LEGISLATIVE AUDIT COMMISSION

Review of
Department of Public Health
Two Years Ended June 30, 2017

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REVIEW: 4492
DEPARTMENT OF PUBLIC HEALTH
TWO YEARS ENDED JUNE 30, 2017

FINDINGS/RECOMMENDATIONS - 28

ACCEPTED - 12
ACCEPTED AND PARTIALLY IMPLEMENTED - 9
IMPLEMENTED - 7

REPEATED RECOMMENDATIONS - 18

PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 24

This review summarizes the auditors' report of the Illinois Department of Public Health for the two years ended June 30, 2017, filed with the Legislative Audit Commission May 18, 2018. The auditors performed a compliance examination in accordance with State law and *Government Auditing Standards*.

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

Dr. Nirav D. Shah was the Director of the Department during the audit period. He served from January 2015 through January 2019. The current Director is Dr. Ngozi Ezike. She is an internist and pediatrician, and has delivered inpatient care at Stroger Hospital and primary and preventative care at community and school-based clinics. She served for 15 years with the Cook County Health Department, previously as medical director of the Cook County Juvenile Detention Center and Austin Health Center. Educated at Harvard University and UC-San Diego, Dr. Ezike is a national policy advisor on juvenile correctional health topics.

The average number of employees was:

Division	**FY17**	**FY16**	**FY15**
Director's Office	79	85	97
Office of Preparedness & Response	50	50	49
Office Finance and Administration (IT)	71	77	119
Office of Policy, Planning and Statistics	96	94	69
Office Health Promotion	54	54	54
Office of Health Care Regulation	401	400	415
Office Health Protection (Laboratories)	314	316	341
Office of Women's Health	35	34	39
TOTAL	**1,100**	**1,110**	**1,183**

Expenditures From Appropriations

During FY16, the Department operated without enacted appropriations until PA99-0409, PA99-0491, and PA99-0524 were signed into law on August 20, 2015, December 7, 2015 and June 30, 2016, respectively. During the Impasse, the Circuit Court of St. Clair County in *AFSCME Council 31 v. Munger* ordered the Comptroller to draw and issue warrants for wages of State employees at their normal rates of pay. Additionally, PA 99-0524 authorized the Department to pay FY16 costs using its FY17 appropriations for non-payroll expenditures.

- The Department used FY17 appropriations to pay FY16 costs amounting to approximately $14.8 million for 2,837 invoices.
- During FY16, the Department incurred $165,000 in Prompt Payment Interest for 454 invoices from 250 vendors.
- Two vendors participated in the Vendor Payment Program (VPP) for 26 invoices totaling almost $2,200.

During FY17, the Department operated without enacted appropriations until Public Act 100-0021 was approved on July 6, 2017. During the Impasse, the Circuit Court of St. Clair County in *AFSCME Council 31 v. Munger* ordered the Comptroller to draw and issue warrants for wages of State employees at their normal rates of pay. The Public Act also authorized the Department to pay for all costs incurred prior to July 1, 2018, using either its FY17 or FY18 appropriations for non-payroll expenditures.

- The Department did not anticipate using FY18 money to pay for any FY17 costs after the end of the extended lapse period in FY17 to September 30, 2017.
- During FY17, the Department incurred $33,700 in Prompt Payment Interest for 56 invoices from 34 vendors.
- Three vendors participated in the Vendor Payment Program (VPP) for 118 invoices totaling approximately $52,800.

The General Assembly appropriated over $605.3 million to the Department in FY17. The Department expended about $372.8 million including $72.5 million (12.0%) from the General Revenue Fund, $155.8 million (41.8%) from the Public Health Services Fund, and $144.4 million (46.2%) from 59 other funds. Total expenditures from appropriated funds were about $372.8 million in FY17 compared to approximately $348.2 million in FY16 which represents an increase of about $24.6 million, or 7.0%, over FY16. Some of the significant changes in expenditures from FY16 to FY17 were as follows:

- $28.2 million increase in the Commitment to Human Services Fund was due to no appropriation in the past.
- $4.9 million decrease in the Public Health Services Fund was due to less lump sum expenditures.
- $1.1 million decrease in the Compassionate Use of Medical Cannabis Fund was due to a decrease in information technology costs.
- $1.8 million decrease in the Public Health Laboratory Services Revolving Fund was due to the large amount of laboratory commodities purchased in FY16 to stock up in preparation for another budget impasse.

- $2.9 million increase in the Budget Stabilization Fund was due to no appropriation for the fund in prior years.
- $3.4 million increase in the Tobacco Settlement Recovery Fund was due to lower spending in the previous fiscal year as a result of the budget impasse.

Appendix A contains a summary of appropriations and expenditures for the period under review by fund and by object. Lapse period expenditures were $61.7 million, or 16.5%, in FY17 and $62.9 million, or 18.1%, in FY16. The majority of the lapse spending in FY17 and FY16 could be attributed to grant payments, delay in completion of grant agreements, turnover in employees, and lack of timely enacted appropriations.

Cash Receipts

The Department of Public Health has collection responsibility for licenses, fees, or other types of revenue. Overall receipts decreased from $266.0 million in FY16 to $234.7 in FY17. Some of the significant variations in receipts from FY16 to FY17 are described as follows.

- $22.2 million decrease from the Public Health Services Fund was due to the end of the federal stimulus grants and the federal grant passed through from the Department of Insurance to fund navigators who assisted with the signups for the Health Insurance Marketplace.
- $2.9 million increase in fees from the Compassionate Use of Medical Cannabis Fund was due to the significant increase in applicants to the medical cannabis program.
- $2.2 million increase from the Public Health Laboratory Services Revolving Fund was due to the receipt of FY16 billings that were initially rejected in addition to the current fiscal year billings.
- $5.7 million decrease from the Maternal and Child Health Services Block Grant Fund was due to less federal grant money received in the fiscal year.
- $1.2 million decrease from the Preventative Health and Health Services Block Grant Fund was due to the timing of federal drawdowns.
- $9.0 million decrease from the Public Health Special State Projects Fund was due to lower indirect cost rate allocations approved by the Department of Health and Human Services and less funding for Healthcare and Family Services compared to the prior fiscal year.

Appendix B provides a summary of the Department's cash receipts. Most of the Department's receipts are from federal grant revenue ($159.8 million in FY17) and fees and licenses ($50.5 million in FY17).

Changes in State Property

Appendix C provides a summary of the changes in State property for which the Department was accountable during FY17 and FY16. The value of the Department's property decreased from $23.7 million as of July 1, 2015 to $21.3 million as of June 30, 2017. The Department's

property is almost entirely comprised of equipment. Misstatements in property report and records were noted in Recommendation No. 3.

Activities and Performance Indicators

Appendix D provides a summary of the Department's activities and performance indicators. The information was taken directly from the Agency's Service Efforts and Accomplishments forms for FY17 and FY16. Information for a number of activities was not available for FY16.

Accountants' Findings and Recommendations

Condensed below are the 28 findings and recommendations included in the audit report. Eighteen were repeated from prior audits. The following updated responses are presented on the basis of updated information provided by Tom Alger, former Chief Internal Auditor, via electronic mail received April 5, 2019.

Accepted or Implemented

1. Implement procedures to maintain records of complete commodities inventories to ensure accurate accounting records and reports. (Repeated-2013)

Finding: The Illinois Department of Public Health (Department) did not exercise adequate internal controls over its commodities inventories. The Department reported a commodities inventory balance of $5,574,641 at June 30, 2017. However, auditors noted nine of 22 (41%) Department programs or divisions did not report the dollar amount of their commodities inventory in the June 30 balance.

Without the Department providing complete and adequate documentation to enable testing, the accountants were unable to complete their procedures and provide useful and relevant feedback regarding the Department's commodities.

During the current examination, Department management stated a lack of staff, competing priorities, and the lack of systems capable of tracking inventory were all contributors to the deficiency.

Response: Accepted. The Department will implement procedures to strengthen internal controls over the reporting of commodities inventories. In an effort to accurately report commodities inventories, all programs will be advised of the importance of ensuring that June 30 balances are reported.

Updated Response: Implemented. The Department has added a level of approval over the reporting of commodities inventories to help ensure accurate reporting of balances at June 30.

2. Perform a detailed inventory of computer equipment to ensure accuracy and determine whether confidential information is stored on each unit. Also, establish procedures to immediately assess if a computer may have contained confidential information whenever it is reported lost, stolen or missing during the annual physical inventory, and document the results of the assessment. Further, establish policies and procedures to ensure compliance with the Data Security on State Computers Act. (Repeated-2011)

Finding: The Department did not have adequate controls over its purchased and leased computer equipment. During a review of the Department's computer equipment inventory for the FY16 and FY 17, auditors noted the following:

- The Department was unable to locate 25 desktop computers and 10 laptop computers during its annual inventories. The Department conducts an annual physical inventory of all equipment with an acquisition cost of $500 or more and reported it was unable to locate missing computer inventory totaling $16,019 in FY16 and $20,746 in FY17.

- The Department did not perform a detailed assessment at the time the computers could not be located; and, therefore, had not determined whether the missing computers may have contained confidential information.

- The Department did not have a policy for clearing data and software from computer equipment before transfer either outside or within the Department.

- The Department did not maintain updated purchased and leased computer inventory listings. The computer inventory listing included surplused computers. Three of 25 (12%) leased computers tested could not be located because the list was not updated with the correct location. Auditors also noted five stolen/lost laptops were not removed from the leased computer inventory listing.

During the current examination period, Department management stated the deficiencies were due to lack of training, staff turnover, and lack of communication between the inventory coordinators in the program areas and the inventory control coordinator at central office.

Response: Due to the rapid staff turnover, the Department was without a Property Coordinator for the majority of the Fiscal Year 2016 inventory period. Since hiring a new coordinator, the individual has worked diligently to clean up and maintain better control on the areas listed in this finding. The Department has also been working with DCMS to have them sign and return surpluses in a timely manner. The Department is developing improved procedures and documents so the Location Coordinators can have better instruction, guidance, and more responsibility for the equipment assigned to them.

Updated Response: Partially Implemented. Performing 2019 Inventory and reconciling inventories. Implementation anticipated by 6/1/2019.

Accepted or Implemented – continued

3. **Designate sufficient trained backup staff and strengthen procedures over property and equipment to ensure timely and accurate recordkeeping for all State assets. Further, include a supervisory review process in its procedures to ensure clerical, technical, and other errors are promptly detected and corrected. In addition, regularly survey inventories for transferable equipment and report any such equipment to the Property Control Division of DCMS. Identify assets that are obsolete, damaged or unused and, if necessary, removed from the Department's records. (Repeated-2013)**

Finding: The Department did not maintain adequate controls over its property and related records. Some of the conditions noted were as follows:

Property Deletions:

- For 12 of 60 (20%) property deletions tested, totaling $64,608, the Department did not maintain the required detailed supporting documentation. In addition, four of 60 (7%) property deletions tested, totaling $16,557, were assigned improper transaction codes.

- Five of 60 (8%) deletions tested, totaling $13,419, lacked documentation of the approval by the DCMS's Property Control Division.

Physical observation of equipment:

- Eight of 120 (7%) items tested did not have a property tag.

- Thirteen of 60 (22%) items tested during the physical inspection were not recorded in the property records.

Review of property records:

- No cost was recorded in the property records for 48 equipment items purchased in May 2017 as of June 30, 2017.

- One vehicle, totaling $15,288, was recorded twice in the property records. Four vehicles, totaling $60,161, transferred out during Fiscal Year 2015 through Fiscal Year 2017, were not removed from the property records. Ten vehicles, totaling $99,123, were transferred to the Department from DCMS during Fiscal Year 2016 and were not added to the property records.

Capital lease assets:

During testing, copies of the Accounting for Leases-Lessee (SCO-560) Forms submitted to the Office of the Comptroller during FY17 and FY16 were not provided to the accountants.

Due to these conditions, the accountants were unable to conclude the Department's population records were sufficiently precise and detailed to test the Department's capital lease assets. In addition, due to these limitations, the accountants were unable to conclude the Department's Schedule of Changes in State Property on page 115 was complete and appropriately reported.

During the current examination, Department management stated the property control problems were due to rapid turnover in the location coordinator positions and also in the Central Inventory coordinator position. In addition, training was not being passed on and divisions were not following processes and procedures.

Updated Response: Accepted. Office Liaisons have been more diligent in visually confirming existence of assets. However with new SAP asset management system IDPH is having problems reconciling inventory because system reports do not pull tag numbers in or other information necessary for reconciliation. Pending new Administration Rules and new guidance from CMS and instructions associated with SAP.

New Property Control Coordinator did not start until June of 2017 and until that time the position was vacant. Once the new Coordinator started, and also as he began to prep for the conversion to the new SAP system, clean up occurred and he has drafted preliminary procedures to issue to Office Liaisons. Issuance of documented procedures pending. Awaiting new Administrative Rules and property control changes so they can be incorporated. Continued follow up with Comptroller's Office regarding classification guidance. New Property Control Coordinator now follows up with CMS to confirm receipt of surplus assets and receives associated documentation.

4. Strengthen controls to ensure documentation of the timely review of grantee's quarterly and monthly reports are maintained. In addition, ensure grantees submit timely programmatic and financial reports as required by the grant agreements. (Repeated-2007)

Finding: The Department did not adequately administer and monitor its awards and grants programs.

During FY16 and FY17, the Department expended over $257 million (43%) for awards and grants of its approximately $596 million total expenditures. For the eleven grant programs selected for testing, auditors examined 60 grant agreements totaling $15,755,040.

- For 22 of 60 (37%) grant agreements tested, 61 quarterly/monthly program reports did not have evidence of a review by Department personnel.

- For 26 of 60 (43%) grant agreements tested, 65 quarterly/monthly program reports were not reviewed timely. The reviews were made from 31 to 135 days after receipt. In addition, review dates for 12 quarterly program reports were not indicated, so timeliness of review could not be determined.

Accepted or Implemented – continued

- For 32 of 60 (53%) grant agreements tested, 136 quarterly/monthly program reports were submitted to the Department from 3 to 320 days after the deadline.

In addition, during the prior examination period, the accountants noted various other deficiencies such as the Department did not have written procedures established to uniformly guide the administration of the awards and grants under its jurisdiction, there were no established administrative rules for grants filed with the Joint Committee on Administrative Rules, and there was no standardized methodology or formal criteria for monitoring grantees. With the implementation of the Grant Accountability and Transparency Act (30 ILCS 708) during the examination period, administrative rules were enacted and the grant agreements required grantees to submit monthly reports within 10 to 30 days following the end of the month and quarterly reports no later than 30 days following the period covered by the report.

During the current examination period, Department management stated the deficiencies noted were due to staff vacancies and a lack of training.

Response: Accepted. In Fiscal Year 2018, the Department standardized periodic reporting using the State's uniform grant reporting templates and is in the process of moving reporting into its grant management software. This software records and date-stamps all user transactions, including grantee submission and Department's review of financial and programmatic reports. Therefore, the Department will be able to aggregately track timeliness of report submission and review, and the software will record evidence of review. Additionally, the Department intends to follow the Statewide Grantee Compliance Enforcement System, which requires State agencies to place a "hold" on payments to grantees who fail to timely submit reports. Lastly, when the rules promulgated by the Governor's Office of Management and Budget (GOMB) pursuant to the Grant Accountability and Transparency Act are finalized, the Department intends to establish administrative rules in line with GOMB's rules.

Updated Response: Accepted. IDPH has been working on developing new processes over grant administration.

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

Finding: The Department did not have adequate controls over contracts to ensure they contained all necessary provisions, were properly approved, and accurately reported. During testing, auditors noted the following:

- One of 40 contracts tested, totaling $358,482, was not approved in writing by the Chief Executive Officer, Chief Fiscal Officer and Chief Legal Counsel as required.

- One of 40 contracts tested, totaling $112,131, did not contain the required disclosure of financial interest statement and standard vendor certifications. The contract was for the maintenance of the Department's laboratory software.

- Eleven of 40 (28%) contract obligation documents (CODs) tested contained incorrect Illinois Procurement Bulletin publication dates, reference numbers, and contract start dates.

During the current examination period, Department management stated the deficiencies were caused by extreme rates of staff turnover, lack of staff, and a lack of adequate training.

Updated Response: Implemented. Office of Finance and Administration has been working with division staff to train them on preparing Contract Obligation Documents. In addition, Office of Finance and Administration is currently staffed and working to ensure approvals are attained, certifications and disclosures are obtained prior to contract execution, and documents are audited and completed correctly.

6. Ensure completion of planned audits and audits of major systems of internal accounting and administrative control at least once every two years to comply with the Fiscal Control and Internal Auditing Act. (Repeated-2013)

Finding: The Department failed to comply with the Fiscal Control and Internal Auditing Act. During a review of the Department's internal auditing activities, auditors noted the following:

- Five of the 15 (33%) audits and reviews included in the approved two-year internal audit plan for FY16 and FY17 were not completed. One additional audit was completed which was not included in the audit plan.

- Not all major systems of internal accounting and administrative control were conducted on a periodic basis so that all major systems were reviewed at least once every two years. In addition, the internal audits did not include grants received or made by the Department.

Related to exceptions noted during the current engagement, Department management stated a lack of staffing and competing priorities led to the deficiencies.

Response: Accepted. The Department is currently without a Chief Internal Auditor or auditing staff. The Department is currently in the process of seeking a replacement. When hired, the Chief Internal Auditor will address mandated audit compliance.

Updated Response: Accepted. IDPH has hired a Chief Internal Auditor as of June 2018; however, staff has not been added to date.

Accepted or Implemented – continued

7. Ensure overtime is properly approved in advance and timely and accurately reported. (Repeated-2011)

Finding: The 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 $2,091,118 for nearly 45,000 hours of overtime during FY16 and FY17. Auditors tested a sample of 48 pay periods and 62 employees who worked overtime during Fiscal Years 16-17. The employees in the sample incurred 1,498 hours of overtime during the pay periods tested. Based upon a review of the overtime pre-approval requests and overtime worked details, auditors noted the following:

- For 19 of 62 (31%) employees tested, overtime pre-approval requests totaling 220 hours were not pre-approved by the supervisors. These requests were approved from one to 238 days after the overtime was worked.

- Eleven of 62 (18%) employees tested had overtime pre-approval requests that exceeded the allowed maximum of 10 hours. These requests ranged from 12 to 25 hours.

- Thirteen of 62 (21%) employees tested worked 100 hours of overtime and did not enter the detail in the timekeeping system, eTime, within two workdays as required. The details were submitted and entered from three to 35 days after the overtime was worked.

- One of 62 (2%) employees tested was credited an additional two hours compensation time in error. The Department subsequently corrected the error upon notification.

During the current examination, Department management attributed the issues noted due to the insufficient training and monitoring of eTime.

Response: Accepted. The Department has provided guidance documents which outline the process to follow if pre-approval is not possible and if additional overtime is necessary. The updated Directive 16-02, revised on August 24, 2016, provides clarity on the requirements for overtime pre-approval, including the level of detail which must be provided to justify the need for overtime and overtime worked.

Updated Response: Partially Implemented. Refining the report to ensure all information we want is captured in it and doing quality checks to verify accuracy of the information. Once report is verified for accuracy, validate offices with greatest delinquency and design intervention for specific offices. Implementation anticipated by 6/30/2019.

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

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

During the current examination period, the Department did not employ the required minimum number of surveyors per licensed long-term care beds during FY16-17, which is one surveyor for every 300 beds or .33%. Auditors selected a sample of six months during the examination period and noted the Department employed surveyors at the rate of .12% to .27%.

In addition, 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 examination period, Department management stated hiring challenges remained due to lack of funding, staff turnover, and transfers within programs. Department management further stated rules for certification fees were not prepared and filed due to Title XVIII of the Social Security Act, Section 1864, not allowing for the imposition of fees on any health care facility for any survey relating to the determination of compliance of such facility.

Response: Accepted. The Department continues to diligently respond to its statutory obligations to meet the required number of surveyors. The Office of Health Care Regulation has hired new staff and has continued to work diligently at posting positions, hiring, and training to increase the number of surveyors for the State.

The Department has drafted a legislative proposal to amend the Law. This amendment would no longer require the Department to establish and charge a fee to any facility or program applying to be certified to participate in the Medicare program under Title XVIII of the federal Social Security Act or in the Medicaid program under Title XIX of the federal Social Security Act to cover the costs associated with the application, inspection, and survey of the facility or program and processing of the application.

Updated Response: Accepted. While the Office of Health Care Regulation concurs with the finding, a realistic plan cannot be developed due to the complex nature of the statute. The Office continues to diligently respond to its statutory obligations and to hire new staff in accordance with the Personnel Code and the existing collective bargaining agreement.

9. Maintain documentation and timely deposits receipts into the State Treasury. Further, promptly pursue payment for all returned checks, including suspending or revoking licenses and permits issued.

Accepted or Implemented – continued

Finding: The Department did not timely deposit cash receipts and did not timely or adequately follow-up on returned checks. During testing, auditors noted the following:

- Fourteen of 60 (23%) receipts tested, totaling $8,177,569, were deposited from one to 13 days late.

- For three of 60 (5%) receipts tested, totaling $9,785, the Department did not maintain documentation of the date when the check was received. Therefore, timeliness of the deposits could not be determined.

- For three of 60 (5%) returned checks tested, totaling $700, upon notification of the check being returned, the Department did not suspend or revoke the licenses and permits issued. In addition, the Department did not maintain documentation of collection activities performed to ensure a new check was received in a timely manner. These returned checks had been outstanding for up to 535 days and no alternative payment had been received.

Department management stated the transition of staff in Accounts Receivable and new employee orientation resulted in the issues noted.

Updated Response: Implemented. The Department has implemented a procedure whereby the divisions deliver checks to the Validation Unit upon receipt. The divisions will retain a copy of the check where necessary to gather documentation in support of the receipt. The Department has added a procedure whereby the Validation Unit will provide a second notification to the divisions on a quarterly basis of any outstanding returned checks. This will help ensure the divisions have followed up on collection.

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

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

During the prior and current examination periods, Department management cited a lack of independent authority for establishment of administrative rules as the reason for failure to meet this requirement. The Department is referenced in the Act as an agency that is required to collaborate with DHS in the establishment and adoption of joint rules for pre-qualification of human service providers. Department management stated the Department, unlike other human service agencies, does not generally provide the types of direct services that DHS and other similar agencies provide. Department programs are generally population-based and not direct services. Although the Department has participated in a contracts work group when requested

by the lead agency, and common financial grant language was developed and implemented, joint rules were not established due to complexities of aligning the functions and processes of multiple State agencies.

Updated Response: Implemented. The Department concurs with the finding and recommendation. Section 1-37a of the Act requires the Department of Human Services to take the lead on these joint rules that are also required by Section 2310-12a of the Law. However, Department of Human Services repealed the legislative requirement for these joint rules, as the Grant Accountability and Transparency Act (GATA) (30 ILCS 708) is now a law and the Governor's Office of Management and Budget is promulgating rules that include several mandates for State agencies.

GATA requires rulemaking to implement prequalification and uniform contract language that will apply to all state grants. The Department intends to establish administrative rules in line with GATA rules. Therefore, the Department no longer needs to make joint rules with the Department of Human Services, and supports its effort to repeal the requirement.

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

Finding: The Department did not conduct employee performance evaluations in a timely manner. During testing, auditors noted the following:

- Twenty-five of 54 (46%) employees' performance evaluations tested were not completed within 30 days after the end of the evaluation period. The delinquencies ranged from one to 290 days late.

- Four of 44 (9%) employees tested did not have a performance evaluation performed for the fiscal year tested.

During the current examination period, Department management stated its management staff failed to follow policy and conduct the evaluations. Further, budgetary constraints, the management to union staff ratio and competing priorities for management focus contributed to the delinquencies.

Updated Response: Implemented. Revised Evaluation Smart Sheets to track past due evaluations and upcoming evaluations; set up automated notification to the individuals listed as the 'contact person' for emails; and provided report to senior leadership for individual follow-up on past due evaluations.

12. Strengthen controls to ensure required reports are timely filed and accurate. File corrected Agency Workforce Reports to comply with the Illinois State Auditing Act within 30 days of the examination release. (Repeated-2003)

Accepted or Implemented – continued

Finding: The Department did not file required reports accurately or in a timely manner. During testing, auditors noted the following:

- The Department did not file its Travel Headquarter Reports (TA-2) Reports during Fiscal Year 2016 and Fiscal Year 2017 with the Legislative Audit Commission.

- The figures reported on the Department's 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 presented for 13 of 16 (81%) employee groups in the FY15 Report and 10 of 16 (63%) employee groups in the FY16 Report.

During the current examination period, Department management stated a lack of staff available to work on the reports resulted in the failure to comply with reporting timelines and requirements.

Response: Accepted. The Equal Employment Opportunity Officer responsible for preparing the report will: 1) revise statistical calculations to agree with supporting data provided by the Office of Human Resources and; 2) file amended reports for FY15 and Fy16 within 30 days of the audit release.

The Department will submit along with a corresponding transmittal memorandum, the required TA-2 forms to the Legislative Audit Commission by the filing deadlines. The Department will implement additional procedures to comply with office/division accurately reporting of employee changes in headquarters. Further, to ensure full compliance, each new employee upon hire, must sign a vehicle insurance certification form as part of a condition of employment that defines office, home and headquarters.

Updated Response: Partially Implemented. Agency Travel Coordinator continues to work with Offices for timely submission of data needed for the report and to ensure certifications are completed. Identify existing discrepancies and will prepare revised SOS Workforce Reports for 2015 and 2016 and forward to all relevant parties by end of fiscal year. Implementation anticipated by 12/31/2019.

13. Continue to work to ensure compliance with all aspects of the distressed facility requirements of the Nursing Home Care Act. (Repeated-2015)

Finding: The Department did not comply with provisions of the Nursing Home Care Act to publish and notify distressed facilities, establish a mentor program and sanctions, and report on revocation criteria and recommended statutory changes. These provisions of the Act were first effective on July 29, 2010.

However, the Department had drafted rules with regard to distressed facilities which were forwarded to the Long-term Care Advisory Board for discussion and consideration.

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

Response: Accepted. The Office of Health Care Regulation drafted rules in 2017 for consideration and advisement by the Long Term Care Advisory Board (Advisory Board). The Long Term Care Association requested during the Advisory Board meeting on November 16, 2017 for more time to address the issues through legislation making Distressed Facilities similar to the federal Special Focus Facilities.

Updated Response: Partially Implemented. On February 15, 2019, HB3710 was filed to amend Section 3-304.2 (Designation of distressed facilities). The proposed legislation contains language presented to the Advisory Board. The Office has until March 5, 2019, to submit a position response. The legislation will be an agenda item at the upcoming meeting scheduled for May, 2019.

14. Ensure cash balance and appropriation reconciliations are promptly performed and timely supervisory review are completed and documented.

Finding: The Department did not maintain adequate controls over its monthly cash balance and appropriation reconciliations. During testing of monthly reconciliations between the Office of the Comptroller (Comptroller) records and Department records, auditors noted the following:

- Twelve of 24 (50%) reconciliations tested of the ending balance of available cash per the Department's records to the Comptroller's Monthly Cash Report (SBO5) were performed from one to 118 days late. In addition, 20 of 24 (83%) SBO5 reconciliations tested were not reviewed in a timely manner. The supervisory reviews were completed from one to 146 days late.

- For nine of 24 (38%) reconciliations tested of the Department's expenditure records to the Monthly Appropriation Status Report (SBO1), the timeliness of completion could not be determined as the Department did not document the preparation date. In addition, ten of 24 (42%) SBO1 reconciliations tested were prepared from four to 98 days late.

- For 21 of 24 (88%) SBO1 reconciliations tested, there was no documentation of an independent review. In addition, for three of 24 (13%) SBO1 reconciliations tested, the supervisory reviews were completed from 84 to 125 days late.

Accepted or Implemented – continued

Department management stated staff shortages and changing of positions resulted in the untimely reconciliation and review of cash and appropriation balances.

Response: Accepted. Lack of staffing or continuous roll over of staff has made it nearly impossible to train staff on reconciling procedures which causes them to be set aside. The Department has hired new staff and is working to training them and making deadlines to ensure that the reconciliations are completed in compliance with the SAMS procedures.

Updated Response: Accepted. With new SAP system, inconsistencies found between information from Comptroller's Office and SAP system. With recent access to HANA reporting system, beginning to test concurrence in data.

15. Comply with the mandate concerning Alzheimer's disease data gathering or continue to seek legislative changes. (Repeated-2015)

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

There are approximately 102 coroners and medical examiners in Illinois. During the current examination, auditors noted the Department submitted a legislative proposal to repeal the statutory requirements, but it was not approved.

Department management stated, as they did during the prior examination period, the mandate was passed by the General Assembly without providing funding for implementation. Department management further stated funding for this project was never received nor requested from the General Assembly.

Response: Accepted. The provisions of the Code require 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. The Department's lack of implementation of these provisions does not impact the provision of or impede access to care for persons with Alzheimer's Diseases and related disorders. The Department concurs that a legislative remedy should be sought and will work through the State's legislative processes to do so.

Updated Response: Accepted. The Office of Health Promotion continues to seek a legislative solution as this requirement is not appropriate for the Department.

16. Establish controls to ensure employees' time records and leave requests are completed, submitted in a timely manner, and approved by their supervisor. Also, regularly review the eTime users list and make the necessary access rights cancellation to the Department of Innovation and Technology. (Repeated-2015)

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Finding: The Department did not exercise adequate controls over employee time reporting to ensure employees' work hours and leave requests were timely reported and user access rights were reviewed and timely cancelled. During testing, auditors noted the following:

- Thirty-five of 110 (32%) Daily Time Reports (DTRs) tested were not timely completed. The employees completed their DTRs from one to 34 days late.

- Two of 110 (2%) DTRs required to be completed were not submitted, and the employee was still paid despite the lack of required time reports. One of 110 DTRs tested was not approved by the employee's supervisor.

- Eight of ten (80%) leave requests tested were not submitted by the employees prior to taking the leave. The leave requests were submitted from one to ten days after leave.

During a review of the eTime users, auditors noted the Department did not cancel eight terminated employees' access to eTime. One of these employees left the Department in FY15, two in FY16, and five in FY17.

Department management stated they did not have a Directive in FY16 outlining the timeframes within which employees were to submit leave requests when unable to submit them prior to the absence. In FY17, staff was not yet fully familiar with the newly established Directive. Department management also stated the failure to cancel access to eTime was due to lack of staff and oversight.

Response: Accepted. The Department is exploring the feasibility of an additional bi-monthly review of the Master Timekeeper's Workbox which will monitor the delay in timekeeping entries and supervisor approvals. Notices will be sent to employees, their supervisors and the Deputy Director of the Office to address delinquencies. Employees who remain non-compliant are subject to corrective and progressive discipline.

Updated Response: Partially Implemented. Office continues to look at feasibility to bi-monthly reviews/report on past due timekeeping entries. Emails are currently being sent to employees with past due entries.

As part of the Off Boarding process, information is sent to DoIT regarding suspension and/or termination of employee access to systems such as eTime. Therefore the plan is to collaborate with DoIT staff to identify ways to improve the process for Off Boarding employees in regards to disabling access to the eTime system.

17. Designate and train sufficient staff and backup staff to assume responsibilities to ensure continuous compliance with State laws, rules and regulations, as well as continuous enforcement of established controls.

Accepted or Implemented – continued

Monitor the submission of accident reports to ensure the requirements are being met as required by the Illinois Administrative Code and the State of Illinois-Self Insured Motor Vehicle Liability Plan.

Enforce vehicle maintenance schedules to ensure vehicle safety, to reduce future year expenditures for repairs, and to extend the useful lives of vehicles.

Enforce controls to ensure proper reporting of fringe benefits 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 submitted to DCMS by the established due date. (Repeated-2007)

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

The Department's fleet consisted of 80 vehicles at June 30, 2016 and 2017. Of those vehicles, 47 were personally assigned to employees during FY16 and 43 in FY17.

- The Department was unable to provide supporting documentation showing submission of two of nine (22%) vehicle accident reports reviewed to the Department of Central Management Services (DCMS).

- Nine of 37 (24%) vehicles tested did not undergo an annual inspection during the examination period;

- Thirty-four of 37 (92%) vehicles tested received oil changes 1,300 to 12,000 miles or one to four months past the allowed oil change interval;

- For seven of 37 (19%) employees tested who were assigned State vehicles, the Department was unable to provide justification for the commuting miles of more than 30% of the vehicle's total mileage. Five of these employees had commuting miles that ranged from 2,243 to 4,814 miles or 32% to 53% of the vehicles' total mileage during Fiscal Year 2016. Two employees had commuting miles of 3,447 and 4,832 miles or 34% and 42% of the vehicles' total mileage during Fiscal Year 2017.

During the current examination, Department management stated the deficiencies were due to staff turnover, competing priorities, and a lack of policies and procedures.

Updated Response: Accepted. IDPH has instituted new intranet page that staff can access with instructions regarding use of State vehicles. In addition, CMS is in the process of implementing a new electronic reporting system which should allow for better tracking of this information. The new electronic State vehicle reporting system CMS is implementing will alert IDPH to these inconsistencies. Onboarding procedures have helped to reduce the untimely submission of license and auto liability forms and the new Agency Vehicle Coordinator has improved follow up activities. Agency Vehicle Coordinator continues to work with Offices for timely submission of data needed for reporting.

18. Ensure applications for registry identification cards are approved or denied within 30 days of receipt of a completed application or renewal and supporting documentation and work with the appropriate parties to ensure the Medical Cannabis Advisory Board complies with the Act. Also, comply with the administrative rules or update them.

Finding: The Department did not comply with the Compassionate Use of Medical Cannabis Pilot Program Act. During testing, auditors noted the following:

- The Department did not approve three of 25 (13%) sampled applications for a registry identification card for the use of medical cannabis within 30 days of receipt of a completed application and supporting documentation. The Department approved these applications from two to five days late. Department management stated the delay was due to re-assignment of the cases due to staff leave.

- The reduced application fee for a three-year registry card of a qualifying patient in the Department's administrative rules differed from the fee collected by the Department. The adopted rules required a fee of $150 while the Department charged $125. Department management stated there was an error in their administrative rules.

- There were no board members appointed to the Medical Cannabis Advisory Board (Advisory Board), no meetings, and no annual report issued. Department management stated the Act requires the Governor to appoint the members of the Medical Cannabis Advisory Board and members have not been appointed yet.

Updated Response: Partially Implemented. The Office of Health Promotion continually seeks improvements to medical cannabis application processing procedures to improve the timeliness. Public Act 100-1114, passed on August 28, 2018, extended the timeframe for processing applications to 90 days from the date of receipt. The Department is working with the new Governor's administration to address appointments to the advisory committee. Proposed rules were promulgated on December 1, 2018 and included a correction to the fee-related issues.

Accepted or Implemented – continued

19. Comply with the Code and appoint members to the Childhood Cancer Research Board or seek legislative remedy. Further, timely fill the vacancies on the Home Health and Home Services Committee and the Long Term Care Facility Advisory Board as required by statute. (Repeated-2011)

Finding: The 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. Testing noted the Department failed to abide by the following statutory committee and board requirements during the examination period:

- The Childhood Cancer Research Board;
- Home Health and Home Services Advisory Committee; and
- Long-Term Care Facility Advisory Board.

Department management stated, in regard to the Childhood Cancer Research Board, the $71,000 balance in the special State fund was insufficient to implement the competitive grant application process required to administer grant funds for childhood cancer research. Department management further stated the Board was to be funded by an Illinois income tax check-off, which was discontinued due to failure to achieve the minimum required annual check-off receipt amount. Department management stated the vacant positions remained on the Committee and Advisory Board due to lack of candidates.

Updated Response: Partially Implemented. The Department concurs with the finding and recommendation. The Department will seek a legislative remedy to eliminate the mandates associated with the Childhood Cancer Research Board. The Department continues to seek candidates to fill the vacancies during this timeframe and has been successful in approving a candidate for the advocacy or legal representation on behalf of residents and their immediate families.

20. Update the information disseminated to breast cancer patients, consult with appropriate medical societies and patient advocates related to breast cancer in developing the information to be disseminated, and submit the required report to the General Assembly.

Finding: The Department failed to provide updated information to breast cancer patients, had not consulted with appropriate medical societies in developing the information disseminated, and did not submit the required report to the General Assembly.

Updated Response: Implemented. The Department has a medical professional(s) with expertise in the area of breast cancer and issued an updated brochure.

21. Assess each program accepting credit card payments, the methods in which payments can be made, and match these methods to the appropriate Self-Assessment Questionnaire (SAQ).

Complete the appropriate SAQ(s) for the environment and submit documentation supporting its validation efforts to the Treasurer's Office and the E-Pay program vendor.

Maintain contact with the Treasurer's Office to ensure sufficient knowledge and awareness of PCI Compliance status, issues, and guidance surrounding the E-Pay program. (Repeated-2015)

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

The Department accepted credit card payments for multiple programs. In FY16 and FY17 the Department handled over 29,234 transactions totaling approximately $3.37 million and over 41,151 transactions totaling approximately $4.57 million, respectively.

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

- Formally assessed each program accepting credit card payments, the methods in which payments could be made, matched these methods to the appropriate Self-Assessment Questionnaire (SAQ), and contacted service providers and obtained relevant information and guidance as deemed appropriate.

- Completed a SAQ addressing all elements of its environment utilized to store, process, and transmit cardholder data.

- Submitted compliance documentation to the Treasurer's E-Pay program vendor.

PCI DSS was developed to detail security requirements for entities that store, process or transmit cardholder data. Cardholder data is any personally identifiable data associated with a cardholder.

During the current examination period, Department management stated a lack of resources and competing priorities were the reason for the deficiency.

Response: Accepted. The Department continues to work closely with each program accepting credit card payments, how those payments are made, and ensure compliance with the appropriate SAQ(s). The Department seeks to complete the appropriate SAQ(s) and submit

Accepted or Implemented – continued

the necessary documentation to the Treasurer's Office and the E-Pay program vendor. Additionally, the Department will forge continuous communication with the Treasurer's Office to ensure training for program staff about PCI Compliance status, issues, and a thorough understanding of compliance issues.

Updated Response: Accepted. DoIT working with vendor, treasurer's office, departments/offices to sunset FORTE and implement JetPay credit card system. The office (OPR/EMS) does not take any direct credit card information from any licensee. This is done through the vendor/Treasurer and the office is notified that the licensee payment has been made. Not complete at this time. DoIT manages the project plan and timelines with the department/offices accordingly.

22. Comply with change control policies and procedures requiring approval, formal testing plan, change control sign-off form, and developers' segregation of duties. Further, restrict programmer access to all production program and data. If programmer access is necessary in some situations, establish and enforce compensating controls to ensure appropriate management oversight and approval of changes. (Repeated-2015)

Finding: The Department did not comply with the Change Control Procedures, as required. Specifically:

- The Department did not complete a formal Change Control Sign-off form to ensure changes to existing systems were adequately documented and approved.

- The Department did not have an effective segregation of duties for programmers developing or maintaining its computer systems.

During the current examination period, Department management attributed the deficiencies to oversight and a lack of staff.

Response: Accepted. The Department determines that programmer access is necessary and will enforce compensating controls to ensure appropriate management oversight and approval for changes. The Department will comply with its change control policies and procedures requiring approval, testing plan, change control sign-off, and appropriate oversight of change control for production systems.

Updated Response: Accepted. We are piloting a Change Management Tool called Microsoft Team Foundation Server (TFS) which is Change Control system and tracks changes requests with approvals. The Staff Piloting the new tool will follow the process below to ensure changes are properly managed, assigned, monitor and approved.

23. Draft and adopt rules required by the Counties Code and the Long-term Care Facilities Act.

Finding: The Department did not adopt rules required by the Counties Code and the Authorized Electronic Monitoring in Long-term Care Facilities Act. During testing of statutory mandates, auditors noted the following:

- The Department did not draft or adopt rules required by the Counties Code regarding specific information that must be reported to the Department by the coroner or medical examiner in the event of death caused by drug overdose.

Department management stated coroners and medical examiners had already been reporting drug overdose information when completing the medical certification of cause of death. Therefore, Department management determined it did not necessitate the promulgation of rules.

- The Department did not adopt the rules required by the Authorized Electronic Monitoring in Long-term Care Facilities Act (210 ILCS 32/65). The Act, effective January 1, 2016, addresses the authorized placement of electronic monitoring devices in the residents' rooms of an intermediate care facility for the developmentally disabled licensed under the Intellectually Disabled/Developmentally Disabled (ID/DD) Community Care Act that has 30 beds, a facility licensed under the Medically Complex for Developmentally Disabled (MC/DD) Act, or a long-term care facility under the Nursing Home Care Act.

Department management stated it determined the Act as self-implementing and does not necessitate the promulgation of rules.

Updated Response: Partially Implemented. The Vital Records administrative rules is in a vital records rules update package that's in process. At present, the Division of Legal Services' Rules Coordinator E. Conley has the package. So this has a long way to go before the rule is adopted, notably the State Board of Health, which meets quarterly.

The Office of Health Care Regulation submits this plan in response to the State of Illinois Department of Public Health, Compliance Examination For the Two Years Ended June 30, 2017, Item 2017-023, Page 69, "Formal Department Rules Not Adopted, Bullet #2, "The Department did not adopt the rules required by the Authorized Electronic Monitoring in Long Term Care Facilities Act (Act) (210 ILCS 32/65). The Act....or a long term care facility under the Nursing Home Care Act..." (This Office has no authority for coroners/medical examiners reporting of deaths caused by drug overdoses cited in Bullet #1, Item 2017-023.)
-A review request will be made of the current General Counsel for a determination of whether rules must be drafted or if the previous position of self-executing remains. The Office will then proceed as advised.

Accepted or Implemented – continued

24. Ensure compliance with all provisions of the Medically Complex for the Developmentally Disabled Act (MC/DD).

Finding: The Department did not comply with provisions of the MC/DD 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.

Some of the conditions noted included:

- The Administrative Code was not updated to address the requirement that each policy should include periodic review of the use of restraints.

- The Department did not develop a de-identified database of residents who have injured facility staff, facility visitors, and other residents.

- The Department did not file emergency rules with the Office of the Secretary of State's (Office) regarding the provision of services to identified offenders.

Department management stated amendments to the Administrative Code have been drafted by the Department, with the legal division, but they are included with numerous other amendments under review and waiting for approval of revisions. Department officials also stated a de-identified database of residents who have injured facility staff, visitors, and other residents was not developed due to funding not being provided for the development of the database. They further stated such incidents are minimal due to the severity of the residents' disabilities, and all facilities are required to report such incidents to the Department, and review of such incidents are included in the Department's annual survey process. Department officials also stated a continuing record of all residents determined to be identified offenders was not available due to the established management tools not keeping pace with the amendatory acts which segregated these providers from other long term care providers.

Updated Response: Partially Implemented. The Office is in the process of drafting rules to meet the provisions of the Act. Industry providers continue to seek legislative remedy to amend the Act language. This item will be included on the upcoming meeting agenda for May, 2019.

The Office will collaborate with the Office of Policy, Planning and Statistics which has oversight for the Identified Offenders Program to determine if that Office maintains that identified offender by facility. If that Office maintains the information, the data will be included in the 2018 Report to the General Assembly. If that Office does not maintain the information, the Offices will discuss the steps necessary to obtain the information.

25. Ensure the Advisory Committee complies with its mandated duties.

Finding: The Department did not ensure the proper composition of the Advisory Committee on Neonatal Abstinence Syndrome, the initial Committee meeting was held within the required timeframe, and submission of the annual reports to the General Assembly and Governor's Office.

Updated Response: Implemented. The Department concurs with the finding and recommendation. The Department has appointed representatives from a local or regional public health agency and the Department of Children and Family Services. The Department will ensure that annual reports are properly submitted to the General Assembly and the Office of the Governor going forward.

26. Ensure capital asset additions are accurately recorded in the Central Inventory System (CIS) and the monthly CIS Fixed Asset Depreciation Balance Report is reviewed to assure accuracy of capital asset depreciation calculations and to ensure correct depreciation amounts are reported in the SCO-538. In addition, ensure user rights to CIS are cancelled when appropriate and review the CIS access list for accuracy.

Finding: The Department did not ensure depreciation expenses were accurately calculated and reported and system access rights were reviewed and timely cancelled.

During a review of depreciation for 25 new capital asset additions during FY16 and FY17, auditors noted the following:

- Depreciation start dates and asset lives were inaccurately recorded in the CIS Fixed Asset Depreciation Balance Report for 12 of 25 (48%) capital assets tested.

- Depreciation expense of new additions of capital assets during Fiscal Years 2016 and 2017 were not calculated and adjusted in the CIS Fixed Asset Depreciation Balance Report until August 2016 and August 2017, respectively.

During a review of the CIS users, auditors noted the Department did not revoke 29 terminated employees' access to CIS. In addition, the Department did not revoke full access of three employees who are no longer in Inventory Control positions.

Department management stated the issues noted were due to staff turnover in property control positions.

Updated Response: Accepted. Access rights were corrected pre-SAP and new SAP access is monitored. Still working with Comptroller's Office regarding capital asset depreciation schedules.

Accepted or Implemented – continued

27. Strengthen controls over voucher processing to ensure timely approval of invoice vouchers and timely submission of out-of-state travel requests. Also, regularly review the Accounting Information System (AIS) list of users and make the necessary access rights cancellation request to DoIT. In addition, comply with State law by ensuring timely submission of the aggregate dollar amount of any bills held to the Comptroller as required.

Finding: The Department did not have adequate controls over voucher processing. During testing of invoice vouchers processed during the examination period, auditors noted the following:

- Sixty-one of 345 (18%) vouchers tested were approved from 2 to 314 days late.

- The Department did not submit the request for out-of-state travel to be approved by the Governor's Office of Management and Budget (Office) in a timely manner.

During a review of the Accounting Information System (AIS) users, auditors noted the Department did not cancel the AIS access rights of six terminated employees. The Department subsequently removed the employees' access rights upon notification.

During a review of the Department's compliance with the submission of the aggregate dollar amount of any bills held as of June 30, the Department submitted the information to the Office of the Comptroller (Comptroller) three days late.

Department management stated the deficiencies were due to staff shortages, turnover, competing priorities, and training issues in its fiscal offices.

Updated Response: Accepted. Training materials for staff have been developed and will be posted on the intranet to minimize errors found in travel vouchers which contributes to delayed voucher approvals. In addition, with the implementation of SAP, there are definitive approval paths. However, with the implementation of SAP, there has been a steep learning curve in the use of the system by Office and Central fiscal staff and has resulted in a backlog. SAP processing also takes longer than with the Legacy system. Also, Travel Coordinator continues to improve compliance. Access rights were corrected and are regularly monitored.

28. Monitor programs to ensure all parties involved are following the required provisions. Also, comply with an approved vaccine replacement plan as required.

Finding: The Department failed to ensure the Vaccines for Children (VFC) program was providing proper reimbursements to the Centers for Disease Control (CDC).

The VFC program is a federally-funded program that provides vaccines at no cost to children ages 18 and younger who might not otherwise be vaccinated because of the inability to pay. In order to utilize the VFC's vaccine distribution infrastructure for the State-funded Children Health Insurance Program (CHIP), the Department and the Department of Healthcare and Family Services (HFS) entered into an Intergovernmental Agreement (Agreement) beginning July 1, 2012, that allowed HFS to reimburse the Department for vaccines used for the CHIP program.

Beginning in October 2013, the CDC required the Department to purchase vaccines directly from the pharmaceutical companies and no longer allowed the reimbursement for the CHIP program. Nevertheless, between October 2013 and October 2016, the program continued to operate according to the agreement with HFS.

The CDC issued a letter in 2017 requiring the Department to submit a written dose-for-dose replacement plan. As of the end of fieldwork, the Department continued to negotiate with the CDC over the specific terms of replacement, and estimates it will need to replace 502,190 vaccine doses totaling $24,161,267 over a seven-year-period. The Department submitted a replacement plan for approval to the CDC on June 5, 2018.

Response: Accepted. However, the following describes the situation and circumstances noted above.

On February 2016, the Department received a letter from the CDC requesting reimbursement for CHIP vaccines purchased during 2013 thru 2015.

During July 2012, the Department entered into an Agreement with HFS. This Agreement allowed the Department to assist HFS in the acquisition and distribution of vaccines through the CDC's vaccine procurement and distribution channels (i.e., VFC).

During 2012, the CDC, through their VFC program, provided vaccines to children qualified under CHIP. At the end of each calendar quarter, VFC providers would report vaccine claim data to HFS. HFS would forward the claim data to the Department. The Department would pay the drug companies based on the claim data. Inventories of vaccines were maintained by VFC and CHIP vaccines were replenished through this process. This process was referred to as the Replenishment Model and was ended by the CDC on September 2013.

After September 2013 and during 2016, the CDC required the Department on behalf of HFS to purchase vaccines directly from the drug companies. Also, the CDC required the Department to pre-purchase the vaccines using a CDC tool (VPET) to determine how many of which vaccines to purchase.

The Department requested payment based on VPET estimates from HFS. However, according to State law, invoices can only be paid for services actually provided. Payment was deferred until the vaccines were provided to the children. HFS then reviewed their internal claim data as to who would be eligible for receiving CHIP vaccines vs. the vaccine orders based on VPET. HFS found there to be variances between the two sets of data and paid the Department based on HFS' claim data. The claim data was found to show much lower volumes of vaccine as compared to VPET volumes. Also, the practitioners issuing vaccines to the children were

Accepted or Implemented – concluded

not tracking the participants within each vaccine program. Therefore, there was no definitive data available but the Department's agreement with the CDC to purchase based on VPET estimates.

VPET CDC vaccine (FFY2014-FFY2016)	$61.3 million
HFS reimbursement based on claim data	$39.5 million
CDC vaccine short-fall – Amount Owed	$21.8 million*

As a result, the Department was ordering a fraction of the vaccine estimated by VPET and the CDC was making up for the vaccine short-fall. This was the cause for the February 2016 letter from the CDC.

For the period 2013 thru 2016, the CDC and the Department agreed the vaccine short-fall to be a volume of 502,190 vaccines representing $24.2 million.

On October 2016, Department's Director ceased providing vaccines on behalf of the HFS' CHIP program.

**The difference between the "CDC vaccine short fall – Amount Owed $21.8 million" and the agreed upon reimbursement of $24.2 million represents the increased cost of replacing the vaccines.*

Emergency Purchases

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

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

Procurement Policy Board and published in the online electronic Bulletin at least 14 days before the public hearing.

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

During FY16 the Department filed four affidavits for emergency purchases totaling $433,399 as follows:

- $30,000 for a medical director.
- $256,556 for cancer registry services.
- $96,000 for EMT/trauma nurse testing.
- $50,843 for HIV care management for newborns.

During FY17 the Department filed two affidavits for an emergency purchase totaling $1,640,389 as follows:

- $1,538,702 for Medical Cannabis Registry System.
- $101,687 for hotline for pregnant HIV positive women.

Headquarters Designations

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

The Department last filed a report on July 7, 2015 which indicated there were no employees assigned to locations other than official headquarters. Finding No. 12 relates to the TA-2 reports not filed by the Department.

REVIEW: 4492
DEPARTMENT OF PUBLIC HEALTH
TWO YEARS ENDED JUNE 30, 2017

APPENDIX A

Summary of Appropriations and Expenditures
I. By Fund

	FY17	FY16	FY15
Total Appropriations	**$ 605,340,500**	**$ 546,852,181**	**$ 604,074,227**
Expenditures			
General Revenue Fund	$ 72,556,625	$ 67,075,504	$ 110,692,948
Food & Drug Safety Fund	451,442	398,917	1,319,913
Penny Severns Breast, Cervical & Ovarian Cancer Research Fund	-	-	436,722
Fire Prevention Fund	-	-	596,501
Rural/Downstate Health Access Fund	7,268	9,634	-
Alzheimer's Disease Research Fund	89,016	133,223	89,630
Public Health Services Fund	155,814,062	160,704,378	169,598,533
Hospital Licensure Fund	304,888	72,602	14,569
Compassionate Use of Medical Cannabis Fund	1,997,395	3,084,071	3,143,827
Stroke Data Collection Fund	3,054	-	-
Community Health Center Care Fund	-	18,091	55,977
Facility Licensing Fund	620,089	1,155,617	2,319,743
Heartsaver AED Fund	-	12,582	31,468
Illinois School Asbestos Abatement Fund	743,639	745,817	620,624
Diabetes Research Checkoff Fund	-	-	133,000
Carolyn Adams Ticket for the Cure Grant Fund	631,170	391,273	1,429,083
Illinois Health Facilities Planning Fund	1,593,070	1,745,263	1,863,359
Emergency Public Health Fund	2,409,305	3,191,831	3,664,310
Public Health Water Permit Fund	42,085	54,059	48,232
Nursing Dedicated & Professional Fund	1,012,571	584,355	1,152,637
Long Term Care Monitor/Receiver Fund	20,595,336	22,835,099	22,198,341
Home Care Services Agency Licensure Fund	834,897	1,190,397	1,015,681
Used Tire Management Fund	95,336	495,034	441,867
African-American HIV/AIDS Response Fund	213,549	-	-
Tattoo & Body Piercing Establishment Registration Fund	147,803	294,301	225,936
Public Health Lab Services Revolving Fund	2,256,929	4,074,061	2,287,286
Long Term Care Provider Fund	1,299,269	1,322,054	1,321,921
Lead Poisoning, Screening, Prevention & Abatement Fund	725,325	1,200,002	1,718,456
Tanning Facility Permit Fund	57,450	170,259	236,630
Plumbing Licensure & Program Fund	1,584,292	1,865,691	1,674,729
Regulatory Evaluation & Basic Enforcement Fund	21,477	22,036	30,447
Trauma Center Fund	4,112,276	4,452,216	1,433,351
EMS Assistance Fund	1,181,131	1,342,491	712,951
Multiple Sclerosis Research Fund	1,076,833	1,949,703	1,921,907
Quality of Life Endowment Fund	524,597	465,495	1,396,662
Health Facility Plan Review Fund	1,277,117	1,342,397	1,941,677
Pesticide Control Fund	368,100	325,827	368,306
Death Certificate Surcharge Fund	2,560,754	812,829	1,585,621
Commitment to Human Services Fund	28,208,887	-	-
Healthy Smiles Fund	287,503	173,685	251,383
Budget Stabilization Fund	2,979,219	-	-
DHS Private Resource Fund	-	-	6,931
Assisted Living & Shared Housing Regulatory Fund	658,733	590,972	720,237
Tobacco Settlement Recovery Fund	10,103,502	6,693,348	12,496,639
Pet Population Control Fund	-	190,623	232,122
Private Sewage Disposal Program Fund	195,999	223,195	218,645

Appendix A - continued

	FY17	FY16	FY15
Public Health Federal Projects Fund	157,279	149,427	121,524
Maternal & Child Health Services Block Grant Fund	16,843,804	18,705,321	18,353,991
Preventive Health & Health Services Block Grant Fund	2,304,815	3,165,225	2,326,208
Public Health Special State Projects Fund	18,264,833	19,806,400	19,002,192
Metabolic Screening & Treatment Fund	15,508,100	14,944,978	13,542,479
Hearing Instrument Dispenser Examination & Disciplinary Fund	95,929	72,224	70,013
Illinois State Podiatric Disciplinary Fund	-	-	49,514
Build Illinois Bond Fund	-	-	657,491
Total	**$ 372,816,753**	**$ 348,252,507**	**$ 405,772,214**

II. By Major Object

Expenditures	FY17	FY16	FY15
Personal services	$ 89,191,519	$ 92,615,713	$ 97,854,689
State employee retirement	20,764,370	22,159,815	21,825,009
Social Security/Medicare contributions	6,560,907	6,808,151	7,176,732
Group insurance	11,902,300	12,530,234	11,721,085
Contractual services	55,004,716	42,325,239	46,518,555
Travel	2,654,383	2,715,570	3,185,596
Printing	184,761	166,521	167,957
Commodities	11,359,232	8,287,138	7,981,779
Equipment	867,136	108,370	537,373
Telecommunication	1,971,744	908,764	1,834,634
Operation of auto equipment	139,790	92,704	143,887
Interest-Prompt Payment	33,690	165,246	2,592
Interfund cash transfers	679,000	679,000	679,000
Awards and grants	171,435,442	158,668,898	206,090,978
Refunds	67,763	21,144	52,348
Total Expenditures	**$ 372,816,753**	**$ 348,252,507**	**$ 405,772,214**

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APPENDIX B

Summary of Cash Receipts

	FY17	FY16	FY15
Federal Grant Revenue	159,885,250	189,519,789	188,981,649
Fees and Licenses	50,558,372	43,977,227	42,627,205
Non-Operating Revenue	144,237	518,917	311,344
Other Revenue			
Fines and Penalities	1,785,583	1,305,195	2,465,892
Scholarships	135,114	190,269	172,474
Long Term Care	1,373,579	1,393,373	1,253,849
Pharmaceutical Rebates	13,937,694	13,252,139	3,588,622
Healthcare & Family Services	5,606,546	13,024,159	18,268,039
Other, Miscellaneous	1,325,047	2,837,826	2,195,329
Total Cash Receipts	**$ 234,751,422**	**266,018,894**	**$ 259,864,403**

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APPENDIX C

Changes in State Property

	FY17	FY16
Balance, July 1	**$ 23,456,151**	**$ 23,736,332**
Additions	604,204	258,233
Deductions	(312,115)	(47,836)
Transfers	(2,358,636)	(490,578)
Balance, June 30	**$ 21,389,604**	**$ 23,456,151**

Note: The above schedule was derived from the property reports (C-15) submitted to the Office of the Comptroller which have been reconciled to Department records. During testing, auditors noted misstatements in Department property reports and records, including capital lease and equipment amounts reported in this schedule. (See Finding No. 3 for details.)

APPENDIX D

Summary of Activities and Performance Indicators

	FY17	FY16
Health Protection		
Number of lead poisoning cases investigated	1,614	656
Number of children screened for blood lead poisoning	231,783	224,272
Total newborn screening tests performed	2,624,682	2,684,418
Number of newborn screen tests reported	173,419	N/A
Total newborn screening test results reported	173,419	175,788
Number of Lab Tests performed	3,020,693	N/A
Number of children referred for lead follow-up exceeding 10 mcg/d1	1,569	N/A
Immunization rate for all Illinois children under 2 years of age including Chicago (4:3:1:3:3:1:3 series)	54.9%	51%
Percent of infants receiving MMR (1) doses	81.7%	83.1%
Preparedness and Response		
Number of trauma cases	43,508	46,500
Number of hospitals designated as trauma centers	67	66
Health Care Regulation		
Number of licensed Long Term Care (LTC) facility annual inspections	974	1,003
Percent of Complaints uploaded and closed in the federal database by the 70-day mandated timeframe for surveys	89%	N/A
Percent of LTC facilities in compliance at first revisit of annuals	90%	88%
Health Promotion		
Number of specimens screened for genetic/metabolic disorders	169,787	178,746
Number of newborn hearing screenings performed for hearing loss by Illinois hopitals	146,750	150,261
Number of persons approved for a medical cannabis registry identification card	14,439	5,044
Number of infants confirmed with genetic/metabolic conditions identified through a newborn screening	222	127
Women's Health		
Number of requests to Women's Healthline	490	N/A
Total Number of Breast Cancer screenings	18,826	N/A
Percent of abnormal breast screenings with complete follow-up	97.2%	N/A
Percent of abnormal Pap tests with complete follow-up	97.3%	96.4%
Total number of unduplicated clients	66,572	N/A
Policy, Planning & Statistics		
Number of continuing nursing scholarship awards	75	82
Estimated number of patients seen by providers in shortage areas	103,500	126,000
Number of hours providers provided care to patients in Healthcare Provider Shortage Areas (HPSAs)	69	84