS 165/72-15) requires the Department and the Department of Human Services to report their findings to the General Assembly by December 31, 2022.

Department management stated they were unaware of a collaboration between the Department and the Department of Human Services to run this program. Department management also stated the Illinois Criminal Justice Information Authority has been running the R3 program.

Failure to carry out the mandated duties is noncompliance with the Act and does not achieve the legislative intent for the affected program, which is to redirect funding and provide solutions to address the underlying causes of crime and violence.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. Department staff will reach out to the Department of Human Services to collaborate. Department staff also will contact the Illinois Criminal Justice Information System (responsible for R3) to understand their data needs and to collaborate.

UPDATED RESPONSE:
Under Study
No change.

36. The auditors recommend the Department establish or approve a certified nursing assistant program to comply with State laws.

FINDING: *(Failure to Establish or Approve a Certified Nursing Assistant Intern Program) - New*

The Illinois Department of Public Health (Department) did not establish or approve a Certified Nursing Assistant Intern Program as required by the Department of Public Health Powers and Duties Law (Law).

During the current examination period, the Department did not establish or approve a Certified Nursing Assistant Intern Program. The Law (20 ILCS 2310-434) requires the Department to establish or approve a Certified Nursing Assistant Intern Program (Program) to address the increasing need for trained health care workers and provide additional pathways for individuals to become certified nursing assistants. The Law also requires the Department to collect data from participating facilities and publish a report on the extent the Program brought individuals into continuing employment as certified nursing assistants in long-term care. The report shall be published no later than six months after the Program end date. The Program ends three years after it becomes operational. The Law states that a facility participating in the Program shall submit data twice annually in a manner and time determined by the Department. Failure to submit data will result in suspension of the facility's Program.

Department management stated they have not started the Certified Nursing Assistant Intern Program due to competing priorities.

Failure to carry out mandated duties is noncompliance with State laws and does not achieve the legislative intent of the program to address the increasing need for trained health care workers.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department has not started developing this Certified Nursing Assistant Intern Program due to competing priorities. The Department will further investigate what is needed to operationalize this Program.

UPDATED RESPONSE:
Under Study
No change.

37. The auditors recommend the Department ensure a base year reconciliation of its active members' census data from its underlying records and source documents to a report of the census data submitted to each plan's actuary is properly completed and accurate. They also recommend the Department maintain sufficient documentation of the reconciliation performed, including the methodology used, data traced, exceptions identified, and conclusions reached.

FINDING: *(Inadequate Internal Controls Over Census Data) - New*

The Illinois Department of Public Health (Department) did not retain adequate supporting documentation for its personnel transactions and did not have a reconciliation process to provide assurance census data submitted to its pension and other postemployment benefits (OPEB) plans was complete and accurate.

Census data is demographic data (date of birth, gender, years of service, etc.) of the active, inactive, or retired members of a pension or OPEB plan. The accumulation of inactive or retired members' census data occurs before the current accumulation period of census data used in the plan's actuarial valuation (which eventually flows into each employer's financial statements), meaning the plan is solely responsible for establishing internal controls over these records and transmitting this data to the plan's actuary. In contrast, responsibility for active members' census data during the current accumulation period is split among the plan and each member's current employer(s). Initially, employers must accurately transmit census data elements of their employees to the plan. Then, the plan must record and retain these records for active employees and then transmit this census data to the plan's actuary.

The auditors noted the Department's employees are members of both the State Employees' Retirement System of Illinois (SERS) for their pensions and the State Employees Group Insurance Program sponsored by the State of Illinois, Department of Central Management Services (CMS) for their OPEB. In addition, they noted these plans have characteristics of different types of pensions and OPEB plans, including single employer plans and cost-sharing multiple-employer plans. Finally, they noted CMS' actuaries use SERS' census data records to prepare the OPEB actuarial valuation.

During their testing, the auditors noted the Department submitted its reconciliation of its census data recorded by SERS as of June 30, 2021, however, the Department did not maintain sufficient documentation that a complete reconciliation was properly performed to its internal records to establish a base year ended June 30, 2021 of complete and accurate census data.

For employers participating in plans with multiple-employer and cost-sharing characteristics, the American Institute of Certified Public Accountants' *Audit and Accounting Guide: State and Local Governments* (AAG-SLG) (§ 13.177 for pensions and § 14.184 for OPEB) notes the determination of net pension/OPEB liability, pension/OPEB expense, and the associated deferred inflows and deferred outflows of resources depends on employer-provided census data reported to the plan being complete and accurate along with the accumulation and maintenance of this data by the plan being complete and accurate. To help mitigate against the risk of a plan's actuary using incomplete or inaccurate census data within similar agent multiple-employer plans, the AAG-SLG (§ 13.181 (A-27) for pensions and § 14.141 for OPEB) recommends an employer annually reconcile its active members' census data to a report from the plan of census data submitted to the plan's actuary, by comparing the current year's census data

file to both the prior year's census data file and its underlying records for changes occurring during the current year.

Further, the State Records Act (5 ILCS 160/8) requires the Department make and preserve records containing adequate and proper documentation of its essential transactions to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds applicable to operations are properly recorded and accounted for to permit the preparation of reliable financial and statistical reports.

Department management stated the individual who completed and submitted the June 30, 2021 and June 30, 2022 census data reconciliations to SERS had retired and access to the files was not turned-over.

Failure to reconcile active members' census data reported to and held by SERS to the Department's records could result in each plan's actuary relying on incomplete or inaccurate census data in the calculation of the State's pension and OPEB balances, which may result in a misstatement of these amounts. Failure to maintain adequate documentation to support a complete and accurate reconciliation was performed is a noncompliance with applicable laws and regulations and hindered the ability of the auditors to perform necessary testing on census data.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work on a plan to ensure the reconciliation is performed and documents are maintained.

UPDATED RESPONSE:
Implemented
The Department agrees with the finding and the recommendation. The Department has established a reconciliation methodology to ensure census data is properly completed and accurate. An audit of census data has been completed for FY23.

38. The auditors recommend the Department ensure application and inspection fees are collected from the salvage warehouses and salvage warehouse stores before issuing licenses or conducting inspections to comply with the Act. They also recommend the Department pursue collection of application and inspection fees not received.

FINDING: *(Noncompliance with the Salvage Warehouse and Salvage Warehouse Store Act) - New*

The Illinois Department of Public Health (Department) did not issue licenses as required by the Salvage Warehouse and Salvage Warehouse Store Act (Act).

During the current engagement period, 87 salvage warehouses and salvage warehouse stores applied for licenses during Fiscal Years 2022 and 2023. The auditors noted the following:

- The Department did not receive payments for license renewal for two of 14 (14%) salvage warehouses and salvage warehouse stores tested but granted licenses. Additionally, for three of 14 (21%) salvage warehouses and salvage warehouse stores tested, the Department did not receive payments for their inspection or examination, but the Department conducted the annual inspections.

- The Department was not able to provide a copy of the license issued for one of 14 (7%) salvage warehouses and salvage warehouse stores tested, therefore, the auditors were unable to determine validity and expiration of the license.

The Act (240 ILCS 30/2) requires the Department to issue a license upon payment by the applicant of a license fee of $100 per annum to the Department. The Act states that all licenses shall expire on December 31st of each year and shall be renewed only upon application made to the Department and accompanied by the required fee. Additionally, the Act (240 ILCS 30/4) requires the Department to examine or inspect the salvage warehouses and salvage warehouse stores at least annually. The Act states the Department shall set and cause to be collected a fee of $50 for each examination or inspection and for warehouses exceeding 10,000 square feet an additional fee of not more than $30 for each additional 10,000 square feet or portion thereof. In addition, the State Records Act (5 ILCS 160/8) requires the head of each agency to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency designed to furnish information to protect legal and financial rights of the State and of persons directly affected by the agency's activities.

Department management stated the issues noted were due to oversight and competing priorities.

Granting licenses and inspections to salvage warehouses and salvage warehouse stores without collection of the application and inspection fees is noncompliance with the Act and resulted in the loss of revenues.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will work to ensure the application and inspection fees are collected appropriately. The Department will pursue collection of fees not paid.

UPDATED RESPONSE:
Under Study
No change.

39. The auditors recommend the Department implement the mandated programs and duties by seeking and obtaining funding to administer the programs or seek legislative remedy to the statutory requirements.

FINDING: *(Failure to Request Funding to Implement Programs Mandated by State Laws) - New*

The Illinois Department of Public Health (Department) did not implement various programs mandated by State laws. In addition, the Department did not request funding for these programs through the appropriation process.

During our testing of statutory mandates, the following mandated programs and duties were not implemented. Although the mandate has language that reads "from funds appropriated for the purpose...", the Department did not request funding for these programs during either fiscal year under examination as follows:

- The Department did not award grants to physicians practicing obstetrics in rural designated shortage areas and did not establish conditions, standards, and duties relating to the application for and receipt of the grants.

  The Department of Public Health Powers and Duties Law (Law) (20 ILCS 2310/2310-220), previously coded as 20 ILCS 2310/55.73 and effective December 2, 1994, requires the Department to award grants to physicians practicing obstetrics in rural designated shortage areas, from funds appropriated for the purpose of reimbursing those physicians for the costs of obtaining malpractice insurance relating to obstetrical services. The Law also requires the Department to establish reasonable conditions, standards, and duties relating to the application for and receipt of the grants.

  Department management stated they did not receive appropriations for this program during Fiscal Years 2022 and 2023 and did not request funding due to competing priorities and oversight.

- The Department did not award grants to regional poison resource centers and did not develop standards to delineate the responsibilities of poison resource centers receiving funds.

  The Department of Public Health Act (Part 1) (Act) (20 ILCS 2305/8) effective September 6, 1990, requires the Department to annually make grants to regional poison resource centers, from funds appropriated for the purpose of providing fast, accurate information for poison prevention, detection, surveillance, and treatment. The Act also requires the Department to develop standards to delineate the responsibilities of poison resource centers receiving funds under this Act.

Department management stated they did not receive appropriations for this program during Fiscal Years 2022 and 2023 and did not request funding due to competing priorities and oversight.

- The Department, in cooperation with the Department of Human Services (DHS), did not maintain a smoking cessation program for participants in the Women, Infants and Children Nutrition Program.

  The Law (20 ILCS 2310/2310-435), previously coded as 20 ILCS 2310/55.44 and effective July 1, 1997, requires the Department, in cooperation with DHS, to maintain a smoking cessation program for participants in the Women, Infants and Children (WIC) Nutrition Program. The Law requires the program to include, but not limited to, tobacco use screening, education on the effects of tobacco use, and smoking cessation counseling and referrals.

  Department management stated this is an unfunded mandate. Department management also stated they have not maintained a specific smoking cessation for participants in the WIC Nutrition Program, but they receive an annual appropriation for the operation of the Illinois Tobacco Quitline which offers unlimited counseling calls provided by certified tobacco treatment specialists.

The following mandates had language that reads "subject to appropriation". However, the Department did not request funding for these programs during either fiscal year under examination as follows:

- The Department did not create a program of services for people with multiple sclerosis to help those persons stay in their homes and out of institutions.

  The Law (20 ILCS 2310/2310-394) effective July 18, 2008, requires the Department to create a program of services for persons with multiple sclerosis to help those persons stay in their homes and out of institutions. The Law also requires the Department collaborate with consumers to develop a program of services that is consumer directed.

  Department management stated they did not receive appropriations for this program during Fiscal Years 2022 and 2023 and did not request funding due to competing priorities and oversight.

- The Department did not establish an Arthritis Prevention, Control, and Cure Program.

  The Arthritis Prevention, Control, and Cure Act (410 ILCS 2/10(a)), effective January 1, 2006, requires the Department to establish, promote, and maintain an Arthritis Prevention, Control Program (Program) to raise public awareness, educate consumers, and educate and train health professionals, teachers, and human services provides, and for other purposes. The Arthritis Prevention, Control, and Cure

Act requires the Program to include (1) a needs assessment; (2) establishment of an Advisory Council on Arthritis; (3) raise public awareness on the causes and nature of arthritis, personal risk factors, the value of prevention and early detection, ways to minimize preventable pain, and options for diagnosing and treating the disease; and (4) technical assistance from entities with appropriate expertise to carry out the goals of the Program.

Department management stated the mandate is subject to appropriation and an appropriation has not been provided. The Department did not request funding due to competing priorities and oversight. Department management also stated they will seek legislative remedy to be relieved of this mandate.

- The Department did not develop and distribute education and outreach materials that will inform and educate parents of children with autism spectrum disorder who are enrolled in Medicaid and eligible to receive relevant services.

  The Autism Spectrum Disorders Reporting Act (410 ILCS 201/33), effective January 1, 2023, requires the Department to develop and distribute education and outreach materials, developed to address common literacy levels, that will inform and educate parents of children with autism spectrum disorder who are enrolled in Medicaid and eligible to receive relevant services and explain how to access those services.

  Department management stated the mandate is subject to appropriation and an appropriation has not been provided. The Department did not request funding due to competing priorities and oversight. Department management also stated they will seek legislative remedy to be relieved of this mandate.

Failure to carry out the mandated programs and duties is noncompliance with State laws and does not achieve the legislative intent for the affected programs.

DEPARTMENT RESPONSE:
The Department agrees with the finding and recommendation. The Department will seek funding to implement the mandated programs or seek legislative remedy to the statutory requirements.

UPDATED RESPONSE:
Under Study
No change.

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 five 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 a statement with the Procurement Policy Board and the Auditor General 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.

DPH had 3 emergency purchases in the first quarter of FY22:

- Estimated Cost - $6,000,000 in federal funds for a 90-day contract to ensure continuity of critical services provided to HIV positive Illinoisans during the RFP process.
- Estimated Cost - $54,750 in federal funds for a short-term contract to monitor hospitals and the quality of care they provide to perinatal patients during the RFP process.
- Estimated Cost - $55,014 in state funds for a short-term contract for maintaining the Hospital Report Card/Consumer Guide to Health Care System.

There was 1 emergency purchase in the third quarter of FY22 for an estimated cost of $54,750 in federal funds for a short-term contract to monitor hospitals and the quality of care they provide to perinatal patients during the RFP process.

There were 2 in the first quarter of FY23:

- Estimated Cost - $119,500 in state funds for a 90-day contract to expand the existing Lab Web Portal to include the ability to order monkeypox testing through an Electronic Testing, Ordering and Reporting Portal.
- Actual Cost - $141,123 in federal funds for an IT software package containing EM Vaccine Track Software to assist with COVID and MPX Vaccine response.

There was 1 in the second quarter of FY23 for an estimated cost of $325,020 in state funds for 6 instruments to test Ebolaviruses and reagent test kits.

There was 1 in the third quarter of FY23 for an estimated cost of $54,750 in federal funds for a short-term contract to monitor hospitals and the quality of care they provide to perinatal patients during the RPF process.

There was 1 in the fourth quarter of FY23 for an estimated cost of $88,686.99 in state funds for a short-term contract to operate the HIV, STD and Viral Hepatitis Hotline as required by statute during the RFP process.

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.

As of July 2023, IDPH had 475 employees assigned to locations others than official headquarters.