State of Illinois Department of Public Health

STATE COMPLIANCE EXAMINATION

FOR THE TWO YEARS ENDED JUNE 30, 2025

PERFORMED AS SPECIAL ASSISTANT AUDITORS FOR THE AUDITOR GENERAL, STATE OF ILLINOIS

Roth&Co

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2025

TABLE OF CONTENTS

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2025

DEPARTMENT OFFICIALS

Director	Dr. Sameer Vohra, MD, JD, MA
Chief Fiscal Officer (08/16/25 – Present)	Mr. Jacob Cisco
Chief Fiscal Officer (07/01/23 – 08/15/25)	Ms. Nicole Hilderbrand
General Counsel	Ms. Rukhaya Alikhan
Chief Internal Auditor (12/01/24 – Present)	Ms. Leighann Manning
Chief Internal Auditor (07/01/23 –11/30/24)	Ms. Candice Long

DEPARTMENT OFFICES

The Department of Public Health's primary administrative offices are located at:

525-535 West Jefferson Street
Springfield, Illinois 62761

69 West Washington Street, Suite 3500
Chicago, Illinois 60602

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

MANAGEMENT ASSERTION LETTER

July 7, 2026

Roth & Company, LLP
540 West Madison Street, Suite 2450
Chicago, Illinois 60661

Roth & Company, LLP:

We are responsible for the identification of, and compliance with, all aspects of laws, regulations, contracts, or grant agreements that could have a material effect on the operations of the State of Illinois, Department of Public Health (Department). We are responsible for and we have established and maintained an effective system of internal controls over compliance requirements. We have performed an evaluation of the Department's compliance with the following specified requirements during the two-year period ended June 30, 2025. Based on this evaluation, we assert that during the years ended June 30, 2024 and June 30, 2025, the Department has materially complied with the specified requirements listed below.

A. The Department has obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

B. The Department has obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

C. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

D. Other than what has been previously disclosed and reported in the Schedule of Findings, State revenues and receipts collected by the Department are in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts is fair, accurate, and in accordance with law.

E. Money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department have been properly and legally administered, and the accounting and recordkeeping relating thereto is proper, accurate and in accordance with law.

Yours truly,

SIGNED ORIGINAL ON FILE

Sameer Vohra, MD, JD, MA
Director

SIGNED ORIGINAL ON FILE

Jacob Cisco
Chief Fiscal Officer

SIGNED ORIGINAL ON FILE

Rukhaya Alikhan
Chief Legal Counsel

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2025

STATE COMPLIANCE REPORT

SUMMARY

The State compliance testing performed during this examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants; the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States; the Illinois State Auditing Act (Act); and the *Audit Guide.*

ACCOUNTANTS' REPORT

The Independent Accountants' Report on State Compliance and on Internal Control Over Compliance does not contain scope limitations or disclaimers, but does contain a modified opinion on compliance and identifies material weaknesses over internal control over compliance.

SUMMARY OF FINDINGS

Number of	**Current Report**	**Prior Report**
Findings	40	39
Repeated Findings	34	27
Prior Recommendations Implemented or Not Repeated	5	4

SCHEDULE OF FINDINGS

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings	
2025-001	14	2023/2007	Inadequate Controls over the Administration of State Vehicles	Material Weakness and Material Noncompliance
2025-002	19	2023/2013	Lack of Controls over Contracts	Material Weakness and Material Noncompliance
2025-003	23	2023/2017	Voucher Processing Internal Controls Not Operating Effectively	Material Weakness and Material Noncompliance
2025-004	27	2023/2021	Lack of Adequate Controls over Review of Internal Controls over Service Providers	Material Weakness and Material Noncompliance

SCHEDULE OF FINDINGS (Continued)

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings (Continued)	
2025-005	30	2023/2021	Inadequate Controls over Personnel Files	Material Weakness and Material Noncompliance
2025-006	33	2023/2023	Receipt Processing Internal Controls Not Operating Effectively	Material Weakness and Material Noncompliance
2025-007	36	New	Change Control Weakness	Material Weakness and Material Noncompliance
2025-008	38	2023/2013	Property Control Weaknesses	Significant Deficiency and Noncompliance
2025-009	41	2023/2017	Noncompliance with the MC/DD Act	Significant Deficiency and Noncompliance
2025-010	44	2023/2007	Inadequate Administration and Monitoring of Awards and Grants Programs	Significant Deficiency and Noncompliance
2025-011	47	2023/2011	Inadequate Controls over Approval and Reporting of Overtime	Significant Deficiency and Noncompliance
2025-012	49	2023/2013	Failure to Employ an Adequate Number of Surveyors	Significant Deficiency and Noncompliance
2025-013	51	2023/2007	Employee Performance Evaluations Not Conducted Timely	Significant Deficiency and Noncompliance
2025-014	53	2023/2003	Failure to Submit and Accurately File Required Reports	Significant Deficiency and Noncompliance
2025-015	56	2023/2015	Noncompliance with Distressed Facilities Provisions of the Nursing Home Care Act	Significant Deficiency and Noncompliance

SCHEDULE OF FINDINGS (Continued)

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings (Continued)	
2025-016	58	New	Noncompliance with Nursing Home Care Act	Significant Deficiency and Noncompliance
2025-017	60	2023/2017	Lack of Controls over Monthly Reconciliations	Significant Deficiency and Noncompliance
2025-018	62	2023/2015	Failure to Establish Policies and Procedures on Alzheimer's Disease and Related Disorders	Significant Deficiency and Noncompliance
2025-019	64	2023/2021	Noncompliance with the Alzheimer's Disease Assistance Act	Significant Deficiency and Noncompliance
2025-020	65	2023/2015	Inadequate Controls over Employee Time Reporting	Significant Deficiency and Noncompliance
2025-021	67	2023/2013	Inadequate Internal Controls over Commodities	Significant Deficiency and Noncompliance
2025-022	69	2023/2011	Statutory Committee and Board Requirements	Significant Deficiency and Noncompliance
2025-023	71	2023/2017	Noncompliance with the Breast Cancer Patient Education Program	Significant Deficiency and Noncompliance
2025-024	72	2023/2017	Formal Department Rules Not Adopted	Significant Deficiency and Noncompliance
2025-025	75	2023/2019	Inadequate Controls over Accounts Receivable	Significant Deficiency and Noncompliance
2025-026	77	2023/2021	Weaknesses in Cybersecurity Programs and Practices	Significant Deficiency and Noncompliance
2025-027	80	2023/2021	Noncompliance with the Equity in Long-term Care Quality Act	Significant Deficiency and Noncompliance

SCHEDULE OF FINDINGS (Continued)

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings (Continued)	
2025-028	82	2023/2021	Noncompliance with the Tobacco Products Compliance Act	Significant Deficiency and Noncompliance
2025-029	84	2023/2015	Weaknesses with Payment Card Industry Data Security Standards	Significant Deficiency and Noncompliance
2025-030	86	2023/2023	Noncompliance with the Tattoo and Body Piercing Establishment Registration Act	Significant Deficiency and Noncompliance
2025-031	88	2023/2023	Trainings Not Completed Within the Required Timeframe	Significant Deficiency and Noncompliance
2025-032	92	2023/2023	Noncompliance with the Tanning Facility Permit Act	Significant Deficiency and Noncompliance
2025-033	94	2023/2023	Noncompliance with the Abused and Neglected Long Term Care Facility Residents Reporting Act	Significant Deficiency and Noncompliance
2025-034	96	2023/2023	Noncompliance with the Underlying Causes of Crime and Violence Study Act	Significant Deficiency and Noncompliance
2025-035	98	2023/2023	Inadequate Internal Controls over Census Data	Significant Deficiency and Noncompliance
2025-036	101	2023/2023	Failure to Request Funding to Implement Programs Mandated by State Laws	Significant Deficiency and Noncompliance
2025-037	105	New	Noncompliance with Hospital Licensing Act	Significant Deficiency and Noncompliance

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2025

SCHEDULE OF FINDINGS (Continued)

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings (Continued)	
2025-038	106	New	Noncompliance with Suicide Prevention, Education, and Treatment Act	Significant Deficiency and Noncompliance
2025-039	107	New	Noncompliance with the Psychiatry Practice Incentive Act	Significant Deficiency and Noncompliance
2025-040	109	New	Noncompliance with the Equity and Representation in Health Care Act	Significant Deficiency and Noncompliance
			Prior Findings Not Repeated	
A	110	2023/2021	Noncompliance with the Emergency Medical Services Act	
B	110	2023/2023	Failure to Designate a Staff to Handle Men's Health Issues and Create Men's Health Division	
C	110	2023/2023	Failure to Conduct Firearms Restraining Orders Awareness Program	
D	110	2023/2023	Failure to Establish or Approve a Certified Nursing Assistant Intern Program	
E	111	2023/2023	Noncompliance with the Salvage Warehouse and Salvage Warehouse Store Act	

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2025

EXIT CONFERENCE

The findings and recommendations appearing in this report were discussed with Department personnel at an exit conference on June 24, 2026.

Attending were:

Department of Public Health
Mr. Sameer Vohra, MD, JD, MA, Director
Ms. Laura Vaught, Chief of Staff
Ms. Heather Whetsell, Deputy Chief of Staff
Ms. Allison Nickrent, Chief Governmental Affairs
Ms. Ashley Thoele, Chief Operating Officer
Ms. Leighann Manning, Chief Internal Auditor
Ms. Alikhan Rukhaya, Chief Legal Counsel
Ms. Erin Davis, Deputy General Counsel
Ms. Samantha Helton, Deputy Director Human Resources
Mr. Jacob Cisco, Chief Fiscal Officer
Ms. Jacqueline Schuerman, Business Process Analyst
Ms. Sarah Isenhart, Internal Auditor
Ms. Kristin Rzeczkowski, Staff Assistant

Office of the Auditor General
Ms. Stephanie Wildhaber, Senior Audit Manager

Roth & Company, LLP – Special Assistant Auditors
Ms. Elda Arriola, Partner
Mr. John Reazo, Supervisor
Ms. Rochelle Reyes, Senior Associate

The responses to the recommendations for findings 2025-001 through 2025-008; 2025-010 through 2025-014; 2025-016 through 2025-023; and 2025-025 through 2025-040 were provided on June 29, 2026, and the responses to the recommendations for findings 2025-009; 2025-015; and 2025-024 were provided on July 6, 2026 by Ms. Leighann Manning, Chief Internal Auditor.

Roth&Co

INDEPENDENT ACCOUNTANTS' REPORT
ON STATE COMPLIANCE AND ON INTERNAL CONTROL OVER COMPLIANCE

Honorable Christopher B. Meister
Auditor General
State of Illinois

Report on State Compliance

As Special Assistant Auditors for the Auditor General, we have examined compliance by the State of Illinois, Department of Public Health (Department) with the specified requirements listed below, as more fully described in the *Audit Guide for Financial Audits and Compliance Attestation Engagements of Illinois State Agencies (Audit Guide)* as adopted by the Auditor General, during the two years ended June 30, 2025. Management of the Department is responsible for compliance with the specified requirements. Our responsibility is to express an opinion on the Department's compliance with the specified requirements based on our examination.

The specified requirements are:

A. The Department has obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

B. The Department has obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

C. The Department has complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

D. State revenues and receipts collected by the Department are in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts is fair, accurate, and in accordance with law.

E. Money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department have been properly and legally administered and the accounting and recordkeeping relating thereto is proper, accurate, and in accordance with law.

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Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the Illinois State Auditing Act (Act), and the *Audit Guide*. Those standards, the Act, and the *Audit Guide* require that we plan and perform the examination to obtain reasonable assurance about whether the Department complied with the specified requirements in all material respects. An examination involves performing procedures to obtain evidence about whether the Department complied with the specified requirements. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risks of material noncompliance with the specified requirements, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our modified opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

Our examination does not provide a legal determination on the Department's compliance with the specified requirements.

Our examination disclosed material noncompliance with the following specified requirements applicable to the Department during the two years ended June 30, 2025. As described in the accompanying Schedule of Findings as items 2025-001 through 2025-007, 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. As described in the accompanying Schedule of Findings as item 2025-006, the Department had not ensured the State revenues and receipts collected by the Department were in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts was fair, accurate, and in accordance with law.

In our opinion, except for the material noncompliance with the specified requirements described in the preceding paragraph, the Department complied with the specified requirements during the two years ended June 30, 2025, in all material respects. However, the results of our procedures disclosed instances of noncompliance with the specified requirements, which are required to be reported in accordance with criteria established by the *Audit Guide* and are described in the accompanying Schedule of Findings as items 2025-008 through 2025-040.

The Department's responses to the compliance findings identified in our examination are described in the accompanying Schedule of Findings. The Department's responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The purpose of this report is solely to describe the scope of our testing and the results of that testing in accordance with the requirements of the *Audit Guide*. Accordingly, this report is not suitable for any other purpose.

Report on Internal Control Over Compliance

Management of the Department is responsible for establishing and maintaining effective internal control over compliance with the specified requirements (internal control). In planning and performing our examination, we considered the Department's internal control to determine the examination procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the Department's compliance with the specified requirements and to test and report on the Department's internal control in accordance with the *Audit Guide*, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that have not been identified. However, as described in the accompanying Schedule of Findings, we did identify certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with the specified requirements on a timely basis. A material weakness in internal control is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material noncompliance with the specified requirements will not be prevented, or detected and corrected, on a timely basis. We consider the deficiencies described in the accompanying Schedule of Findings as items 2025-001 through 2025-007 to be material weaknesses.

A significant deficiency in internal control is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies described in the accompanying Schedule of Findings as items 2025-008 through 2025-040 to be significant deficiencies.

As required by the *Audit Guide*, immaterial findings excluded from this report have been reported in a separate letter.

The Department's responses to the internal control findings identified in our examination are described in the accompanying Schedule of Findings. The Department's responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing based on the requirements of the *Audit Guide*. Accordingly, this report is not suitable for any other purpose.

SIGNED ORIGINAL ON FILE

Chicago, Illinois
July 7, 2026

2025-001. **FINDING** (Inadequate Controls over the Administration of State Vehicles)

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

The Department's fleet consisted of 104 vehicles at June 30, 2024 and 127 at June 30, 2025. Of those vehicles, 60 were personally assigned to employees during Fiscal Year 2024 and 71 in Fiscal Year 2025.

During testing, we noted the following:

- The Department did not ensure its vehicles were properly maintained during the engagement period. The auditors reviewed the maintenance records for 30 vehicles and noted the following:

    - Seven (23%) vehicles tested received oil changes 136 to 8,361 miles past the allowed oil change interval. Additionally, five (17%) vehicles tested had inadequate documentation; therefore, we were not able to determine whether these vehicles had oil changes within the allowed interval.

    - One (3%) vehicle tested did not receive a tire rotation, as required. Additionally, five (17%) vehicles had tire rotations past the allowed interval. Further, five vehicles (17%) had inadequate documentation; therefore, we were not able to determine whether these vehicles had tire rotations within the allowed interval.

    - Six (20%) vehicles tested did not undergo an annual inspection during the engagement period.

    - The Department was not able to provide the maintenance records for ten (33%) vehicles tested; as such, we were not able to determine whether these vehicles were properly maintained.

    - The Department was not able to provide sufficient supporting documentation on the disposal and transfer of one (3%) vehicle. In addition, one (3%) vehicle was not operational during the physical inspection of vehicles.

  The Illinois Administrative Code (Code) (44 Ill. Admin. 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. Admin. Code 5040.400) requires all State-owned or leased vehicles to undergo regular service and/or repair to maintain the vehicles

2025-001. **FINDING** (Inadequate Controls over the Administration of State Vehicles) - Continued

in road worthy, safe, operating condition and appropriate cosmetic condition. The State Records Act (5 ILCS 160/8) requires the Department to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and 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.

- The Department did not exercise adequate control over the personal use of State vehicles. As part of our testing, we requested the Department provide the population of its employees who are allowed the personal use of State vehicles. In response to the request, the Department provided such population; however, there was an employee who did not report State vehicle usage to the Department's Payroll Division during Fiscal Years 2024 and 2025. Due to this deficiency, we 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 monitoring and reporting of employee fringe benefits. Even given the population limitation noted above, we performed our testing. During our testing, we noted:

    - Fifty-six of 56 (100%) monthly vehicle logs and vehicle use certification forms tested were not 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, 20 of 56 (36%) 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 net overstatement of reported fringe benefit payments for tax purposes totaling $234 in Fiscal Year 2024 and $225 in Fiscal Year 2025.

    - One of 56 (2%) vehicle use certification forms tested differed as to the number of commuting days the State vehicle was used with the fringe benefit reported in the payroll voucher, resulting in an overstatement of fringe benefit payments for tax purposes totaling $3 in Fiscal Year 2024.

  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,

2025-001. **FINDING** (Inadequate Controls over the Administration of State Vehicles) - Continued

or $3 per day. Fringe benefits are to be included in the employee's wages for tax purposes.

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

  - Fourteen of 40 (35%) employees tested did not submit the certification forms during the engagement period.

  - Two of 40 (5%) employees tested submitted the certification forms 49 and 56 days late.

  - One of 40 (3%) employees tested did not sign the certification form.

  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 assignment to DCMS. We noted the following:

  - The Department submitted the Fiscal Year 2024 Individually Assigned Vehicle (IAV) Report 427 days late.

  - One of 30 (3%) employees tested submitted the vehicle assignment authorization form 8 days late.

  The Code (44 Ill. Admin. 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

2025-001. **FINDING** (Inadequate Controls over the Administration of State Vehicles) - Continued

employee's headquarters and residence.

- The Department did not properly and timely submit accident reports. We noted the following:

  - Two of five (40%) Illinois Motorist Report forms (Form SR-1) tested were not properly signed by the employees.

  - Two of five (40%) Form SR-1s tested were not timely filed with the DCMS. The Form SR-1s were submitted 3 and 156 days late.

  The Code (44 Ill. Admin. Code 5040.520(i)) states in all cases, the completed Form SR-1 (DCMS Claim Intake Form effective October 29, 2024) must be submitted to the DCMS Auto Liability Unit no later than 7 calendar days following the accident or the driver and State agency risk forfeiture of coverage under the State's auto liability plan.

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, employee errors, and a lack of policies and procedures.

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. Failure to maintain a complete population of employees authorized personal use of State vehicles and to reconcile vehicle logs, certification forms, and payroll reporting weakens the Department's internal control over fringe benefit monitoring and reporting. As a result, the Department is at risk of inaccurate reporting of taxable fringe benefits, noncompliance with Internal Revenue Service requirements and Department policy, and incomplete or unreliable records for audit purposes. 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 and timely report vehicle assignment changes and accidents to DCMS lessens government oversight for fleet efficiency and accountability for State resources. (Finding Code No. 2025-001, 2023-001, 2021-001, 2019-001, 2017-017, 2015-018, 2013-015, 11-13, 09-14, 07-17)

2025-001. **FINDING** (Inadequate Controls over the Administration of State Vehicles) - Continued

RECOMMENDATION

We recommend the Department:

- 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 and accidents, as well as the required annual report on Individually Assigned Vehicles, are properly completed and submitted to DCMS by the established due date.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department began implementing controls and strengthened processes to comply with the finding, including a newly implemented Fleet Management System, new standard operating procedures, and automated tracking technology.

2025-002. **FINDING** (Lack of Controls over Contracts)

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 our testing, we requested the Department to provide a population of contractual agreements, emergency purchases, and interagency agreements. In response to our requests, the Department provided such populations; however, the emergency purchases listing provided by the Department did not agree with the emergency purchases reported to the Office of the Auditor General and in the Agency Contract Report (SC-14 Report). There were contractual agreements not reported in the SC-14 Report. Due to these conditions, we 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).

Even given the population limitations noted above, we performed our testing.

During our testing of 60 contractual agreements, we noted:

- Six (10%) contractual agreements, totaling $460,438, were filed with the Comptroller more than 30 days after their execution and were not accompanied by a Late Filing Affidavit.

- One (2%) contractual agreement, totaling $390,425, did not contain the required financial disclosures and conflict of interest certification.

- One (2%) contractual agreement, totaling $55,000, did not disclose whether a subcontractor would be utilized.

- One (2%) contractual agreement, totaling $154,478, indicated an incorrect award code.

- Four (7%) contractual agreements, totaling $1,240,079, were not properly completed and dated. All four contractual agreements did not contain the dates when the authorized Department representative signed the contractual agreements and three contractual agreements did not contain the printed name and title of the authorized Department representative.

- Six (10%) contractual agreements, totaling $1,208,400, did not contain the required standard certifications.

2025-002. **FINDING** (Lack of Controls over Contracts) - Continued

- For four (7%) contractual agreements, totaling $3,384,968, the Department did not post the purchase requisition in Bidbuy; therefore, we were unable to test if the request to contract was approved.

- For seven (12%) contractual agreements, the total maximum contract amounts per executed agreements totaled $6,808,099; however, the total maximum contract amounts reported in the SC-14 totaled $5,201,495.

- For three (5%) contractual agreements, the contract beginning and ending dates reported in the SC-14 were different from dates in the executed agreements.

- For 42 (70%) contractual agreements, the Contract Obligation Documents (CODs) were not properly completed. We noted the following:

    - Thirty-one CODs, totaling $13,150,874, had incorrect appropriation codes.

    - Four CODS, totaling $641,149, had incorrect award codes.

    - Two CODS, totaling $1,149,940, had contract beginning and ending dates different from the dates indicated in the executed agreements.

    - Fifteen CODS, totaling $841,862, did not indicate the procurement reference numbers.

    - One COD did not state the correct maximum contract amount. The maximum contract amount entered in the COD totaled $68,500; however, the total maximum contract amount in the executed agreement was $111,600.

    - Seven CODS, totaling $751,159, included incorrect Illinois Procurement Bulletin/Bidbuy publication dates or did not indicate the publication dates at all.

    - One COD stated that subcontractors would be utilized; however, the executed contract indicated non-utilization of subcontractors. Additionally, one COD stated that subcontractors would not be utilized; however, the executed agreement did not disclose whether subcontractors would be utilized.

2025-002. **FINDING** (Lack of Controls over Contracts) - Continued

The Illinois Procurement Code (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.

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.

The SAMS Manual (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, and detailed description of the contract, in addition to other applicable information.

2025-002. **FINDING** (Lack of Controls over Contracts) - Continued

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 system for monitoring and tracking of contracts and competing priorities.

Without the Department providing a complete and accurate population of contractual agreements and emergency purchases entered into during the examination period, we were unable to adequately complete procedures to provide useful and relevant feedback to the General Assembly. Failure to 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. (Finding Code No. 2025-002, 2023-004, 2021-004, 2019-005, 2017-005, 2015-004, 2013-006)

RECOMMENDATION

We 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, and
- compliance with the requirements of the Procurement Code and State laws.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The process of contract monitoring was evaluated and has been strengthened. This includes a newly established Division of Procurement and developed tracking system.

2025-003. **FINDING** (Voucher Processing Internal Controls Not Operating Effectively)

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 our ability to rely upon the processing integrity of the Enterprise Resource Planning System (ERP) operated by the Department of Innovation and Technology (DoIT), we 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, we 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 7 of 140 (5%) 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 Manual (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 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 (FCIAA) (30 ILCS 10/3001) requires the Department 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, we qualified our opinion because we 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, we conducted an analysis of the Department's expenditures data for Fiscal Years 2024 and 2025 and noted the following:

2025-003. **FINDING** (Voucher Processing Internal Controls Not Operating Effectively) - Continued

- The Department owed 83 vendors interest, totaling $9,508, in Fiscal Years 2024 and 2025; however, the Department had not approved these vouchers for payment to the vendors.

  The State Prompt Payment Act (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 10,159 of 60,108 (17%) vouchers processed during the examination period, totaling $215,605,889. We noted these vouchers were approved between 31 and 412 days after receipt of a proper bill or obligating document.

  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. The Code (74 Ill. Admin. Code 1000.50) also requires the Department to process payments within 30 days after physical receipt of Internal Service Fund bills.

- Two of 60 (3%) awards and grants vouchers tested, totaling $436,500, were not coded with proper detail object codes.

  The SAMS Manual (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 within a common object.

Additionally, during our detail testing of travel vouchers, we noted:

- One of the top 10 (10%) travelers tested requested reimbursement twice for the same travel expenses. The traveler was overpaid $924.

  The FCIAA (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 funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. Good internal controls require a thorough review of all travel vouchers submitted to ensure employees are not reimbursed twice for the same expenses incurred.

2025-003. **FINDING** (Voucher Processing Internal Controls Not Operating Effectively) - Continued

- The Department did not properly complete 34 of 40 (85%) travel vouchers tested, totaling $35,417. The vouchers had missing voucher dates and voucher numbers.

  The SAMS Manual (Procedure 17.20.10) requires each State agency to enter specific information on the travel voucher.

- For one of 40 (3%) travel vouchers tested, totaling $130, the Department reimbursed the employee with meals or per diem rates not in accordance with rates set forth by the Governor's Travel Control Board, resulting in an overpayment of $11.

  The Code (80 Ill. Admin. Code 3000.500) states the per diem allowance shall be in accordance with the rates promulgated pursuant to 5 U.S.C. 5702 (a)(1)(A).

- For 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 Code (80 Ill. Admin. 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 competing priorities.

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 obligations due may result in noncompliance, unnecessary interest charges, and cash flow challenges for payees.

2025-003. **FINDING** (Voucher Processing Internal Controls Not Operating Effectively) - Continued

In addition, failure to approve vouchers for payment of interest due, submit travel vouchers and related travel request forms, and ensure vouchers are properly recorded represent noncompliance with laws and regulations and increases the likelihood that errors or irregularities could occur. (Finding Code No. 2025-003, 2023-017, 2021-018, 2019-021, 2017-027)

RECOMMENDATION

We recommend the Department design and maintain internal controls to provide assurance its data entry of key attributes into ERP is complete and accurate. Further, we recommend the Department approve proper bills and obligations due, approve vouchers for payment of interest due to vendors, submit travel vouchers and request forms in a timely manner, and ensure vouchers are properly recorded.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the testing period, the Department had begun implementing 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, including training, a new tracking system, and clarifying personnel duties.

2025-004. **FINDING** (Lack of Adequate Controls over Review of Internal Controls over Service Providers)

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.

We 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, we 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, we 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.

2025-004. **FINDING** (Lack of Adequate Controls over Review of Internal Controls over Service Providers) - Continued

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.

This finding was first reported during the period ended June 30, 2021. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

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. (Finding Code No. 2025-004, 2023-026, 2021-030)

RECOMMENDATION

We 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.

2025-004. **FINDING** (Lack of Adequate Controls over Review of Internal Controls over Service Providers) - Continued

- 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.

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.

2025-005. **FINDING** (Inadequate Controls over Personnel Files)

The Illinois Department of Public Health (Department) did not exercise adequate internal controls over its personnel files.

As part of our testing, we requested the Department to provide a population of new hires, active, terminated and employees who were on leave of absence (LOA) during the examination period. In response to our requests, the Department provided such populations; however, there were employees who were not included in the listings of terminated, active, and employees on LOA provided by the Department. Due to these conditions, we were unable to conclude the Department's population records of terminated, active, and LOA 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, we performed our testing.

During our testing, we noted:

- Two of 60 (3%) Employment Eligibility Verification Forms (I-9 forms) were not properly completed. Section 1 of one I-9 form was not signed and dated by the employee, and one I-9 form was dated with the employee's date of birth instead of the date the I-9 form was signed; therefore, we were unable to determine timeliness of completion.

- For two of 60 (3%) employees tested, the required I-9 forms were not maintained in the personnel files.

Additionally, we obtained from the Department the lists of employees who were required to file Statements of Economic Interest during Fiscal Year 2024 and Fiscal Year 2025 and compared those lists to the corresponding records maintained by the Office of the Secretary of State (SOS). Based on our review, we noted the following:

- Three of 449 (<1%) employees identified by the Department as required to file Statements of Economic Interest for Fiscal Year 2024 were not included on both the Department's listing and the SOS filing list. Consequently, these employees did not file the required Fiscal Year 2024 Statement of Economic Interest.

- One of 431 (<1%) employees required to file a Statement of Economic Interest was not included on the Department's Fiscal Year 2025 filing list. The Department did not request SOS to add the employee to the filing list until April 21, 2025. As a result, the employee filed the required Statement of Economic Interest on June 10, 2025, 40 days after the applicable filing deadline.

2025-005. **FINDING** (Inadequate Controls over Personnel Files) - Continued

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 Department to preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect legal and financial rights of the State and of persons directly affected by the Department's activities.

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. Effective internal controls should ensure I-9 forms are properly and timely completed and maintained.

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. Further, the Act (5 ILCS 420/4A-105) requires that all qualified persons submit a verified written statement of economic interest by May 1 of each year with the SOS.

This finding was first reported in Fiscal Year 2021. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated the issues were due to employee errors.

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 lists of persons required to file statements of economic interests represents noncompliance with the Act and may result in required filings not being submitted by the applicable deadline. (Finding Code No. 2025-005, 2023-027, 2021-031)

2025-005. **FINDING** (Inadequate Controls over Personnel Files) - Continued

RECOMMENDATION

We recommend the Department strengthen its controls to ensure proper completion and maintenance of I-9 forms and lists of persons required to file statements of economic interests are complete.

DEPARTMENT RESPONSE

The Department accepts this finding. The Department notes that the data presented in the finding indicates an immaterial issue with the controls measured by this audit. The Department has implemented effective controls to address previous findings in this area, resulting in very minimal, but reasonable, instances of noncompliance with the population data, such as the aforementioned 1%, 0.8%, and 1%.

2025-006. **FINDING** (Receipt Processing Internal Controls Not Operating Effectively)

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

Due to our ability to rely upon the processing integrity of the Enterprise Resource Planning (ERP) System operated by the Department of Innovation and Technology (DoIT), we 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, we 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:

- Fourteen of 140 (10%) receipt attributes were not properly entered into the ERP System. Therefore, the Department's internal controls over receipts processing **were not operating effectively**.

- Twenty-five of 140 (18%) refund 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, the Statewide Accounting Management System Manual (SAMS) (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 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.

2025-006. **FINDING** (Receipt Processing Internal Controls Not Operating Effectively) - Continued

Due to this condition, we qualified our opinion because we 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, we conducted an analysis of the Department's receipts, refunds, and returned checks data for Fiscal Years 2024 and 2025 to determine compliance with the Act. We noted:

- The Department did not deposit 295 receipt items, $10,000 or more, on the day received.

- The Department did not deposit 996 receipt items, exceeding $500 but less than $10,000, within 48 hours. Additionally, for 9 receipt items within the same dollar range, the deposit dates recorded in the ERP System did not agree with the supporting documentation.

- The Department did not deposit 421 receipt items, less than $500, on the 1st or 15th of the month, whichever was earlier. Additionally, for 395 receipt items less than $500, the deposit dates recorded in the ERP System did not agree with the supporting documentation.

- For two of 40 (5%) returned checks tested, totaling $995, the Department had already issued the license and acceptance of the testing fee but failed to obtain replacement payments and revoke the license upon notification of the check being returned. The receivables from these returned checks were written off.

The Act (30 ILCS 230/2(a)) 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. Further, receipt items, in total exceeding $500 but less than $10,000, are to be deposited within 48 hours. Lastly, receipt items totaling less than $500 are to be deposited once the total exceeds $500 or on the 1st or 15th of the month, whichever is earlier. The Illinois State Collection Act of 1986 (30 ILCS 210/3) and the SAMS Manual (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.

2025-006. **FINDING** (Receipt Processing Internal Controls Not Operating Effectively) - Continued

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 employee error.

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 timely deposit receipts delays the recognition of available cash within the State Treasury, could delay the payment of State obligations, and is noncompliance with the Act. 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. (Finding Code No. 2025-006, 2023-030)

RECOMMENDATION

We recommend the Department design and maintain internal controls to provide assurance its data entry of key attributes into ERP is complete and accurate. Further, we recommend the Department timely deposit receipts into the State's treasury. Finally, we recommend the Department promptly pursue payment for all returned checks, including revoking licenses.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the course of the audit, the Department implemented a revision to its data entry process to provide assurance that key attributes and deposit dates are complete and accurate. The Department has established a procedure to ensure prompt payment for all returned checks and revocation of licenses where warranted.

2025-007. **FINDING** (Change Control Weakness)

The Illinois Department of Public Health (Department) had weaknesses in its change management controls.

As a result of the Department's mission to promote health through prevention and control of disease and injury, the Department maintained several computer applications, such as PKU Billing System, Cashbook System, Receipts System, Genetic Counseling System (GCS), Environment Health Licensing System, and Illinois Comprehensive Automated Immunization Registry Exchange (I-Care).

During testing of 23 system change requests covering I-Care, we noted the Department had not:

- properly approved one (4%) system change request prior to change development, and

- established adequate segregation of duties by allowing the same personnel to:

    - develop and deploy system changes for three (13%) change requests;
    - deploy and test system changes for four (17%) change requests; and
    - approve and develop system changes for three (13%) change requests.

In addition, we noted the Department had not developed and formalized its change management policy or procedure for all its critical applications.

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, Configuration Management and System and Services Acquisition section requires entities to document controls over changes to their environment, applications, and data. 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 funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources.

Department management indicated the issues were due to oversight and competing priorities.

Lack of enforcement of change control procedures increases the risk of unauthorized, improper, or erroneous changes to the Department's environment, applications, and data. (Finding Code No. 2025-007)

2025-007. **FINDING** (Change Control Weakness) - Continued

RECOMMENDATION

We recommend the Department ensure controls are suitably designed and implemented to protect computer systems and data.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

2025-008. **FINDING** (Property Control Weaknesses)

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

During our testing, we noted the following:

Property Additions:

- Twenty of 60 (33%) property additions tested, totaling $825,508, were recorded 2 to 262 days late. The Illinois Administrative Code (Code) (44 Ill. Admin. Code 5010.400) requires the Department to adjust its property records within 90 days of acquisition, change, or deletion of equipment items.

Property Deletions:

- For three of three (100%) computers tested that were disposed of, totaling $30,030, the Department did not provide documentation to determine whether the storage devices had confidential data and were properly wiped. The Data Security on State Computers Act (20 ILCS 450/10) requires (i) the Department of Central Management Services (DCMS) or any other authorized agency that disposes of surplus electronic data processing equipment by sale, donation, or transfer to implement a policy mandating that computer hardware be cleared of all data and software before disposal by sale, donation, or transfer and (ii) the head of each Agency to establish a system for the protection and preservation of State data on State-owned electronic data processing equipment necessary for the continuity of government functions upon relinquishment of the equipment to a successor executive administration.

Physical Observation

- Three of 60 (5%) items tested, totaling $16,410, were not found at the location indicated on the Department's property listing. The Statewide Accounting Management System Manual (SAMS) (Procedure 29.10.10) requires the Department to maintain current property records, including the location. Additionally, the Code (44 Ill. Admin. Code 5010.230) requires the Department to correctly enter each item's location code number on its property listing.

- Two of 60 (3%) items tested, totaling $37,389, had missing tags. After notification by the auditors of the issue, the Department subsequently assigned new tag numbers to the equipment. The Code (44 Ill. Admin. Code 5010.210) requires the Department to mark each piece of State-owned equipment in its possession to indicate that it is the property of the State of Illinois. Additionally,

2025-008. **FINDING** (Property Control Weaknesses) - Continued

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.

- Forty-two of 45 (93%) surplus items tested, totaling $26,399, had not been recycled, issued, or transferred to DCMS. The Code (44 Ill. Admin. Code 5010.620) requires all agencies to regularly survey their inventories for transferable equipment and report any such equipment on proper forms to the Property Control Division of DCMS.

Annual Certification of Inventory

- The Department did not submit the annual certification of inventory for Fiscal Year 2024 to DCMS. The SAMS Manual (Procedure 29.10.10) requires the Department to maintain a permanent record of all property. A listing of the permanent record is required to be submitted to DCMS annually in a format prescribed by DCMS.

Agency Report of State Property (C-15 Report)

- Eight of eight (100%) quarterly C-15 Reports required to be filed during Fiscal Years 2024 and 2025 were not reviewed. The SAMS Manual (Procedure 29.10.10) requires the C-15 Report to be submitted to the agency official responsible for approving it for review and signature before it is submitted to the Office of Comptroller for processing.

- Two of eight (25%) quarterly C-15 Reports required to be filed during Fiscal Year 2024 were submitted seven and eight days late. The SAMS Manual (Procedure 29.20.10) requires the Department to submit the C-15 Report to the Office of Comptroller no later than the last day of the month following the last day of the quarter.

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, lack of familiarity with certain applicable State property requirements, and the related position being vacant for several months.

2025-008. **FINDING** (Property Control Weaknesses) - Continued

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. (Finding Code No. 2025-008, 2023-002, 2021-002, 2019-003, 2017-003, 2015-005, 2013-007)

RECOMMENDATION

We 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.

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 during the audit process. Improvements have included filling of critical positions, new tracking procedures, and new tracking technology procured.

2025-009. **FINDING** (Noncompliance with the MC/DD Act)

The Illinois Department of Public Health (Department) did not comply with provisions of the MC/DD Act (Act). The Act (210 ILCS 46), 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 our testing of certain provisions of the Act, we noted the following:

- During testing of the inspections conducted for the State license renewals of the 10 MC/DD facilities during Fiscal Year 2024 and Fiscal Year 2025, we noted the following:

    - Seven (70%) facilities were inspected by the Department 10 to 437 days after the effective date of the renewal licenses. Additionally, one (10%) facility was not inspected but was issued a renewal license.

    - For two (20%) facilities tested, documentation supporting the submission date or the Department's receipt date of facility comments was not maintained. As a result, we were unable to determine whether the facilities' comments were submitted within the required timeframe.

    The Act (210 ILCS 46/3-212(a)), effective January 1, 2023, 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 developed a de-identified database of residents who have injured other residents; however, the Department still has not developed a de-identified database of residents who have injured facility staff and facility visitors. 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,

2025-009. **FINDING** (Noncompliance with the MC/DD Act) - Continued

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 and visitors was not developed due to minimal technology within the Department. Department management further stated it is still working with its technology provider to add additional fields to its new technology system to capture all fields required which will require facilities to report injuries on non-residents.

- The Department did not maintain required information on the facilities database posted on its website. 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, including information in the possession of the Department that is listed in Section 3-210. The Department did not post on its website the following information: the rates charged for the services provided by the facility and items for which a resident may be separately charged; and a record of personnel employed or retained by the facility who are licensed, certified, or registered by the Department of Financial and Professional Regulation. The Act (210 ILCS 46/3-210) requires the facility to retain the following information for inspection: (1) a complete copy of every inspection report of the facility received from the Department during the past 5 years; (2) a copy of every order pertaining to the facility issued by the Department or a court during the past 5 years; (3) 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; (4) a copy of the statement of ownership required by Section 3-307; (5) a record of personnel employed or retained by the facility who are licensed, certified, or registered by the Department of Financial and Professional Regulation; (6) a complete copy of the most recent inspection report of the facility received from the Department; and (7) a copy of the current Consumer Choice Information Report.

  Department management indicated the failure to update the information on its 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.

2025-009. **FINDING** (Noncompliance with the MC/DD Act) - Continued

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 those under the age of 22 and residing in MC/DD facilities. (Finding Code No. 2025-009, 2023-003, 2021-003, 2019-002, 2017-024)

RECOMMENDATION

We recommend the Department ensure it complies with all provisions of the Act.

DEPARTMENT RESPONSE

The Department accepts the finding and recommendation.

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 continue to monitor scheduling so that inspections occur within the 120-day window of the applicable licensure renewal. The Department will implement steps to conform to the 120-day requirement. This finding does not reflect major deviations in inspections based on legal interpretation.

Additionally, during the audit period, the Department has continued implementation of a newly procured licensing system.

2025-010. **FINDING** (Inadequate Administration and Monitoring of Awards and Grants Programs)

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

During Fiscal Years 2024 and 2025, the Department expended over $673 million (44%) for awards and grants of its approximately $1.5 billion total expenditures. We sampled 52 grant programs from the following offices: Health Promotion; Health Protection; Disease Control; Women's Health; Preparedness and Response; Policy, Planning & Statistics; and Center for Minority Health Services. For the 52 grant programs selected for testing, we examined 60 grant agreements totaling $48,045,116.

- For 46 of 60 (77%) grant agreements tested, 220 quarterly or monthly program reports were submitted to the Department from 1 to 414 days after the deadline. Of these grant agreements, the Department did not withhold payments or issue a Stop Payment Status notification to 5 of 51 (10%) awardees, even though the quarterly or monthly program reports were submitted between 16 to 25 business days after the applicable due dates. Additionally, the Department did not place 22 of 51 (43%) awardees in temporary Stop Payment Status when required, although the grantees submitted their quarterly or monthly program reports between 31 and 414 business days after the applicable due dates.

- For 23 of 60 (38%) grant agreements tested, 32 quarterly or monthly program reports were not reviewed timely. The reviews were made from 31 to 182 days after receipt.

- For four of 60 (7%) grant agreements tested, nine quarterly or monthly program reports did not have evidence of a review by Department personnel.

- For six of 60 (10%) grant agreements tested, 21 quarterly or monthly program reports were not submitted to the Department by the grantee.

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

2025-010. **FINDING** (Inadequate Administration and Monitoring of Awards and Grants Programs) - Continued

standards. The Illinois Administrative Code (Code) (44 Ill. Admin. Code 7000.80(f)(1)(C) and (D)) requires the Department to withhold payments to the grantee if a report is more than 15 business days past the original or extended due date and requires Department rules to include awardee notification of the State agency contact for Stop Payment Status inquiries. If the report is not submitted within 30 business days after the original or extended due date, the Department shall place the awardee in temporary Stop Payment Status on the Illinois Stop Payment List. Further, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

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 attributed the conditions noted above to issues including staffing capacity and vacancy, staff expertise, system technicality, inadequate policy on document retention, miscommunication of report submission deadlines to grantees, and competing priorities. Further, Department management stated they did not withhold payments, issue a Stop Payment Status notification to awardees, or place grantees on stop-payment status for late reporting because taking such actions may cause awardees to suspend or hold program implementation, thereby affecting the intended benefits to the public.

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. Failure to withhold payments, issue a Stop Payment Status notification to awardees, or place grantees in temporary stop-payment status when required reports are not timely submitted weakens enforcement of reporting requirements, diminishes accountability and oversight, and increases the risk of misuse of funds. Continued payments without required reporting undermine internal controls, compromise transparency, and may result in agency noncompliance with State regulations, and inconsistent treatment of grantees. As a result, funds could remain unspent, untimely recovered, or be utilized for activities other than the intended purpose without detection by the

2025-010. **FINDING** (Inadequate Administration and Monitoring of Awards and Grants Programs) - Continued

Department. (Finding Code No. 2025-010, 2023-005, 2021-005, 2019-004, 2017-004, 2015-001, 2013-001, 11-1, 09-1, 07-1)

RECOMMENDATION

We recommend the Department strengthen its controls to ensure documentation and timely review of grantees' required quarterly and monthly reports are maintained. In addition, the Department should ensure that grantees submit timely progress reports and other required reports to comply with the provisions of the grant agreements and invoke stop-payment actions when required reports are not submitted timely. Further, we recommend the Department implement monitoring controls to ensure timely identification of delinquent reports and consistent application of enforcement procedures.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has worked with the Bureau of Finance, the Bureau 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.

2025-011. **FINDING** (Inadequate Controls over Approval and Reporting of Overtime)

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 $7,547,133 for 99,019 hours of overtime during Fiscal Year 2025 and $6,840,556 for 94,099 hours of overtime in Fiscal Year 2024. We tested a sample of 60 pay periods and 48 employees who worked overtime during Fiscal Years 2024 and 2025. The employees in our sample incurred 443 hours of overtime during the pay periods tested. Based on our review of the overtime pre-approval requests and overtime worked details, we noted the following:

- Three of 48 (6%) employees tested worked 15 hours of overtime and did not enter the details in the timekeeping system, eTime, within the required submission dates. The details were submitted and entered from one to three days after the deadlines.

- For three of 48 (6%) employees tested, overtime pre-approval requests totaling 14 hours were not timely submitted by employees. These requests were submitted from one to five days after the overtime was worked.

- For seven of 48 (15%) employees tested, overtime pre-approval requests totaling 31 hours were not pre-approved by the supervisors. These requests were approved from two to seven days after the overtime was worked or the overtime was submitted, whichever is later.

- Twenty-seven of 48 (56%) employees tested had overtime pre-approval requests that exceeded the allowed maximum hours. These requests ranged from 20 to 90 hours.

According to the Timekeeping Protocols of the Department's Employee Guidelines, Directive 16-02 , overtime pre-approval requests must be submitted and approved in eTime prior to the overtime being worked. Prior to May 30, 2024, overtime pre-approval requests are limited to a maximum of ten hours. Overtime worked details must be submitted in the timekeeping system within two working days. Effective May 30, 2024, overtime pre-approval requests should closely reflect the amount of overtime that is needed for each pay period. Overtime worked requests must be submitted in eTime within seven days of the start of the following work week. If additional time is required, a new overtime pre-approval request may be submitted for the total amount of estimated overtime hours needed. In the event

2025-011. **FINDING** (Inadequate Controls over Approval and Reporting of Overtime) - Continued

that a pre-approval request cannot be submitted in eTime prior to the overtime being worked, the employee must request and receive approval from their supervisor in writing prior to working overtime. Such approval, as well as the justification, shall be referenced in the comment section when the overtime pre-approval request is submitted in eTime. Overtime worked without the supervisor's pre-approval (whether in eTime or otherwise) is not guaranteed to be approved.

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.

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 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, overtime worked details are timely submitted, and pre-approved allowable overtime limits are adhered to undermines accountability controls and increases the risk the Department would pay unnecessary personal service expenditures. (Finding Code No. 2025-011, 2023-006, 2021-007, 2019-007, 2017-007, 2015-007, 2013-009, 11-9)

RECOMMENDATION

We recommend the Department ensure overtime pre-approval requests are timely submitted, properly approved in advance, complied with allowable overtime limits, and documentation of pre-approval is maintained.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has worked to ensure that overtime pre-approval requests are timely submitted, properly approved in advance, and documentation of pre-approval is maintained by way of regularly informing employees of the timekeeping Directives related to this. Timeframes of information sharing continue to be assessed to continuously improve in this area.

2025-012. **FINDING** (Failure to Employ an Adequate Number of Surveyors)

The Illinois Department of Public Health (Department) failed to comply with the provision of the Department of Public Health Powers and Duties Law (Law) (20 ILCS 2310) related to surveyors for long term care beds.

The Department did not employ the required minimum number of surveyors per licensed long term care beds during Fiscal Years 2024 and 2025, which is one surveyor for every 300 beds or 0.33%. We selected a sample of six months during the examination period to determine if the required number of surveyors were employed. During testing, we noted the following:

- For four of six months tested, nine of 11 (82%) regional offices of the Department employed surveyors at the rate of 0% to 0.326%.

- For one of six months tested, 10 of 11 (91%) regional offices of the Department employed surveyors at the rate of 0% to 0.32%.

- For one of six months tested, eight of 11 (73%) regional offices of the Department employed surveyors at the rate of 0% to 0.28%.

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.

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 they implemented several hiring strategies to address the legislatively mandated minimum surveyor-to-bed ratios, including immediate backfilling of vacancies and allocating resources to increase the number of surveyors across all regions. They also received additional budget funding to support the hiring of surveyors needed to meet this mandate. However, despite these efforts, they were still unable to meet the required minimum surveyor-to-bed ratios.

Failure to hire an adequate number of surveyors could lead to inadequate monitoring of long-term care facilities. (Finding Code No. 2025-012, 2023-007, 2021-008, 2019-008, 2017-008, 2015-008, 2013-010)

RECOMMENDATION

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

2025-012. **FINDING** (Failure to Employ an Adequate Number of Surveyors) - Continued

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department in good faith has continued to build its enforcement staff and work force over the last three years. 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 have been developed in each Region in LTC, Assisted Living, Immediate Care Facilities/Developmental Disabilities and Specialized Mental Health Rehabilitation Facility. Work continued during the audit period to continue increasing the number of surveyors hired by the Department, resulting in the highest numbers of surveyors seen in three years, with 301 surveyors on staff in May 2026. This is 58 surveyors higher than January of 2023.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
SCHEDULE OF FINDINGS – CURRENT FINDINGS
For the Two Years Ended June 30, 2025

2025-013. **FINDING** (Employee Performance Evaluations Not Conducted Timely)

The Illinois Department of Public Health (Department) did not conduct employee performance evaluations in a timely manner and did not update its Employee Handbook to reflect the changes in the Illinois Administrative Code pertaining to the timeframes for preparing the performance evaluations.

We selected 60 employees for review of performance evaluations conducted during the examination period. A total of 67 evaluations should have been completed for the applicable year tested, including probationary and annual evaluations.

During testing, we noted the following:

- Ten of 67 (15%) employees' performance evaluations tested were conducted from one to 232 days late.

- Ten of 60 (17%) employees tested did not have a performance evaluation completed for the evaluation period tested.

- Five of 67 (7%) employees' performance evaluations tested were not finalized timely after the supervisor conducted the performance evaluation. The delinquencies ranged from three to 192 days late.

- One of 67 (1%) employees' performance evaluations tested was not signed by the employee.

Additionally, the Department did not update its Employee Handbook to reflect the changes to the performance evaluation requirements pursuant to the Illinois Administrative Code (Code) (80 Ill. Admin. Code 302.270) effective July 16, 2024.

The Code (80 Ill. Admin. Code 302.270) requires the Department to evaluate certified employees once per calendar year, and at least once during a probationary period.

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 the untimely performance evaluations and the failure to update the Employee Handbook 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 a foundation for

2025-013. **FINDING** (Employee Performance Evaluations Not Conducted Timely) - Continued

recommendations of salary adjustments, promotions or demotions, discharge, layoff, recall, and reinstatement decisions. 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. (Finding Code No. 2025-013, 2023-008, 2021-009, 2019-010, 2017-011, 2015-011, 2013-013, 11-10, 09-11, 07-14)

RECOMMENDATION

We recommend the Department enforce internal controls to ensure performance evaluations are conducted in a timely manner for all employees in accordance with the Code. Additionally, we recommend the Department periodically review and update its written policies to reflect current State regulations.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has worked to ensure that performance evaluations are conducted in a timely manner for all employees in accordance with the Code and its Directive. This includes an automated monthly reminder system as well as enhanced training.

2025-014. **FINDING** (Failure to Submit and Accurately File Required Reports)

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

During testing, we noted the following:

- The Department did not properly report the required information in the Agency Workforce Reports. We 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 12 of 16 (75%) employee groups in the Fiscal Year 2023 Agency Workforce Report and 14 of 16 (88%) employee groups in the Fiscal Year 2024 Agency Workforce Report.
    - The Department did not provide documentation to support the position openings information reported in the Fiscal Year 2023 and Fiscal Year 2024 Agency Workforce Reports and salary bracket details for both males and females with disabilities (PWDs) in the Fiscal Year 2023 Agency Workforce Report; therefore, accuracy of the reported information could not be determined.

  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 Illinois State Auditing Act (30 ILCS 5/3-2.2) requires a 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 two funds, the Department did not provide the degree to which program goals were met in its Fiscal Year 2024 Agency Fee Imposition Report Form and for one fund in its Fiscal Year 2025 Agency Fee Imposition Report Form.

  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

2025-014. **FINDING** (Failure to Submit and Accurately File Required Reports) - Continued

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, and Native American Employment Plans, and Bilingual Needs and Bilingual Pay Reports in Fiscal Year 2024.

  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, and Native American Employment Plans and bilingual employment strategies and programs. Additionally, the African American Employment Plan Act (Act) (20 ILCS 30/20) requires the Department to report annually to DCMS and DHR, in a format prescribed by DCMS, all of its activities in implementing the African American Employment Plan.

- The Department prepared the Fiscal Year 2024 and Fiscal Year 2025 annual reports required by the Perinatal HIV Prevention Act (Act) but did not submit these reports to the Governor and the General Assembly.

  The Act (410 ILCS 335/35) requires the Department to prepare an annual report for the Governor and the General Assembly on the implementation of this Act that includes information on the number of HIV-positive pregnant women who presented with known HIV status, the number of pregnant women rapidly tested for HIV in labor and delivery, the number of newborn infants rapidly tested for HIV exposure, the number of preliminarily HIV-positive pregnant women and preliminarily HIV-exposed newborn infants identified, the confirmatory test result for each preliminarily positive rapid HIV test performed on the woman and newborn, the number of families referred to case management, and other information the Department determines is necessary to measure progress under the provisions of this Act. The report shall also include the Department's assessment of the needs of health care professionals and facilities for ongoing training in implementation of the provisions of this Act and the Department's recommendations to improve the program.

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

2025-014. **FINDING** (Failure to Submit and Accurately File Required Reports) - Continued

appropriate corrective action or procedures.

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 employee errors.

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. (Finding Code No. 2025-014, 2023-009, 2021-010, 2019-011, 2017-012, 2015-012, 2013-014, 11-12, 09-12, 07-16, 05-12, 03-8)

RECOMMENDATION

We recommend the Department strengthen its controls to ensure required reports are accurately reported and supporting documentation is maintained. We 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.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has strengthened its controls to ensure required reports are accurately reported and supporting documentation is maintained. This includes establishing an internal review process and increasing communication lines with external partners.

2025-015. **FINDING** (Noncompliance with Distressed Facilities Provisions of the Nursing Home Care Act)

The Illinois Department of Public Health (Department) did not comply with provisions of the Nursing Home Care Act (Act) (210 ILCS 45) to publish and notify distressed facilities, establish a mentor program and sanctions, and report on revocation criteria and recommended statutory changes.

During our testing, we 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 Act (210 ILCS 45/3-304.2(c) through (h)) includes the following requirements:

- 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 the rules were drafted by the Division of Administrative Rules and Procedures and have been approved for presentation to the

2025-015. **FINDING** (Noncompliance with Distressed Facilities Provisions of the Nursing Home Care Act) - Continued

Long Term Care Facility Advisory Board (Board). Although the rules have already been approved by the Department's Director and the Office of the Governor, the Department is still awaiting additional input from the Office of Health Care Regulation before bringing the draft to the Board.

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. (Finding Code No. 2025-015, 2023-010, 2021-011, 2019-012, 2017-013, 2015-013)

RECOMMENDATION

We 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.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department understands this requirement and the finding citing that there are no administrative rules for distressed facilities. The Department recognizes the importance of regulations for long-term care facilities. The Department will endeavor to issue rules for distressed facilities. 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.

2025-016. **FINDING** (Noncompliance with the Nursing Home Care Act)

The Illinois Department of Public Health (Department) did not comply with the requirements of the Nursing Home Care Act (Act) (210 ILCS 45).

During our testing of statutory mandates, we noted the following:

- The Department did not adopt rules on the following: (1) accepting on-the-job experience in lieu of clinical training from any individual who participated in the temporary nursing assistant program during the COVID-19 pandemic before the end date of the temporary nursing assistant program and left the program in good standing; and (2) requiring the certification exam for nursing assistants be offered in both English and Spanish.

  The Act (210 ILCS 45/3-206(a)(5)) requires the Department to accept on-the-job experience in lieu of clinical training from any individual who participated in the temporary nursing assistant program during the COVID-19 pandemic before the end date of the temporary nursing assistant program and left the program in good standing, and notify all approved certified nurse assistant training programs in the State of this requirement. The Act also requires the Department to adopt rules that require the certification exam for nursing assistants to be offered in both English and Spanish. Further, the Act requires the Department to not place any restrictions on which candidates may take the exam in Spanish instead of English, including, but not limited to, any requirement to be employed by a facility prior to testing or any requirement for a specified number of facility residents to speak a specific language.

- The Department did not report the total number of offenders in the Fiscal Year 2024 Long-Term Care Annual Report.

  The Act (210 ILCS 45/2-201.6 (e-5)) requires the Department to keep a continuing record of all residents determined to be identified offenders and shall report the number of identified offender residents annually to the General Assembly.

- The Department did not timely submit the accounting of all federal and State fines received by the Department in the preceding fiscal year by the fund in which they have been deposited. The Fiscal Year 2023 and Fiscal Year 2024 reports were submitted on July 1, 2024, and July 1, 2025, respectively. Both reports were 5 and half months late. Additionally, these reports were only submitted to the Governor and the General Assembly. The Department was unable to provide documents supporting submission of the reports to the Long-Term Care Facility Advisory Board and the State Ombudsman;

2025-016. **FINDING** (Noncompliance with the Nursing Home Care Act) - Continued

therefore, we were unable to determine timeliness of submission or whether the reports were submitted at all.

The Act (210 ILCS 45/3-518) requires that beginning January 15, 2014, and each January 15 thereafter, the Department shall submit to the General Assembly, the Department's Long-Term Care Facility Advisory Board, and the State Ombudsman an accounting of all federal and State fines received by the Department in the preceding fiscal year by the fund in which they have been deposited.

Department management stated the issues noted were due to competing priorities and oversight by the program staff responsible for submitting the annual reports.

Failure to adopt the required rules and carry out the mandated duties are noncompliance with the Act and does not achieve the legislative intent for the affected programs. (Finding Code No. 2025-016)

RECOMMENDATION

We recommend the Department adopt rules required by the Act and submit reports accurately and timely to the appropriate oversight authorities.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

2025-017. **FINDING** (Lack of Controls over Monthly Reconciliations)

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

During testing of monthly reconciliations between the Office of Comptroller (Comptroller) records and Department records, we noted the following:

- For the Monthly Appropriation Status Reports (SB01):
    - Nineteen of 32 (59%) reconciliations were not prepared timely. The reconciliations were completed 9 to 498 days late.
    - Three of 32 (9%) reconciliations did not contain documentation of which employee prepared the reconciliations. Additionally, 27 of 32 (84%) reconciliations did not contain documentation of which employee performed the supervisory review and the review dates; therefore, the timeliness of review could not be determined.
- For the Monthly Agency Contract Reports (SC14) or Monthly Obligation Activity Reports (SC15):
    - Twenty-two of 26 (85%) reconciliations were not prepared timely. The reconciliations were completed 18 to 766 days late. Additionally, one (4%) of the reconciliations was not completed.
    - Twenty-four of 26 (92%) reconciliations did not contain documentation of which employee performed the supervisory review and the review dates; therefore, the timeliness of review could not be determined.

The Statewide Accounting Management System Manual (SAMS) (Procedure 07.30.20) states "the effectiveness of any accounting and financial information system is very much dependent on the accuracy of data submitted and the confidence of its users that the system handled that data properly. Agency reconciliation is the primary control that ensures these requirements are being satisfied." In addition, the SAMS Manual 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. Further, the SAMS Manual (Procedure 02.50.10) requires supervisors to review and approve the assigned work of their staff to minimize errors.

2025-017. **FINDING** (Lack of Controls over Monthly Reconciliations) - Continued

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.

Department management indicated the exceptions were due to staff shortages and competing priorities.

Failure to timely prepare and review reconciliations increases the risk of undetected loss or theft and could lead to unresolved differences between Department and Comptroller records, or inaccurate financial reporting. (Finding Code No. 2025-017, 2023-011, 2021-012, 2019-013, 2017-014)

RECOMMENDATION

We recommend the Department ensure monthly reconciliations of obligations, expenditures, and appropriations are timely completed and supervisory review of its reconciliations are maintained.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the reconciliations of the obligations, expenditures, and appropriations were being done, and procedures have been put in place to ensure that they are timely performed.

2025-018. **FINDING** (Failure to Establish Policies and Procedures on Alzheimer's Disease and Related Disorders)

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, we 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.

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.

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 the Dementia Coordinator position was vacated in May 2025 with the replacement filling the position in June 2025. Department management further stated there has not yet been a Statewide central repository or registry created or maintained by a regional Assistance Center. Additionally, a request has been submitted to revise this requirement with no action taken at this point. Discussions with the previous Dementia Coordinator were started on how to gain compliance; however, no action or plan had been put into place. The current Dementia Coordinator is compiling what information has been documented thus far and will assess the situation and feasibility of creating policy to gain compliance.

2025-018. **FINDING** (Failure to Establish Policies and Procedures on Alzheimer's Disease and Related Disorders) - Continued

Failure to carry out the mandated duty does not achieve the legislative intent for the affected program and results in noncompliance with the Code. (Finding Code No. 2025-018, 2023-012, 2021-013, 2019-014, 2017-015, 2015-015)

RECOMMENDATION

We recommend the Department either comply with the mandate or seek legislative changes.

DEPARTMENT RESPONSE

The Department agrees with this recommendation and will consider legislative changes. A meeting was held with the Dementia Coordinator, management and legislative affairs to explore this process. Additionally, other methods of implementation will be explored.

2025-019. **FINDING** (Noncompliance with the Alzheimer's Disease Assistance Act)

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

During testing, we 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 (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.

This finding was first reported during the period ended June 30, 2021. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated the deficiency was due to the Dementia Coordinator position being vacated in May 2025. A new Dementia Coordinator began in June 2025 and reviewed the relevant files related to the program, noting insufficient documentation to demonstrate the Alzheimer's Disease Research, Care, and Support Fund was promoted during the tax return period, in press releases, or on social media platforms.

Failure to carry out the mandated duty is noncompliance with the Act and does not achieve the legislative intent to establish a program for the conduct of research regarding the cause, cure, and treatment of Alzheimer's disease and related disorders. (Finding Code No. 2025-019, 2023-020, 2021-021)

RECOMMENDATION

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

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation for this reporting period. The Department social media kit was approved, and social media posts began in March 2024. In addition, the Department published an Alzheimer's Fund subpage on the Department website with all of the information, including a link to the Schedule G tax form where the public can donate during tax season. With the Dementia Coordinator position being vacated briefly, work to address this finding has restarted during the audit period.

2025-020. **FINDING** (Inadequate Controls over Employee Time Reporting)

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 $184,218,758 and $208,783,608 for payroll and had an average of 1,283 and 1,419 employees during Fiscal Years 2024 and 2025, 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.

We selected 60 employees and reviewed the DTRs for the pay period. During testing, we noted the following:

- Three (5%) DTRs tested were not timely completed. The employees completed their DTRs from 13 to 15 days late.

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

- For eight (13%) DTRs tested, the leave requests were not submitted in advance by the employees. The leave requests were submitted one to 63 days after the leave dates.

- For five (8%) DTRs tested, the leave requests were not timely approved by the Supervisor. The leave requests were approved one to four days after leave requests were submitted.

- For one (2%) DTR tested, the leave request was not completed by the employee but instead was completed by the timekeeper.

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.

2025-020. **FINDING** (Inadequate Controls over Employee Time Reporting) - Continued

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 updated on May 30, 2024, all employees are required to submit a complete and accurate weekly timesheet to the supervisor within seven days of the start of the following work week.

The Illinois Administrative Code (Code) (80 Ill. Admin. Code 303.130) states that 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.

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 competing work demands were the reasons for the untimely submission and approval of DTRs, and their 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. (Finding Code No. 2025-020, 2023-013, 2021-014, 2019-015, 2017-016, 2015-017)

RECOMMENDATION

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

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has worked 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 for updates and has crafted monthly reminders for staff.

2025-021. **FINDING** (Inadequate Internal Controls over Commodities)

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

During testing of the Department's June 30, 2025 year-end commodities inventory balance, we noted the following:

- For seven of 60 (12%) commodity items inspected, the quantities reported on the Department's inventory list did not agree with our physical counts. The discrepancies resulted in a net overstatement of inventory by $15,785. The Department was unable to provide supporting documentation to explain the discrepancies.

- For six of 60 (10%) commodity items inspected, the unit costs reported on the Department's inventory list were inaccurate, resulting in an overstatement of the inventory by $1,493,627. Consequently, the inventory balance reported on the Inventory Analysis form (SCO-577) was overstated by the same amount.

- Three of 60 (5%) commodity items inspected were not reported on the Department's inventory list.

The Department reported a commodities inventory balance totaling $8.1 million at June 30, 2025 to the Office of Comptroller (Comptroller) in its year-end financial reporting packages.

The Statewide Accounting Management System Manual (SAMS) (Procedure 03.60.20) requires the Department 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 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 the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that 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.

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 employee errors.

2025-021. **FINDING** (Inadequate Internal Controls over Commodities) - Continued

Failure to ensure accuracy of commodities inventory balance at fiscal year-end results in inaccurate financial reporting. (Finding Code No. 2025-021, 2023-014, 2021-015, 2019-016, 2017-001, 2015-002, 2013-003)

RECOMMENDATION

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

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has strengthened its internal controls over commodities to ensure its physical year-end inventory balance is accurate through the implementation of an inventory tracking system.

2025-022. **FINDING** (Statutory Committee and Board Requirements)

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 voting members and one nonvoting member 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, 2025, the Committee was comprised of 10 members. The Committee lacked a representative from the private not-for-profit home health agencies, a representative from the general public who is a consumer of home services or a family member of a consumer of home services, a nonvoting member who is a home services worker, a representative of an organization that advocates for consumers, an Illinois licensed physician, and a registered professional nurse with home health agency experience. Additionally, we noted the term for one member had expired prior to June 30, 2025, and the member continued to serve in the Committee without re-application or re-appointment documents.

- 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, 2025, the Advisory Board was comprised of 14 members and lacked a representative from local health departments who is a nonvoting member and a member selected from the recommendations of consumer organizations which engage solely in advocacy or legal representation on behalf of residents and their immediate families.

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.

2025-022. **FINDING** (Statutory Committee and Board Requirements) - Continued

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. (Finding Code No. 2025-022, 2023-015, 2021-016, 2019-018, 2017-019, 2015-020, 2013-018, 11-16)

RECOMMENDATION

We recommend the Department timely fill the vacancies on the Committee and Advisory Board as required by the statute.

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. Additionally, the Department is in the process of implementing a newly procured software system to allow for better tracking of boards and commissions.

2025-023. **FINDING** (Noncompliance with the Breast Cancer Patient Education Program)

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 our testing, we noted the Department submitted the report to the General Assembly on February 13, 2025, 409 days late. The report described activities carried out during Fiscal Years 2022 and 2023 and contained an evaluation of the extent to which activities have been effective in improving the health of racial and ethnic minority groups.

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.

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.

Department management stated they drafted the report in January 2024, but it underwent multiple rounds of reviews from Department leaders requiring significant revisions. The planned target dates were tentative and due to competing deadlines and multiple rounds of edits resulting from the document review, the due date was missed.

Failure to timely submit the report is noncompliance with the Code and inhibits General Assembly oversight of the Breast Cancer Patient Education Program. (Finding Code No. 2025-023, 2023-016, 2021-017, 2019-019, 2017-020)

RECOMMENDATION

We recommend the Department ensure required reports are timely submitted to the General Assembly.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. To meet this requirement, during the audit period, the Department has contracted with a university partner to draft the report to ensure more timely submission.

2025-024. **FINDING** (Formal Department Rules Not Adopted)

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

During our testing of statutory mandates, we 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) and (410 ILCS 35/30). The Equitable Restrooms Act (410 ILCS 35/25), effective January 1, 2020, requires the Department adopt rules to implement that every single-occupancy restroom in a place of public accommodation or 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 a restroom and does not indicate any specific gender. The Equitable Restroom Act (410 ILCS 35/30), effective August 11, 2023, requires the Department to adopt rules to implement that any multiple-occupancy restroom be identified as an all-gender multiple-occupancy restroom and designated for use by any person of any gender. The all-gender multiple-occupancy restroom must include a prominently displayed exterior signage that marks it as an all-gender multiple-occupancy restroom and floor-to-ceiling stall dividers equipped with a sturdy and functioning locking mechanism controlled by the user and a partition privacy cover or strip that ensures that no one is able to see through the space in between the stall divider and door.

  Department management stated rules have not been drafted because the Plumbing Program Advisory Board members were just appointed in 2025 and did not have enough members to make a quorum.

2025-024. **FINDING** (Formal Department Rules Not Adopted) - Continued

- The Department failed to include in its adopted rules in the Illinois Administrative Code (77 Ill. Adm. Code 240.110), the precise standards used for determining what constitutes a material representation 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 failed to address the requirement due to oversight.

- The Department has not adopted the rules required by the Illinois Modular Dwelling and Mobile Structure Safety Act (430 ILCS 115/11) specifically on the following: (1) providing notice of denial, suspension, revocation of seal, or assessment of civil penalties by certified mail or by personal service setting forth the particular reasons for the proposed action and fixing a date, not less than 15 days from the date of the mailing or service; and (2) giving written notice of the time and place of the hearing at least 10 days prior to the hearing. The Illinois Modular Dwelling and Mobile Structure Safety Act, effective August 15, 2014, requires the Department to adopt rules on procedures governing hearings authorized by this Section. Section 11 requires the Department, after notice and opportunity for hearing to an applicant or seal holder, may deny, suspend, or revoke a seal, or assess civil penalties in conformance with this Act, in any case in which he or she finds that there has been a substantial failure to comply with the provisions of this Act or the standards, rules, and regulations under this Act. The notice shall be provided by certified mail or by personal service, setting forth the particular reasons for the proposed action and fixing a date, not less than 15 days from the date of the mailing or service, within which time the applicant or seal holder must request in writing a hearing. Failure to serve upon the Department a request for hearing in writing within the time provided in the notice shall constitute a waiver of the person's right to an administrative hearing. Additionally, the Act requires the Director of the Department or hearing officer

2025-024. **FINDING** (Formal Department Rules Not Adopted) - Continued

to give written notice of the time and place of the hearing, by certified mail or personal service, to the applicant or seal holder, at least 10 days prior to the hearing.

Department management stated the issue noted was due to oversight.

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 represents noncompliance with State laws. (Finding Code No. 2025-024, 2023-018, 2021-019, 2019-022, 2017-023)

RECOMMENDATION

We recommend the Department adopt rules required by the State laws or seek legislative remedy.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department understands this requirement. The Department recognizes the importance of regulations for long-term care facilities. The Department enforces all requirements in the statute related to psychotropic medication usage and administration. The Department will endeavor to issue rules for these facilities. 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 continue to 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. During the audit period, the Department adopted 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). The Department will work with the State Board of Health and the Joint Committee on Administrative Rules as necessary to adopt rules required under the Illinois Modular Dwelling and Mobile Structure Safety Act (430 ILCS 115/11).

2025-025. **FINDING** (Inadequate Controls over Accounts Receivable)

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

The Department reported $23.9 million in accounts receivable, of which $11.5 million was over one year past due, as of June 30, 2025, and $27.9 million, of which $11 million was over one year past due, as of June 30, 2024. During our testing, we noted for 24 of 40 (60%) accounts receivable tested, totaling $442,597, the Department did not timely refer the accounts to the Office of Comptroller's (Comptroller) Offset System or to the Attorney General. The accounts were referred to the Comptroller's Offset System or to the Attorney General from 9 to 1,036 days after the due dates.

The Illinois State Collection Act of 1986 (Act) (30 ILCS 210/3) and the Statewide Accounting Management System Manual (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 Manual (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 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.

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.

Department management stated that the delay in collection efforts and 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, the accounts receivable section being short staffed, and competing priorities.

Failure to timely refer receivables to the Comptroller's Offset System 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. (Finding Code No. 2025-025, 2023-019, 2021-020, 2019-026)

2025-025. **FINDING** (Inadequate Controls over Accounts Receivable) - Continued

RECOMMENDATION

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

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will continue to pursue all reasonable and appropriate procedures to collect on outstanding debts as required by State laws and regulations. During the audit period, the Department started sending letters, putting into offset, sending to outside collections, and improving internal reporting mechanisms to be better aware of needs in this space.

2025-026. **FINDING** (Weaknesses in Cybersecurity Programs and Practices)

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. The Department 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, we noted the Department had not:

- Maintained its own policies and procedures to fulfill the compliance requirements of the DoIT policies in use for Configuration 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 and destruction; and the creation, storage, and testing of backups.
- Established a cybersecurity plan.
- Established a risk methodology.
- Established a data classification methodology.
- Established standard operating procedures over existing vulnerability management processes.

Additionally, the Department was unable to provide the individual user agreements for 11 of 25 (44%) users who were provided access to the I-Care system

2025-026. **FINDING** (Weaknesses in Cybersecurity Programs and Practices) - Continued

application; therefore, we were unable to test if access provisioning was properly approved and documented.

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 the Department 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.

This finding was first reported during the period ended June 30, 2021. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management indicated competing priorities, efforts building data informatics and modernization, and employee turnover contributed to the inability to establish supplemental policies and cybersecurity plans, and to 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. (Finding Code No. 2025-026, 2023-021, 2021-029)

RECOMMENDATION

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

- Maintain policies and procedures over Configuration Management;
- Maintain documentation of the annual review of policies and procedures;
- Establish policies and procedures for controls over data retention and destruction; and the creation, storage, and testing of backups;

2025-026. **FINDING** (Weaknesses in Cybersecurity Programs and Practices) - Continued

- Establish a cybersecurity plan;
- Establish a risk methodology;
- Establish a data classification methodology;
- Establish standard operating procedures over existing vulnerability management processes; and
- Ensure adequate documentation is developed, retained, and provided to auditors.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. 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 established a cybersecurity plan for the agency effective in 2026.

2025-027. **FINDING** (Noncompliance with the Equity in Long-term Care Quality Act)

The Illinois Department of Public Health (Department) did not comply with the Equity in Long-term Care Quality Act (Act) (30 ILCS 772).

During testing, we noted the following:

- The Department did not establish the nursing home labor force promotion, expansion, and retention program.
- The Department did not submit the reports as required by the Act.
- The Department did not provide documentation demonstrating it had obtained Centers for Medicare and Medicaid Services (CMS) approval, requested CMS approval, received a denial of CMS approval, or otherwise determined and documented that the program could not be implemented as required by the statute.

The Act (30 ILCS 772/25) requires the Department, contingent upon approval by the CMS, to establish a nursing home labor force 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 be 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 to 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.

This finding was first reported during the period ended June 30, 2021. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated that the nursing home labor force program is no longer in existence with the CMS. Department management further stated they will propose legislation to update the language of the Act to align with the new program called CMS Nursing Home Staffing Review. However, the Department remains subject to the requirements of 30 ILCS 772/25 unless and until the statute is amended. In addition, the Department did not provide sufficient authoritative documentation demonstrating that CMS approval was unavailable or that the statutory program could not be implemented as written.

2025-027. **FINDING** (Noncompliance with the Equity in Long-term Care Quality Act) - Continued

Failure to establish a nursing home labor force promotion, expansion, and retention program, or to document efforts to obtain CMS approval or otherwise resolve the statutory contingency, represents noncompliance with the Act. Failure to submit the required reports to the General Assembly also constitutes noncompliance with the Act. As a result, the legislative intent of the program to promote, expand, and retain the nursing home workforce and support high-quality nursing home care was not achieved. (Finding Code No. 2025-027, 2023-023, 2021-025)

RECOMMENDATION

We recommend the Department comply with the Act by:

- determining and documenting whether CMS approval is required and available for the nursing home labor force promotion, expansion, and retention program;
- if CMS approval is available, obtaining such approval and establishing the program, including the required partnerships and reports to the General Assembly; or
- if the program cannot be implemented as written, seeking timely legislative amendment or repeal of the statutory requirement.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department is in the process of orienting a new program and will evaluate any updates needed in the Act.

2025-028. **FINDING** (Noncompliance with the Tobacco Products Compliance Act)

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 (Act) (410 ILCS 76).

During testing, we noted the following:

- The Department did not receive annual written certifications from manufacturers of tobacco products in the State and who distribute or sell the tobacco products in the United States. The 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, 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.

This finding was first reported during the period ended June 30, 2021. In subsequent years, the Department has been unsuccessful in implementing appropriate corrective action or procedures.

Department management stated this has not been completed due to competing priorities and due to lack of funding available to implement.

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. (Finding Code No. 2025-028, 2023-024, 2021-027)

RECOMMENDATION

We recommend the Department adopt rules and require tobacco products manufacturers to submit the required annual written compliance certifications to the Department to comply with the Act.

2025-028. **FINDING** (Noncompliance with the Tobacco Products Compliance Act) - Continued

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 consider a legislative remedy.

2025-029. **FINDING** (Weaknesses with Payment Card Industry Data Security Standards)

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 2024 and 2025, the Department handled 72,128 transactions totaling approximately $6.48 million and 74,407 transactions totaling approximately $6.76 million, respectively.

We reviewed the efforts of four of the Department's Divisions to ensure compliance with PCI DSS. During our testing, we noted the Department had not:

- Completed a Self-Assessment Questionnaire (SAQ) and Attestation of Compliance (AOC) during Fiscal Year 2024 for two (50%) Divisions tested; or

- Certified a SAQ and AOC for all programs accepting credit card payments during Fiscal Year 2024 for two (50%) Divisions tested.

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.

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 DSS.

Department management indicated the issues were due to competing priorities.

Failure to complete and certify required SAQs and AOCs represents noncompliance with PCI DSS and could result in the Department being unable to demonstrate cardholder data is adequately protected. Failure to implement procedures to ensure PCI DSS compliance increases the risk of unauthorized access to cardholder data and noncompliance across programs accepting credit card payments. (Finding Code No. 2025-029, 2023-025, 2021-028, 2019-020, 2017-021, 2015-022)

2025-029. **FINDING** (Weaknesses with Payment Card Industry Data Security Standards) - Continued

RECOMMENDATION

We recommend the Department complete the appropriate SAQ(s) and AOC for its environment and maintain documentation supporting its validation efforts.

DEPARTMENT RESPONSE

The Department agrees with the finding and has pursued implementation of the auditor's recommendations. The Department has implemented reminders for this process. Additionally, through an agency-wide reorganization, this process has been centralized, ensuring that it is someone's job duty to track this and ensure compliance.

2025-030. **FINDING** (Noncompliance with the Tattoo and Body Piercing Establishment Registration Act)

The Illinois Department of Public Health (Department) did not receive applications and payments for the annual renewal of certificates of registration of tattoo and body piercing establishments in a timely manner and did not assess penalties.

During our testing, we noted for 25 of 40 (63%) annual renewals of certificates of registration tested, the Department received the application and payment of fees one to 6 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)) lists 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.

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. (Finding Code No. 2025-030, 2023-029)

RECOMMENDATION

We 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.

2025-030. **FINDING** (Noncompliance with the Tattoo and Body Piercing Establishment Registration Act) - Continued

DEPARTMENT RESPONSE

The Department accepts this finding. During the audit period, the Department worked with the software vendor to correct the issues that are preventing the past due permits from being issued correctly. However, the statute cited states that the Department "may" issue fines, implying that this action is voluntary by the Department. The Department has the discretion in its regulations for this statute to assess fines for entities who submit late permit renewals. However, the rules do not state that the Department must issue fines for late renewals. If the Department did not issue fines for establishments who failed to renew permits, that is not a violation of the law. The Department should not be cited for not fining establishments where that authority is discretionary and not required.

ACCOUNTANTS' COMMENT

The auditors acknowledge the Department's assertion that the Act provides the Department discretion to assess late fees and fines. However, the finding is not based solely on the Department's decision not to impose penalties, but also on the Department's failure to effectively enforce compliance with the Act and the Department's own rules. The Department's regulations establish failure to renew a certificate of registration in accordance with Section 35 of the Act as a violation (77 Ill. Admin. Code 797.1700(c)(17)), and provide that a fine shall be issued for violations of the Act (77 Ill. Admin. Code 797.1700(b)), up to the maximum amount established in rule. As a result, auditors continue to conclude the Department's lack of timely enforcement over expired registrations and failure to assess penalties in the instances tested represent noncompliance with the Act and the Code. Additionally, Generally Accepted Government Auditing Standards (GAGAS), also known as the *Yellow Book*, (paragraph 7.45) states when auditors identify or suspect noncompliance with provisions of laws or regulations that have an effect on the subject matter or an assertion about the subject matter that are less than material but warrant the attention of those charged with governance, they should communicate in writing to audited entity officials.

2025-031. **FINDING** (Trainings Not Completed Within the Required Timeframe)

The Illinois Department of Public Health's (Department) employees did not complete all mandatory trainings within the required timeframes.

During our testing of the Department's compliance with training requirements, we noted the following:

Ethics Training:

- Fifty-one 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 163 days late. Additionally, four new hires did not complete the initial ethics training.

- Twenty-two employees did not complete the annual ethics training during the calendar year 2023 and 2024 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.

Harassment and Discrimination Prevention Training and LGBTQIA+ Training:

- Fifty new hires did not complete the initial harassment and discrimination prevention training within 30 days after commencement of employment. These employees completed the initial training from one to 348 days late. Additionally, four new hires did not complete the initial harassment and discrimination prevention training.

- Twenty employees did not complete the annual harassment and discrimination prevention training during the calendar year 2023 and 2024 training periods.

- Forty-two employees did not complete the annual LGBTQIA+ training during the training period.

The Illinois Human Rights Act (775 ILCS 5/2-105(B)(5)(c)) requires the Department to provide training on harassment and discrimination 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 harassment and discrimination prevention training to complete their initial training within 30 days

2025-031. **FINDING** (Trainings Not Completed Within the Required Timeframe) - Continued

after commencement of employment. It also requires each officer, member, and employee to complete, at least annually, a harassment and discrimination prevention training. The Office of the Governor's Equity Office identifies the LGBTQIA+ training as an annual State training. The training states that, as a State employee or appointee, employees must abide by laws and policies that protect LGBTQIA+ people from discrimination and harassment and have a responsibility to help build equitable and inclusive workplaces and services. Therefore, all applicable employees are required to complete the annual LGBTQIA+ Equity and Inclusion training within the designated training period, and management is responsible for ensuring and monitoring compliance.

Health Insurance Portability and Accountability Act (HIPAA) Training:

- Thirty-seven new hires did not complete the initial HIPAA training within 60 days after commencement of employment. These employees completed the initial training from one to 255 days late. Additionally, four new hires did not complete the initial HIPAA training.

- Eleven employees did not complete the annual HIPAA training during the training period.

The Department's Employee Handbook requires HIPAA training to 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:

- Thirty-five 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 one to 255 days late. Additionally, three new hires tested did not complete the initial Cybersecurity Awareness training.

- Thirteen employees did not complete the annual Cybersecurity Awareness training during the training period.

- One hundred fifty-eight Department contractors did not complete the Cybersecurity Awareness training during the training period.

2025-031. **FINDING** (Trainings Not Completed Within the Required Timeframe) - Continued

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.

Diversity, Equity, Inclusion, and Accessibility (DEIA)Training:

- Thirty-two employees did not complete the annual DEIA Training during the training period.

Executive Order 2021-16, effective July 30, 2021, requires all State employees to participate in annual trainings focused on diversity, equity, and inclusion.

Additionally, the Department did not maintain documentation to support completion of ethics, sexual harassment, HIPAA, cybersecurity awareness, LGBTQIA+, and DEIA trainings for 88 new hires and 116 active employees who were separated from the Department during the engagement period. Therefore, we were unable to determine if separated employees completed the trainings during the required training periods.

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

Department management stated that employees are notified of training requirements but competing priorities contributed to inconsistent monitoring of training completion and timeliness of completion.

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, cybersecurity awareness, LGBTQIA+, and DEIA trainings. 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. (Finding Code No. 2025-031, 2023-031)

2025-031. **FINDING** (Trainings Not Completed Within the Required Timeframe) - Continued

RECOMMENDATION

We 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.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. During the audit period, the Department has worked towards implementing changes to correct this finding. A new training tracking system has been established, which has shown great success in ensuring high completion rates of trainings across the Department.

2025-032. **FINDING** (Noncompliance with the Tanning Facility Permit Act)

The Illinois Department of Public Health (Department) did not perform inspections of tanning facilities in a timely manner as required by the Tanning Facility Permit Act (Act) (210 ILCS 145).

During the current engagement period, 83 tanning facilities applied for permits during Fiscal Years 2024 and 2025. We noted the following:

- For three of 14 (21%) tanning facilities tested, the Department performed an initial inspection of the facilities 126 to 142 days after the receipt of the application for a permit. Additionally, for three of 14 (21%) tanning facilities tested, the Department did not conduct an initial inspection after receipt of the application, but the permits were issued.

- One of 14 (7%) tanning facilities tested was not inspected during Fiscal Year 2024.

- For one of 14 (7%) tanning facilities tested, the application for renewal of license was submitted 157 days late; as a result, the Department inspected the facility 111 days after the expiration of the license.

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 to be inspected at least once each year after the initial year in which the facility was granted a permit. Further, the Act (210 ILCS 145/15(a)) requires the Department to issue a permit that will expire on a specified date and may be renewed by submission to the Department at least 30 days before the expiration date, a permit renewal application and the annual renewal fee.

Department management indicated the delay in the initial inspections of the facilities was due to certain tanning facilities not being fully installed or operational within the statutory timeframe. Inspections are also conducted by local health departments (LHDs) that voluntarily participate in the program through grant agreements. Department management also indicated that when facilities are not ready for inspection within the required timeframe, this is not consistently communicated to the Department. Additionally, when LHDs fail to complete required annual inspections, the program records the related deliverable as “not met” during its review of each LHD’s scope of work.

Failure to perform the required initial and annual inspections timely is noncompliance with the Act. (Finding Code No. 2025-032, 2023-032)

2025-032. **FINDING** (Noncompliance with the Tanning Facility Permit Act) - Continued

RECOMMENDATION

We recommend that the Department ensure the initial and annual inspections are conducted, and are performed in a timely manner, as required by 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. During the audit period, the Department has filled the Program Manager position and established an annual inspection schedule.

2025-033. **FINDING** (Noncompliance with the Abused and Neglected Long Term Care Facility Residents Reporting Act)

The Illinois Department of Public Health (Department) did not fully comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) (210 ILCS 30).

During testing, we 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 9 of 40 (23%) reports of resident abuse and neglect tested, the Department initiated the investigations 40 to 138 days after receipt of the report.

Additionally, we noted the Department conducted a continuing education and training program for the prevention, identification, and treatment of resident abuse and neglect for State and local staff, persons and officials required to report, and other persons engaged in or seeking to engage in such efforts. However, the Department failed to provide this education and training to the general public.

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. Admin. Code 400.120(a)) requires all complaint investigations to be initiated within 30 days of the receipt of the complaint by the Central Complaint Registry, except that 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 their failure to provide the education and training program to the general public and instances of untimely investigation of abuse or neglect reported to the program were due to an increase in complaints received by the Department leading to extended timelines for triage, investigation, public notification, and ongoing education.

2025-033. **FINDING** (Noncompliance with the Abused and Neglected Long Term Care Facility Residents Reporting Act) - Continued

Failure to conduct continuing education programs for the general public and timely initiate investigation of reports of abuse and neglect in all facilities represent noncompliance with the Act and do 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. (Finding Code No. 2025-033, 2023-033)

RECOMMENDATION

We recommend the Department conduct continuing education and training programs for the prevention, identification, and treatment of resident abuse and neglect for the general public. We further recommend the Department timely initiate investigation of all reports of neglect and abuse to comply with the Act and Code.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

2025-034. **FINDING** (Noncompliance with the Underlying Causes of Crime and Violence Study Act)

The Illinois Department of Public Health (Department) did not comply with the requirements of the Underlying Causes of Crime and Violence Study Act (Act) (410 ILCS 165).

During testing, the Department and the Department of Human Services (DHS) did not conduct a study and create a process to identify high violence communities, also known as R3 (Restore, Reinvest, and Renew) areas, or 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 DHS 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 DHS 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 DHS to report their findings to the General Assembly by December 31, 2022.

Department management stated that noncompliance with the mandate was due to competing priorities. The Department is exploring opportunities to repeal this mandate.

Failure to carry out statutorily 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. (Finding Code No. 2025-034, 2023-035)

RECOMMENDATION

We recommend the Department continue working with DHS to conduct the study and submit the report to the General Assembly and comply with the Act or seek legislative changes.

2025-034. **FINDING** (Noncompliance with the Underlying Causes of Crime and Violence Study Act) - Continued

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. The Department has continued plans to pursue a legislative solution.

2025-035. **FINDING** (Inadequate Internal Controls over Census Data)

The Illinois Department of Public Health (Department) did not timely complete census data reconciliation to provide assurance that census data submitted to its pension and other postemployment benefits (OPEB) plans were 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.

We 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 (DCMS) for their OPEB. In addition, we noted these plans have characteristics of different types of pension and OPEB plans, including single employer plans and cost-sharing multiple-employer plans. Finally, we noted DCMS' actuaries use SERS' census data records to prepare the OPEB actuarial valuation.

During our testing, we noted that the Department performed a reconciliation of its census data as recorded by SERS for Fiscal Year 2023; however, the Department did not maintain documentation of the submission of its reconciliation to SERS. As such, we were unable to determine whether the reconciliation was submitted timely. In addition, we noted that the Department submitted the Fiscal Year 2024 Census Data Reconciliation 162 days after the deadline.

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

2025-035. **FINDING** (Inadequate Internal Controls over Census Data) - Continued

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 to 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 to 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 procedures are in place for completing the reconciliation; however, the individual who completed and submitted the Fiscal Year 2023 census data reconciliations to SERS had retired, and access to the files was not turned over. Additionally, the delay in the submission of the Fiscal Year 2024 Census Data Reconciliation was due to employee oversight.

Failure to timely reconcile and submit 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 represents noncompliance with applicable laws and regulations and hindered the ability of the auditors to perform necessary testing on census data. (Finding Code No. 2025-035, 2023-037)

RECOMMENDATION

We recommend the Department timely complete the SERS annual reconciliation process of its active members' census data from its underlying records to a report of the census data submitted to each plan's actuary. We also recommend the Department maintain sufficient documentation of the reconciliation performed, including evidence of submission of the census data reconciliation to SERS.

2025-035. **FINDING** (Inadequate Internal Controls over Census Data) - Continued

DEPARTMENT RESPONSE

The Department agrees with the finding. During the audit period, the Department established a reconciliation methodology to ensure data is completed and accurate; a standard operating procedure was also established during the audit period.

2025-036. **FINDING** (Failure to Request Funding to Implement Programs Mandated by State Laws)

The Illinois Department of Public Health (Department) did not implement programs by seeking and obtaining funding to administer the programs.

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 2024 and 2025 and did not request funding due to competing priorities.

- 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 further stated that a specific smoking cessation program for participants in the WIC Nutrition Program has not been maintained; however,

2025-036. **FINDING** (Failure to Request Funding to Implement Programs Mandated by State Laws) - Continued

through the Illinois Tobacco Quitline, WIC participants have access to free professional tobacco cessation counseling and nicotine replacement therapy. The Department has also provided Quitline resources and training to support referrals for WIC clients to the Department of Human Services and to local health departments that operate WIC programs.

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 the program remained unfunded during Fiscal Years 2024 and 2025. The Department did not request funding due to competing priorities.

- 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 the appropriation has not been provided. The Department did not request

2025-036. **FINDING** (Failure to Request Funding to Implement Programs Mandated by State Laws) - Continued

funding during Fiscal Years 2024 and 2025 due to competing priorities.

- 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 the appropriation has not been provided. The Department did not request funding during Fiscal Years 2024 and 2025 due to competing priorities.

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. (Finding Code No. 2025-036, 2023-039)

RECOMMENDATION

We 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.

DEPARTMENT RESPONSE

The Department partially accepts the recommendation. As indicated above, this finding was previously agreed to by Department management during its last compliance examination. However, the finding continues to provide challenges for the Department. The Department does not have a role in the enactment of appropriations and has a funding structure, as enacted by the General Assembly, that generally is prescriptive with regard to supporting a public health program or public health issue. At the same time, however, Department management acknowledges the auditors' concerns that they believe agencies may have a responsibility to remind the legislature of unfunded programs even if the Department does not have a role in enactment of appropriations. To this end, Department management, working with other State offices, will continue to

2025-036. **FINDING** (Failure to Request Funding to Implement Programs Mandated by State Laws) - Continued

collaborate with the auditors in hopes of resolving their concern. Lastly, where applicable, Department management will continue to work with State agency staff, other State agencies, and members of the Illinois General Assembly to discuss each of these programs, including potential estimated costs, to ensure the legislature is informed.

2025-037. **FINDING** (Noncompliance with the Hospital Licensing Act)

The Illinois Department of Public Health (Department) did not monitor and enforce the requirements of the Hospital Licensing Act pertaining to the annual notification of hospital nursing staff rights.

During testing, we noted the Department did not monitor and enforce the requirements of the Hospital Licensing Act (Act) (210 ILCS 85/10.10(d)(6)). The Act requires the Department to monitor and enforce the requirement for the nursing care committee to annually notify the hospital nursing staff of the staff's rights. The annual notice must provide a phone number and an email address for staff to report on noncompliance with the nursing staff's rights. The notice must be provided by email or by regular mail in a manner that effectively facilitates receipt of the notice.

Department management stated they do not perform annual hospital license surveys to monitor compliance with the Act's requirement for annual notification of hospital nursing staff rights, as their oversight activities are limited to complaint-based investigations.

Failure to carry out these mandated duties is noncompliance with the Act and does not achieve the legislative intent to promote an organizational climate that values registered nurses' input in meeting the health care needs of hospital patients. (Finding Code No. 2025-037)

RECOMMENDATION

We recommend the Department monitor and enforce the nursing care committee to annually notify the hospital nursing staff of their rights.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

2025-038. **FINDING** (Noncompliance with the Suicide Prevention, Education, and Treatment Act)

The Illinois Department of Public Health (Department) did not comply with the Suicide Prevention, Education, and Treatment Act (Act) (410 ILCS 53).

The Act (410 ILCS 53/13) requires the Department, in consultation with the Suicide Prevention Alliance (Alliance), to submit an annual report to the Governor and General Assembly on the effectiveness of the activities and programs undertaken under the Illinois Suicide Prevention Strategic Plan (Plan), including any recommendations for modification to Illinois law to enhance the effectiveness of the Plan. The annual report is also required to include the Alliance's review of statutorily prescribed missions of major State mental health, health, aging, and school mental health programs and recommendations, as necessary and appropriate, for statutory changes in the missions and procedures of those programs.

During our testing of statutory mandates, we noted the Department did not submit annual reports for Fiscal Years 2021, 2022, and 2023, as required by the Act. Instead, the Department submitted a consolidated report covering Fiscal Years 2021 through 2023 on December 8, 2023.

Department management stated the issue noted was due to oversight by the program staff responsible for submitting the annual reports.

Failure to submit reports timely represents noncompliance with the Act's annual reporting requirements. Further, the Governor and General Assembly were not provided timely information regarding the effectiveness of activities and programs undertaken under the Plan, including recommendations for statutory changes, if necessary. (Finding Code No. 2025-038)

RECOMMENDATION

We recommend the Department establish and implement procedures to ensure the annual reports required by the Act are prepared and submitted in a timely manner.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. An annual report was filed in 2024. The Department will continue to work towards implementing changes to correct.

2025-039. **FINDING** (Noncompliance with the Psychiatry Practice Incentive Act)

The Illinois Department of Public Health (Department) did not establish a program to provide incentives to psychiatric physicians to ensure psychiatric health care services are available for all citizens of the State, adopt rules, and implement the requirements of the Psychiatry Practice Incentive Act (Act) (405 ILCS 100).

During testing of statutory mandates, we noted the Department did not establish a program to provide incentives to psychiatric physicians, adopt rules, and implement the requirements of the Act.

The Act (405 ILCS 100/15) provided the Department the following powers and duties, among others: (1) to allocate funds to psychiatric practice residency and child adolescent fellowship programs to increase the number of psychiatric physicians in designated shortage areas, increase the percentage of psychiatric physicians establishing practice within the State upon completion of residency, increase the number of accredited psychiatric practice residencies within the State, and increase the percentage of psychiatric practice physicians establishing practice within the State upon completion of residency, (2) to determine procedures for distribution of funds to psychiatric residency programs, (3) to enter into contracts or agreements to carry out the provisions of the Act, (4) to coordinate the psychiatric residency grants program established under this Act, (5) to establish a program, and criteria for such program, (6) to require psychiatric practice residency programs seeking grants to make application according to procedures consistent with the priorities and guidelines established in this Section, and (7) to adopt rules and regulations that are necessary for the establishment of the programs required by this Act.

Additionally, the Act (405 ILCS 100/20) requires residency programs seeking funds to send applications to the Department. The application must include evidence of local support for the program. The Act requires the Department to determine the ratio of State support to local support in a manner that is consistent with the purposes of this Act.

Department management stated they did not request nor receive appropriation for the program; therefore, the Department did not implement the requirements of the Act.

Failure to carry out these mandated duties is noncompliance with the Act and does not achieve the legislative intent to encourage licensed psychiatrists to locate in areas where shortages exist and increase the total number of such physicians in the State. (Finding Code No. 2025-039)

2025-039. **FINDING** (Noncompliance with the Psychiatry Practice Incentive Act) - Continued

RECOMMENDATION

We recommend the Department request funding for and implement the requirements of the Act.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will explore options to implement changes to correct.

2025-040. **FINDING** (Noncompliance with the Equity and Representation in Health Care Act)

The Illinois Department of Public Health (Department) did not comply with the Equity and Representation in Health Care Act (Act) (110 ILCS 932).

The Department has not created and administered the Equity and Representation in Health Care Workforce Repayment and Scholarship Programs (Programs) required by the Act (110 ILCS 932/15). Additionally, the Department has not submitted an annual report to the General Assembly and the Governor of the results of the Programs required by the Act (110 ILCS 932/35).

The Act (110 ILCS 932/15), effective January 1, 2023, requires the Department to create and administer the Equity and Representation in Health Care Workforce Repayment and Scholarship Programs for the purpose of providing scholarship and loan repayment programs to individuals from underrepresented communities pursuing health care careers. Additionally, the Act (110 ILCS 932/35) requires the Department to annually report the results of progress of the Repayment and Scholarship Programs on or before March 15 of each year to the General Assembly and the Governor. The annual report shall include the impact of the Programs on the ability of medically underserved areas to attract and retain eligible health care providers, as well as increase diversity and community representation in the State's health care workforce. The report shall also include recommendations to improve that ability.

Management indicated that competing priorities have delayed the adoption of rules and implementation of the programs.

Formal administrative rules provide a basis for proper implementation and enforcement of State laws. Failure to create the programs and submit the required reports is noncompliance with the Act. (Finding Code No. 2025-040)

RECOMMENDATION

We recommend the Department create and administer the Equity and Representation in Health Care Workforce Repayment and Scholarship Programs and submit the mandated annual reports to the General Assembly and the Governor.

DEPARTMENT RESPONSE

The Department agrees with the finding and recommendation. The Department will work towards implementing changes to correct.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
SCHEDULE OF FINDINGS – PRIOR FINDINGS NOT REPEATED
For the Two Years Ended June 30, 2025

A. **FINDING** (Noncompliance with the Emergency Medical Services Systems Act)

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

During the current examination, our testing indicated the Department sent the EMS renewal notices timely. Additionally, we noted the Illinois Administrative Code (77 Ill. Admin Code 515.835 (d)) was amended on November 1, 2024, which revised the stretcher van provider license validity to four years. (Finding Code No. 2023-022, 2021-023)

B. **FINDING** (Failure to Designate a Staff to Handle Men's Health Issues and Create Men's Health Division)

During the prior examination, the 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 the current examination, the Department created a Section of Men's Health under the Office of Health Promotion, Division of Community Health and Prevention and appointed a Section Chief. (Finding Code No. 2023-028)

C. **FINDING** (Failure to Conduct Firearms Restraining Orders Awareness Program)

During the prior examination, the Department did not conduct a program to promote awareness of firearms restraining orders to the general public as required by the Law.

During the current examination, the Department conducted a program to promote awareness of firearms restraining orders (FRO) to the general public through the Department's webpage containing comprehensive information on FRO, video, and campaign materials aimed at increasing awareness about FRO. (Finding Code No. 2023-034)

D. **FINDING** (Failure to Establish or Approve a Certified Nursing Assistant Intern Program)

During the prior examination, the Department did not establish or approve a Certified Nursing Assistant Intern Program as required by the Law.

During the current examination, our testing indicated the Department amended the Administrative Rules on Certified Nursing Assistant Intern Program requirements to establish and approve the Certified Nursing Assistant Intern Program; however, no facility requested participation in the Program during the examination period. (Finding Code No. 2023-036)

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
SCHEDULE OF FINDINGS – PRIOR FINDINGS NOT REPEATED
For the Two Years Ended June 30, 2025

E. **FINDING** (Noncompliance with the Salvage Warehouse and Salvage Warehouse Store Act)

During the prior examination, the Department did not issue licenses as required by the Salvage Warehouse and Salvage Warehouse Store Act (Act) (240 ILCS 30).

During the current examination, our testing indicated the Department made significant improvements. Therefore, this finding has been moved to the immaterial letter. (Finding Code No. 2023-038)