



State of Idaho
Legislative Services Office

Special Report

A communication to the Joint Finance-Appropriations Committee

REPORT ON UNCORRECTED FINDINGS

Report SR10220

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Serving Idaho's Citizen Legislature



Idaho Legislative Services Office
Legislative Audits Division

REPORT ON UNCORRECTED FINDINGS

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SUMMARY

PURPOSE OF THE REPORT

Idaho Code, Section 67-702, defines the audit function of the Legislative Services Office. Under the direction of the Legislative Council, the Legislative Services Office has the authority to:

- a) Perform the annual audit of the statewide annual financial report prepared by the State Controller.
- b) Perform an annual audit of federal financial assistance provided to the State that meets the requirements established by the federal government.
- c) Perform a management review of each executive department of State government at least once in a three-year period.

As part of this process, we report findings and recommendations to management that are intended to improve operations at various State agencies. We also ask the entity to provide a corrective action plan intended to resolve the concerns noted in the finding.

This report summarizes the findings issued and progress by agencies over the past year in completing those corrective action plans. We believe this information is an important step in the audit process, providing information to decision makers as they allocate limited resources to accomplish the overall goals of the State.

FISCAL YEAR 2017-2019 REPORTING INFORMATION

Report Type	2019			2018			2017		
	Number of Reports Issued	Findings Issued	Open Findings	Number of Reports Issued	Findings Issued	Open Findings	Number of Reports Issued	Findings Issued	Open Findings
Management Review	26	14	12	24	14	9	18	21	6
Agreed-Upon Procedures	2	0	0	2	0	0	2	0	0
Individual Entity Opinion Audit	3	0	0	5	2	2	5	6	5
Comprehensive Annual Financial Report	1	5	5*	1	6	1	1	2	0
Single Audit Report	1	18	18**	1	13	1	1	15	1
Total	33	37	35	33	35	13	27	44	12

*Follow-up work will be completed and reported in the Internal Control Report for fiscal year 2020 issued in February 2021

**Follow-up work will be completed and reported in the Single Audit Report for fiscal year 2020 issued in spring 2021

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BACKGROUND

Each year, the Legislative Audits Division (Division) of the Legislative Services Office completes several reports within three basic audit scopes. We plan our work related to those reports on a fiscal year, starting in June, with audit work to support our opinion on the statewide *Comprehensive Annual Financial Report*. The opinion we provide is based on our determination of the material accuracy of the basic financial statements prepared by the Office of the State Controller for the State of Idaho. This opinion includes the issuance of the *Internal Control Report* to comply with standards issued by the Comptroller General of the United States of America through the Government Accountability Office. This report is used to communicate significant deficiencies and material weaknesses in internal control over financial reporting identified during the audit and noncompliance with laws, regulations, contracts, or grant agreements or instances of fraud.

We then complete work related to the second audit scope, to support our *Single Audit Report*. Audit procedures are scheduled and completed at agencies that we have identified, through required risk assessment processes, with major federal programs awarded through federal grants and programs. We perform procedures to determine that the State of Idaho has provided appropriate internal controls to support compliance with federal requirements and that they have administered those grants and programs as intended by the federal grantors.

Our final audit scope work occurs during approximately 3-6 months of available time after completion of the *Single Audit Report* and before we start the next year's audit of the *Comprehensive Annual Financial Report*. Individual Entity Audit Reports, Agreed-Upon Procedures Reports, and Management Review Reports are completed during this time. The first two types of reports are completed annually, based on agreements with the entities. Management Review Reports are completed no less frequently than every three years, in compliance with statutory requirements. If we identify additional risks, or receive direction through legislation or from Legislative Council, we may visit an agency more often than every three years.

All reports issued by the Division can include findings related to internal control weaknesses, substantive (financial) errors, or noncompliance. These findings are then reported utilizing five distinct elements.

Criteria is the first reporting element and supports the finding with information identifying what is acceptable versus what is not, such as a statute, federal regulation, or internal control best practice. The condition is the next reporting element and identifies the "what" of a finding. Typically this would be specific deficiencies in internal controls tested, errors in financial information reported or presented, or noncompliance with laws, rules, or regulations. We follow that with the cause element that identifies the "why" of a finding. Generally, this is comprised of factors that may have contributed to the condition, such as employee turnover, poorly designed or implemented internal controls, or a lack of knowledge or training. This flows into the next element that addresses what effect the condition may have on the entity or financial statement presentation. It should address why this condition would matter to the entity or the users of that entity's financial information. For example, it may provide some indication of the types of errors that can occur when internal controls are not present, or the magnitude of an error identified, or what a federal grantor may do in response to noncompliance with federal requirements of a grant received. Finally, we include a recommendation to the entity. The

recommendation will indicate an action, such as improvement in the design or implementation of internal controls, staff training or education, or other efforts to improve compliance that should rectify the problem noted in the condition.

All entities are then given an opportunity to express their views on the finding, if they agree or disagree with any of the information we have provided, and finally a corrective action plan. We are required to provide additional auditor's comments to clarify our position if the entity provides information that we consider inconsistent or in conflict with the finding.

Follow-up audit work is completed for all audit scopes to determine if an audit finding is corrected. However, reporting of the results of that work occurs in two different ways, depending on the report type. If we are providing an opinion, such as through Individual Entity Audit Reports, the *Internal Control Report* for the *Comprehensive Annual Financial Report*, or the *Single Audit Report*, we follow *Uniform Guidance* as provided by the Office of Management and Budget that requires the entity under audit to complete the assessment of prior audit findings, which is included in the audit report. If we disagree with the assessment of a corrected prior audit finding, we include a current audit finding addressing it. For Management Review Reports, we provide additional follow-up procedures and reporting to assist the legislature with its oversight function. Management Review reports have three potential follow-up reporting opportunities. Since we may only visit an entity for a full review once in a three-year period, it is important to complete additional follow-up procedures when findings are present to ensure timely correction of findings. The first follow-up review is scheduled for a date that is at least 90 days after the date that we issue the initial report to give the entity adequate time to implement the corrective action plans and to ensure there is enough activity available for testing to provide a basis for determining if the finding is corrected or not. If the finding(s) has not been corrected during the 90-day follow-up work, we will revisit the entity after one year and complete procedures to determine if the corrective action plan has been completed, or revised and completed, and is effective. If the finding still remains uncorrected, we will visit the entity again in one year to provide a final opportunity to correct the finding before we return for the next required cyclical review. Follow-up reports are completed and provided to the legislature and are available on our website.

This report summarizes certain finding information from audits completed during fiscal years 2017, 2018, and 2019. The finding title, recommendation, corrective action plan, auditor's response when necessary, and any follow-up reviews completed for all uncorrected findings are included and reported by audit scope. The full reports, including complete finding information, are available on our website at www.legislature.idaho.gov/lso/audit.

2019 MANAGEMENT REVIEW REPORT UNCORRECTED FINDINGS

IDAHO BRAND BOARD (BOARD)

Finding 1, repeated from Fiscal Year 2017 Management Review Report

Procedures and controls over the proceeds collected under hold orders on the sale of livestock continue to be inadequate to prevent or detect errors or the misappropriation of funds.

Recommendation: We recommend that the Board implement procedures and internal controls to ensure that money held as the result of hold orders is adequately tracked and reconciled to release orders and to ensure unclaimed funds are submitted within 60 days of the sale.

Management's View: The Board has historically been a paper based agency with limited ability to track records electronically. During the Board's prior Management Review this same finding was noted. At that time, the Board's corrective action plan include the anticipation and implementation of a future computer software system to track brand records, including hold orders. The software system is designed in a way which hold orders are created electronically in the field and automatically monitored within the office system.

Due to circumstances beyond the Boards control, full implementation of the software system has been delayed. The automated field submission portion of the project is not complete and the Board has been unable to finalize the original corrective action plan. Due to this continued finding, the Board has developed a modified corrective action plan to resolve this finding. The Board is currently utilizing the office portion of the new software system. The system allows for manual entry and electronic tracking of hold orders. The Board is in the process of implementing a new control procedure to include: issuing numbered and uniquely identifiable paper hold orders within the districts; manually submitting a written copy of all issued and active hold orders to the appropriate district clerk for entry into the software system; and submitting the subsequent release of hold order to the district clerk for entry into the software system when released. The Board is confident this planned control procedure will allow administrative staff the ability to adequately monitor, track and reconcile hold orders and proceeds held to ensure funds are appropriated correctly and in a timely manner. The Board feels this corrective action plan will be fully implemented by January 1, 2021.

Auditor's Concluding Remarks: We thank the Board for its cooperation and assistance throughout the audit. We would like to emphasize that if the corrective action plan is fully implemented and it clearly identifies and tracks hold orders while retaining adequate documentation, the concerns noted in the finding should be corrected. We will review the actions taken by the Board at least 90 days after the issuance of this report to allow time for implementation.

Status: Uncorrected

Next Scheduled Review: The original report was issued December 10, 2020. We will contact the Board to complete follow-up procedures to determine the status of the finding after March 31, 2021.

Finding 2, repeated from Fiscal Year 2017 Management Review Report

Brand inspection receipts are not deposited timely in accordance with Idaho Code.

Recommendation: We recommend that the Board implement policies and procedures to reduce the time between the collection and deposit of receipts in order to comply with Idaho statutes.

Management's View: This finding was previously noted in the Brand Board's prior Management Review. The Board has historically and will continue to have difficulties complying with Idaho Code Section 59- 1014 regarding deposits of cash, checks or other evidences of indebtedness accrued during any twenty- four (24) hour period and which is over two hundred dollars (\$200) or more. This is due to several factors.

Many of the Brand Inspectors live in remote areas where they perform inspections and collect currency daily, including weekends and holidays. They must reconcile payment with inspection certificates, obtain money orders for cash collected, and US mail their work with payment to the District offices to be processed, then deposited by the District Clerk. In addition, the Board has encountered numerous delays in the US mail which cause problems with timely received work and payment to the district offices.

Moreover, all of the Board's District Clerks are part-time employees or only perform accounting duties two days per week; while performing other necessary functions the remainder of the time. This causes problems when a Brand Inspector mails his/her work and it is received in the District office at a time when the District Clerk is not available to process it.

The Board has implemented a policy for Brand Inspectors to turn in their work and payments to the appropriate district clerk weekly. Often times work and payment are turned in more frequently, depending on the duty area of the Brand Inspector. The Board has implemented procedures for district clerks to process work and payments in appropriate intervals in which the work and payment is received.

The implementation of the new software system is expected to increase the Board's ability to achieve the requirements of Idaho Code Section 59-1014. The software system will allow administrative staff the ability to more closely monitor work to ensure payment is mailed and received in a timely manner.

Unfortunately, full implementation of the software system has been delayed and while the board is currently utilizing the office portion of the software; the Board has not seen the entire benefits of automated submission for field inspections or payment.

The Board has worked hard to implement policies, controls and procedures to help reduce the time between the collection and deposit of receipts in order to comply with Idaho Code. While the Board will continue to investigate all avenues of compliance, the Board plans to seek specific permission to deposit at some other interval by the provisions of a resolution of the board of examiners as allowed by Idaho Code Section 59-1014 and pursuant to 67-2025, Idaho Code.

Auditor's Concluding Remarks: We thank the Board for its cooperation and assistance throughout the audit. The deposits reviewed as part of our audit work identified only one of the 25 late deposits was

made within a week and the remaining 88% of the late deposits were made between two and three weeks after receipt of funds. Two of the deposits tested were made more than four weeks after receipt.

We would like to emphasize that while the corrective action plan may address some of the late deposit issues, the Board needs to implement procedures that will fully meet the statutory requirement. Mailing deposits and working with a part-time staff increases the risk that deposits could be lost or misappropriated. The Board should review their corrective action plan to ensure the planned action will address all of the concerns identified in the finding, including an effort to comply with the statute.

Status: Uncorrected

Next Scheduled Review: The original report was issued December 10, 2020. We will contact the Board to complete follow-up procedures to determine the status of the finding after March 31, 2021.

Finding 3, repeated from Fiscal Year 2017 Management Review Report
Travel expenditures were not documented in compliance with State travel policies.

Recommendation: We recommend that the Board implement and strengthen processes for completing and approving travel vouchers to ensure compliance with State travel policies.

Management's View: The Board has policies and process in place to ensure compliance with State travel policies. Due to a similar finding in the prior Management Review, the Board has worked hard to strengthen policy's and processes by implementing two party review and approval of all travel vouchers and provided supplementary training to staff on State Travel Policy. The Board's extra efforts were noted in the prior audit follow-up. The Board feels this finding is a "one off" situation in which office staff was not aware of the correct policy requirement for an atypical travel event. While the Board feels appropriate measures have already been taken to resolve this finding; the Board will continue to enhance current policies and procedures, as well as, seek out new processes to ensure compliance.

Auditor's Concluding Remarks: We thank the Board for its cooperation and assistance throughout the audit. We appreciate the policies and processes that the Board has implemented to address this finding. However, we would suggest that the Board review staff training processes to ensure staff are knowledgeable in the requirements and that a "one off" situation does not occur again.

Status: Uncorrected

Next Scheduled Review: The original report was issued December 10, 2020. We will contact the Board to complete follow-up procedures to determine the status of the finding after March 31, 2021.

DIVISION OF BUILDING SAFETY (DIVISION)

Finding 1
Federal expenditures were under-reported on the Schedule of Expenditures of Federal Awards (SEFA) closing package.

Recommendation: We recommend that the Division strengthen internal controls to ensure that the SEFA closing package submission is complete and accurate.

Management's View and Corrective Action Plan: The Division agrees that strong internal controls need to exist over the completion of Closing Packages required by the State Controller's Office. With that in mind the Division will ensure that it will make every effort to supply timely and accurate information in the completion of same. To that end, the Financial Specialist Senior will on an annual basis assemble the Schedule of Expenditures of Federal Awards (SEFA) Closing Package documentation and submit it to the Financial Specialist who will then review the expenditure amounts to ensure proper reporting. In the event the Financial Specialist identifies errors or needs additional information they will work with the Financial Specialist Senior to make any needed adjustments. The Financial Specialist Senior will use the backup documentation to prepare the SEFA Closing Package and forward it to the Financial Manager for approval and subsequent submission to the State Controller's Office. (Documentation: Electronic SEFA documents in Statewide Accounting System).

Status: Uncorrected

Next Scheduled Review: The original report was issued October 23, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO DEPARTMENT OF ENVIRONMENTAL QUALITY (DEPARTMENT)

Finding 1

Internal controls over the review of annual Title V Air Quality permit invoices were not consistently documented.

Recommendation: We recommend that the Department consistently complete and adequately document internal controls designed to ensure invoices are accurate and prepared timely.

Management's View and Corrective Action Plan: DEQ has modified our internal control process and written procedure to ensure compliance with the Committee of Sponsoring Organizations of the Treadway Commission (COSO) standards. Specifically, the department has implemented a formal, two-step signatory verification process related to Title V permitting invoices between the respective Air and Fiscal Divisions.

The first step in the Title V verification process begins with the Fiscal Division's receipt of emissions inventory data from the Air Division. This emissions data is then utilized in order to calculate the fees for all Title V facilities. Once Fiscal has successfully completed their review of the calculated emissions data from the Air Division, Fiscal then creates the invoices which are submitted to the Air Quality Permit Supervisor and/or Air Bureau Chief for approval. This review by Air ensures the tonnage amounts for each billing are accurate and in accordance with IDAPA rules.

The second step in the review process is performed by Fiscal which encompasses the verification of the fee for service amounts and ensures that they are properly supported through a random sampling of facility invoices. Once Fiscal has concluded the verification and random invoice sampling process, Fiscal will then forward a DEQ Invoice Approval Form to the Air Division which requires two (2)

signatures (one from Air, one from Fiscal) which will certify that the Title V invoices are correct and approved for annual billing.

This signatory document lends support to the successful verification process and collaborative effort between both divisions when producing Title V facility fees. DEQ recognizes that the exchange of information must include adequate source documentation to support financial transactions and demonstrate that departmental controls operate as designed.

Status: Uncorrected

Next Scheduled Review: The original report was issued December 10, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO DEPARTMENT OF INSURANCE (DEPARTMENT)

Finding 1

Reports provided to the United States Department of Health and Human Services (HHS) for the State Health Insurance Assistance Program (SHIP) and the Medicare Improvement for Patients and Providers Act (MIPPA) program did not include evidence of a review or other internal control that would ensure the accuracy of the information provided.

Recommendation: We recommend that the Department design and implement procedures to ensure that staff are properly trained not only to provide for required internal controls related to review and approval of federal reports, but also for cross-training purposes to ensure accurate and timely reporting.

Management's View and Corrective Action Plan: We acknowledge and appreciate the opportunity to improve and to be compliant with the added requirement outlined in the draft report. The DOI recognizes the importance of safeguards and even though there were no errors found in our submission, nor did the submission form request it, due to this audit we more fully appreciate the requirements as outlined and accept the finding.

DOI has already made modifications to improve our federal reporting process. A review step has been added and will be reflected in the reporting beginning September 30, 2020. Documentation of the review will be retained in the individual grant files.

Status: Uncorrected

Next Scheduled Review: This report was issued October 23, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO DEPARTMENT OF JUVENILE CORRECTIONS (DEPARTMENT)

Finding 1

Six purchases were made in violation of State purchasing rules and internal policies.

Recommendation: We recommend that the Department design and implement control procedures to ensure compliance with State procurement and internal policies.

Management's View and Corrective Action Plan: Action 1: All IDJC employees possessing a purchasing card or responsible for purchasing are required to be re-trained on IDJC internal policies and Statewide Purchasing Rules. These employees will sign to acknowledge their understanding of the rules and procedures prior to engaging in purchasing activities. This will be completed no later than November 1, 2020.

Action 2: IDJC financial staff will perform daily review of P-card transactions and invoices. If purchases are identified that are in violation of IDJC policies or State Purchasing rules, the employee and supervisor will be counseled. If multiple violations are found, the employee will no longer have purchasing authority for the agency.

Status: Uncorrected

Next Scheduled Review: The original report was issued October 23, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO BOARD OF NURSING (BOARD)

Finding 1

Supporting documentation for travel expenditures was not maintained in accordance with the State Travel Policy.

Recommendation: We recommend that the Board strengthen internal controls to ensure travel expenditures are supported and are in compliance with the State Travel Policy.

Management's View and Corrective Action Plan: The Board of Nursing Staff recently updated its Travel Request and Reimbursement Procedures to mirror the States Travel Policy. We have also updated the approval and reimbursement process. A copy of our updated procedure is included with this letter. These new procedures went into place on November 9, 2020. A copy of your report and the Board's response, including the new policy, will be provided to Board Members during their quarterly meeting in February 2021.

Status: Uncorrected

Next Scheduled Review: The original report was issued December 29, 2020. We will contact the Office to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO DIVISION OF VOCATIONAL REHABILITATION (DIVISION)

Finding 1

Supporting documentation for travel expenditures was not maintained in accordance with the State Travel Policy.

Recommendation: We recommend that the Division implement and strengthen internal controls for completing and approving travel vouchers to ensure compliance with the State Travel Policy.

Management's View and Corrective Action Plan: We agree with this finding and have taken steps to correct it. This finding was specifically related to the Council for the Deaf and Hard of Hearing (CDHH) program which is an autonomous program that is only under IDVR for administrative support, including fiscal. Our Financial Manager has been in contact with the Director of the CDHH program and has suggested the following corrective action plan:

- 1) Any person who prepares a travel voucher will be required to read the state travel policy.
- 2) CDHH staff will confirm that all council members file a travel voucher even if they are not requesting any reimbursement.
- 3) Correct and complete supporting documentation will be reviewed and confirmed by the approver.

The Director is reviewing the data and is expected to develop a corrective action plan. In addition, the IDVR Financial Manager has informed the CDHH Director that IDVR Fiscal staff will:

- 1) Return any travel vouchers that do not have complete and correct supporting documentation and will let the requester know what else is needed.
- 2) Depend on CDHH staff to make sure a voucher is turned in for every traveler and if IDVR Fiscal is aware that a voucher has not been completed, we will request a voucher for all travel.

Together, these action plans should resolve the issue. Although there were no findings in IDVR's other programs, Fiscal does regular training on travel for these programs and has one scheduled for the fall of 2020.

Status: Uncorrected

Next Scheduled Review: The original report was issued September 4, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO DEPARTMENT OF WATER RESOURCES (DEPARTMENT)

Finding 1

The Department does not ensure monthly progress reports on flood management grant projects are received, as required by its internal flood management grant program guidelines.

Recommendation: We recommend that the Department collect the monthly reports as required in the grant program guidelines, or consider revising the guidelines to provide appropriate oversight for the short term projects.

Management's View and Corrective Action Plan: The agency has reviewed the guidelines that were established for the flood management grant program at the time the program began. Experience has

determined that requiring monthly progress reports does not make sense for all flood management grants, especially those with short construction times.

A request will be made to the Idaho Water Resource Board to amend the guidelines for the flood management grant program to better reflect the actual reporting needs on a grant-by-grant basis.

Status: Uncorrected

Next Scheduled Review: The original report was issued November 5, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

Finding 2

The water supply bank receipt and payment transactions lacked documentation of independent reviews.

Recommendation: We recommend that the Department ensure independent reviews of payments made to owners and receipts from renters are consistently documented and maintained.

Management's View and Corrective Action Plan: The agency has reviewed its current process for reviewing annual payment memorandums and performing monthly review of receipts. The process to review the receipts monthly is cumbersome and time consuming. The water supply bank staff is currently working to streamline this process so it requires less manual review. Until the new process is complete staff will document and maintain the monthly review in the report. They will also verify that any adjustments they requested are completed and maintain that documentation as well.

The supervisor conducting the independent review of payment memorandums submitted by water supply bank staff will document and maintain the documentation of their review within the Excel spreadsheet that is created when the end of the year reconciliation is completed.

Status: Uncorrected

Next Scheduled Review: The original report was issued November 5, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

Finding 3

The receipts for the Revolving Loan Fund Program were not independently reviewed to ensure the accuracy of principal and interest calculations.

Recommendation: We recommend that the Department implement control procedures, which include training the senior financial specialist to ensure an independent review of the interest and principal calculations occurs.

Management's View and Corrective Action Plan: The agency has conducted training and implemented internal controls that ensure independent review of principal and interest calculations.

The Senior Financial Specialist will review the payment to verify the accuracy of the principal and interest calculations and will initial the documentation that is included with the deposit record.

Status: Uncorrected

Next Scheduled Review: The original report was issued November 5, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

2018 MANAGEMENT REVIEW REPORT UNCORRECTED FINDINGS

IDAHO DEPARTMENT OF ADMINISTRATION (DEPARTMENT)

Finding 1

The Department's Federal Surplus Property Program is not in compliance with federal regulations and the State plan.

Recommendation: We recommend that the Department update the state plan of operations to reflect current procedures and ensure compliance with the FMR. We further recommend that the Department design and implement internal control procedures to ensure compliance with the state plan.

Management's View and Corrective Action Plan: We understand the single finding in the report and have taken the following actions to address it.

- November 2019 - The FSP State Plan of Operation was revised and updated to reflect current standards and procedures. The State Plan was approved by GSA on June 16, 2020.
- September 2019 - The FSP went through a State Review of Operations conducted by GSA. The review period covered was from July 1, 2017 through June 30, 2019. GSA found the FSP to be within conformance in all areas. Due to this result, GSA provided a conclusion that the FSP will be on a 4-year review cycle versus a 2-year cycle.

The finding conditions in the report have also been reviewed and the following is IDOA's response to each of them.

Condition 1: Service and handling charges are calculated using a percentage of the item's fair market value as determined by an internet search of like items. The charges are not calculated using a prorated share of the expenses incurred to operate the surplus property program or by using the chart in the plan of operations.

IDOA Response: The FSP State Plan of Operation was updated to identify the primary method of calculating the service cost is the "as is" fair value of the item determined by donee usability, current wholesale cost of similar property, condition and quantity available being utilized as the basis for determining service and handling fee calculation (§5.b). When the base fair value is determined it will be verified against the acquisition cost dollar range chart (§5.c.i) in the plan. The annual operational expenses (§5.ii) and the prorated direct costs (§5.iii) are used to ensure that the assessed fair value is not too low or too high when compared to them.

Condition 2: Working Capital Reserves as of the end of fiscal year 2018 were not sufficient to cover one year of operating expenses. The average expenditures in the program for the fiscal years 2016, 2017, and 2018 were \$449,000, and the cash balance at the end of fiscal year 2018 was \$349,000.

IDOA Response: The FSP State Plan of Operation (§5.g.ii) was updated to compliment Idaho statute 67-5744 (app A). Per the FSP State Plan of Operation and statute 67-5744, the Director of the Department of Administration will establish the amount of working capital reserve at the beginning of

each fiscal year, not to exceed an amount equivalent to the estimated cost of operation of the FSP for the next succeeding fiscal year.

Condition 3: The state plan of operations allows for items to remain in inventory for 18 months before contacting GSA for disposal authorization, but the related FMR states that property held for longer than one year should be evaluated for usability.

IDOA Response: The FSP State Plan of Operation (§7) was updated to align with the regulations set forth in FMR 102-37.290 "Disposing of Undistributed Property". Standard operating procedures are currently being developed that will establish a method of evaluating the usability of donation property after 1-year per FMR 102-37.290.

Condition 4: We tested 20 donations to verify the recipients were eligible to participate in the program and found 16 recipients had exceptions, and several of those items had multiple exceptions.

IDOA Response: All discrepancies noted with Application of Eligibility files have been corrected. FSP personnel attended training conducted by GSA on donee eligibility. Applications of Eligibility submitted to FSP are reviewed by the office administrator prior to a final review and approval from the Bureau Chief. When Applications of Eligibility are renewed, the previous version is being retained in the donee eligibility file if any invoices relate to it.

Condition 5: We tested 15 donated assets with acquisition costs over \$5,000 and found 11 that did not have a utilization verification completed to determine the assets were being used for eligible activities.

IDOA Response: The FSP State Plan of Operation was updated to define utilization verification requirements and establish guidelines for virtual utilization verifications (§10). The Standard Operating Procedure states that when donees receive property that requires utilization verification they are given a Utilization Questionnaire form. This form must be completed and returned to Federal Surplus when the property is placed in use, which, according to the FSP State Plan of Operation must be within 1 year of receiving the property (§6.b). Twelve months after the property is placed in use the donee is sent another Utilization Questionnaire for the donee to report continuous use of the property. Records of utilization verification are retained by the FSP office administrator and monitored weekly for verification checks. FSP personnel attended training conducted by GSA on compliance utilization verification.

Condition 6: The Department has not conducted internal audits or ensured that external audits were completed as required.

IDOA Response: The FSP State Plan of Operation establishes that internal audits of Bureau operations and financial affairs will be conducted as directed by the Director, Division of Purchasing, at least every two years, on years not covered by external audits or GSA reviews (§12). In addition, the Bureau shall provide for external audits of the operations and financial affairs of the Bureau and compliance with the Single Audit Act (31 U.S.C. 7501- 7507) as implemented by Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations".

Condition 7: The Department completed an annual inventory of all items in the surplus property program but did not complete the required quarterly spot checks on 25% of the inventory.

IDOA Response: The FSP State Plan of Operation was updated to reflect the GSA approved inventory process. It establishes that periodically, spot inventory checks shall be made by taking a physical count of the stock on hand and comparing it with the inventory control system, or vis- versa (§3.a.vii). The FSP Standard Operating Procedure states that FSP will increase the number of audits from quarterly to monthly. All differences shall be properly noted and recorded and become a part of the inventory control system.

Status: Uncorrected

Next Scheduled Review: The original report was issued August 11, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED (COMMISSION)

Finding 1, repeated from Fiscal Year 2015 Management Review Report

Internal controls over the Business Enterprise Program (BEP) are not in place to prevent or detect program noncompliance with IDAPA rules and program standards, resulting in vendor noncompliance and unreliable vendor-reported financial records.

Recommendation: We recommend that the BEP implement internal controls to ensure compliance with internal policies and State and federal program requirements. Additionally, we recommend that management address all known issues of vendors providing inaccurate monthly reports per IDAPA 15.02.30.040.

Management's View and Corrective Action Plan: We agree with this finding and as of July 1, 2019, the allowable cost manual is no longer part of the BEP rules. The performance metrics in the allowable cost manual were unable to be met due to it being outdated. This out of date rule expired as part of the Red Tape Reduction Act. For internal controls on monitoring the vendors in the BEP, we have begun scheduling the random audits to ensure financial compliance with the program. We will contract with an accountant to do two audits per year on the vendors. We are also in the process of writing guidelines and accounting practices for the BEP. These will be communicated to the vendors at their bi-annual meeting. These guidelines will be consistent with the general accounting practices of ICBVI. Notices are being sent out to vendors who are late with their reports and/or set aside payments. According to the rule, they will be put on probation if they fail to turn these in on time.

Status: Partially Corrected

Auditor's Follow-up: The original report was issued November 8, 2019 and we contacted the Commission on February 28, 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Commission. On March 17, 2020, we issued the Management Report 90-Day Follow-Up.

The Commission has implemented new policies and procedures relating to processes of the BEP, including actions to be taken for late reporting or payments by BEP vendors. The new policy also

includes provisions for an internal review to verify accuracy of BEP vendor reports twice a calendar year and an external review of two vendors by an external auditor once a year. We reviewed the new policy and the internal reviews that are in process for three vendors and an agreed-upon procedures engagement that is in process for another vendor. No reviews of BEP vendor reports have yet been completed. Furthermore, the current policies do not outline what specific actions will be taken if inaccuracies are noted in the BEP vendors' set-aside reports or how many inaccuracies can be noted before disciplinary action is taken. Because the Commission has created a BEP policy manual, developed a policy for reviewing the accuracy of BEP vendors periodically, and has outlined actions to be taken for late payments, but has not outlined actions to be taken when inaccuracies are noted in the report completed by BEP vendors, we consider this finding partially corrected.

Next Scheduled Review: We will contact the Commission again in April 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

Finding 2, repeated from Fiscal Year 2015 Management Review Report

The Commission does not have sufficient written policies and procedures for general accounting processes and conflicts of interest for the Business Enterprise Program (BEP).

Recommendation: We recommend that the Commission establish written policies and procedures over general accounting processes and conflicts of interest in the BEP.

Management's View and Corrective Action Plan: We agree that ICBVI needs to have written guidelines and procedures for both general accounting processes and regarding conflicts of interest for the BEP program. The allowable cost manual no longer exists in rule. We are working on writing new guidelines to take the place of the allowable cost manual that will be amendable, as needed for updates. There are no conflicts of interest that currently exist in the program. The new conflict of interest policy that was written in 2017 is in effect. That policy outlines that the issue will be brought to the Administrator who will take it to the Commissioners and the agency attorney will be consulted to determine the appropriate actions.

Status: Partially Corrected

Auditor's Follow-up: The original report was issued November 8, 2019 and we contacted the Commission on February 28, 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Commission. On March 17, 2020, we issued the Management Report 90-Day Follow-Up.

The Commission has written new allowable cost guidelines and a conflict of interest policy and general policies for the BEP. Written policies have not yet been created for general receipt and expenditure processes. We consider this finding partially corrected until the remaining processes are properly documented.

Next Scheduled Review: We will contact the Commission again in April 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

IDAHO DEPARTMENT OF CORRECTION (DEPARTMENT)

Finding 1

Several purchases were made in violation of State purchasing rules and internal policies.

Recommendation: We recommend that the Department design and implement control procedures to ensure compliance with State procurement and internal policies.

Management's View and Corrective Action Plan: The agency identified these deficiencies prior to the audit, and added the following controls intended to enforce the review and authorization of purchases:

- a) An electronic purchase order system to increase transparency and reduce the ability to purchase contract items from a non-contracted vendor. This system also adds the ability for reviewers to reject requisitions that do not comply with state statutes, rules, and policies.
- b) Mandatory agency-wide purchasing training for all staff who purchase commodities and/or approve purchasing transactions. We are confident that future audits will show improvement in this area.

Status: Uncorrected

Auditor's Follow-up: The original report was issued January 2, 2020 and we contacted the Department on April 22, 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Department. On July 2, 2020, we issued the Management Report 90-Day Follow-Up.

The Department has implemented an electronic purchase order system in order to enforce the review and authorization of purchases. This system allows reviewers to reject requisitions that do not comply with State statutes, rules, and internal policies. We reviewed a sample of thirty transactions to evaluate compliance with statewide purchasing and internal policies. The sample includes transactions from all institutions and locations for the Department. Of the thirty transactions tested, one purchase was not bid out according to State purchasing rules, three purchases should have been purchased under a statewide contract, and two transactions had purchase orders completed after the purchase was made. The newly implemented system is intended to ensure that purchases adhere to State procurement and internal policies. However, not all purchases are required to go through this system which allowed the non-compliant transactions to occur.

Next Scheduled Review: We will contact the Department again in July 2021 to complete an annual follow-up review to determine if the corrective action plan has been completed and corrects the finding.

Finding 2

The Department does not have adequate controls in place to ensure the safeguarding of assets related to the inmate checking and savings accounts.

Recommendation: We recommend that the Department implement policies and procedures to fully reconcile the inmate accounts and resolve any discrepancies. We further recommend that the Department modify procedures to document review and approvals of the reconciliation. We also recommend that the Department design and implement effective internal control procedures to ensure

the appropriate SSAE reports are reviewed to provide assurance that controls over the inmate banking deposits are handled appropriately.

Management's View and Corrective Action Plan: The agency reconciles each deposit and withdrawal transaction with the bank on a monthly basis, ensuring the safeguarding of inmate trust assets. This work is performed manually by a technician and is reviewed by a manager. The manager will now sign off on each report to document the review. The inmate trust accounting system is currently unable to produce an automated report which documents the reconciliation between the bank balance and the book balance. In response, the agency is working with the subcontractor to produce a functional reconciliation report. In addition, we have obtained documentation from our prime contractor showing adequate controls over inmate trust deposits, will request this report annually, as suggested in the management review.

Auditor's Concluding Remarks: We appreciate the Department's response, but would like to clarify that the current transactional reconciliation procedures are not preventing, or detecting and correcting, discrepancies between the Department's record of account balances and the banks record of those same balances. Additionally, the difference between the two records continues to grow. Developing a process to reconcile the accounts and identify the discrepancy should be a priority of the Department to ensure safeguarding of these assets and accurate recordkeeping.

Status: Partially Corrected

Auditor's Follow-up: The original report was issued January 2, 2020 and we contacted the Department on April 22, 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Department. On July 2, 2020, we issued the Management Report 90-Day Follow-Up.

The Department worked with their vendor and obtained reports to assist in reconciling the monthly deposits and withdrawals. These reports did not provide the information to fully reconcile the ending cash balance. The difference between the book and bank ending cash balance is due to reconciling items from previous months. In order to fully reconcile the ending cash balance, the Department is in the process of completing reconciliations for the prior month's activity. The review of the reconciliation is now documented. We reviewed the April 2020 reconciliation and verified the review was documented. The Department is also requesting and reviewing an SSAE report annually from their vendor. We were able to verify that the Department obtained the SSAE report. We reviewed the report and determined the correct report was received. One exception was noted in the report related to lack of documentation for an employment guide, this exception was not financially related.

Next Scheduled Review: We will contact the Department again in July 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

IDAHO DIVISION OF CAREER TECHNICAL EDUCATION (DIVISION)

Finding 2

Subrecipient monitoring procedures are not in place over CFDA 84.048 the Career and Technical Education grant as required with Uniform Guidance.

Recommendation: We recommend that the Division implement procedures to ensure compliance with all of the requirements as a pass-through entity. We also recommend that the Division design and implement effective internal control procedures to ensure subrecipient monitoring activities are complete and appropriate.

Management's View and Corrective Action Plan: As ICTE stated at the audit entrance meeting, we are well aware of the grant requirement for subrecipient monitoring and we were developing processes and controls for Perkins IV when Perkins V was reauthorized by congress. At that point, there was no reason to move forward with further development for the Perkins IV plan. Perkins V is currently in a statewide transition phase and thus full compliance requirements are not yet established. The Perkins V state plan is anticipated to be approved by the end of fiscal year 2020. ICTE will have a subrecipient monitoring process in place during fiscal year 2021 and will add controls to ensure compliance.

Auditor's Concluding Remarks: We thank the Division for its cooperation and assistance throughout the audit. The 2 CFR 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards applies to CFDA 84.048 Career and Technical Education. The amendment of Perkins IV to Perkins V does not absolve, nor postpone, the Division from complying with these requirements. We continue to recommend that the Division implement procedures and internal controls to ensure compliance with the requirements provided under the Uniform Administrative Requirements, as it relates to the funds they are currently receiving and spending, and not wait until 2021 to implement internal controls to ensure compliance.

Status: Uncorrected

Auditor's Follow-up: The original report was issued January 2, 2020 and we contacted the Department on April 7, 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Department. On May 7, 2020, we issued the Management Report 90-Day Follow-Up.

The Division noted that Perkins IV (CFDA 84.048 Career and Technical Education) has been reauthorized by Congress to Perkins V and is still in a statewide transition phase. The Perkins V State plan is expected to be approved at the end of fiscal year 2020. The Division intends to ensure that subrecipient monitoring processes and controls will be in place for fiscal year 2021, but corrective action has not been completed at this time.

Next Scheduled Review: We will contact the Department again in May 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

IDAHO DEPARTMENT OF LABOR (DEPARTMENT)

Finding 1

Transfer batches were not consistently reviewed for accuracy.

Recommendation: We recommend that the Department strengthen procedures to ensure that transfers are consistently reviewed for accuracy and that review is properly documented.

Management's View and Corrective Action Plan: The cause of failing to sign the batch review was directly related to losing key personnel in January 2016 and June of 2017. Much of our operational knowledge was lost and staff were working tasks they had not previously performed. Batches were reviewed, but the reviewer did not realize they needed to sign the batch. Staff are now aware of the signing requirement and we have modified our procedures. This problem has been resolved and a follow up review can be performed at your convenience to verify the problem has been corrected.

Status: Uncorrected

Next Scheduled Review: The original report was issued September 25, 2020. We will contact the Board to complete follow-up procedures and determine the status of the finding after March 31, 2021.

COMMISSION OF PARDONS AND PAROLE (COMMISSION)

Finding 1

Bond receipts were not deposited timely in accordance with Idaho Code.

Recommendation: We recommend that the Commission implement internal controls to ensure compliance with Idaho Code, Section 59-1014.

Management's View and Corrective Action Plan: As of September 9th, 2019, the agency has corrected this finding by reviewing our processes and subsequently correcting and tightening our internal controls to ensure compliance with Idaho Code. The agency has developed a written policy for receiving funds and the Business Operations Manager, Michelle Day, has reviewed it with appropriate Commission staff.

Status: Uncorrected

Auditor's Follow-up: The original report was issued October 11, 2019 and we contacted the Commission on March 11, 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Commission. On May 8, 2020, we issued the Management Report 90-Day Follow-Up.

The Commission updated policies with regard to deposits of receipts over \$200 as of September 9, 2019 to include a requirement that deposits take place within 24 hours of receipt. Our review of receipts collected after implementation of the new policy identified 2 of the 10 receipts tested were deposited more than three weeks after receipt. Based on this testing, the revised policy has not yet been consistently followed by the staff. The Commission should continue to train staff on the new policies to ensure compliance.

Next Scheduled Review: We will contact the Commission again in May 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

PUBLIC UTILITIES COMMISSION (COMMISSION)

Finding 1

Federal grant expenditures and reimbursements are not reconciled between the Statewide Accounting and Reporting System (STARS) and federal grant reports that created errors in amounts reported on the Schedule of Expenditures of Federal Awards (SEFA).

Recommendation: We recommend that the Commission design and consistently perform procedures to ensure grant receipts are allocated correctly to each fund and agree to the federal SF-270 reports. We also recommend that the Commission update their procedures to ensure all federal expenditures are included in the SEFA closing package. We further recommend that the Commission work with the SCO to determine how best to meet submission deadlines while also ensuring expenditures on the SEFA closing package agree to federal reimbursements reported on the SF-270 reports.

Management's View and Corrective Action Plan: The Commission continues discussions with the Division of Financial Management, the State Controller's CAFR staff, as well as LSO Auditors in trying to find the best practices for dealing with PHMSA's funding practices for the Pipeline Safety Grant. The Grant runs on a calendar year (January 1 to December 31st) cycle each year. While this cycle is common for other federal grant recipients, this particular grant is after the fact reimbursed, not a draw down process.

To further complicate the funding issue, there are only two opportunities to request reimbursement, typically in the fall of each year, for the first six months of expenditures, and then the remaining expenditures (July 1 – Dec 31s) are allowed to be requested for reimbursement in the spring of the following year. These request dates are not set, nor constant and each year the Commission waits for notification from PHMSA that the funding cycle is open. There is anywhere from a 2 to 4 month delay between request for reimbursement and when the Commission actually receives the funds. . In the finding above, we received additional funds after the grant and state fiscal year were closed out. Without being able to adjust expenditures to accommodate the additional funds, the Commission did not have any place to deposit these funds. However, the Commission's approved negotiated indirect rate is higher than the allowed twenty percent for this particular grant. As the Commission had not exceed allowable expenditures it was determined appropriate to deposit the additional funds in the indirect fund (0125) to offset expenditures that benefit the PHMSA fund, and are allowable indirect expenses by OMB.

As noted by the finding, the total amount of funds net to zero. It is only the difference of which fund the dollars were deposited.

In addition to the ever changing funding dates, this annual grant is awarded typically after the calendar year has begun, and state pipeline programs are never awarded a set amount. For example, the CY 2019 grant (which runs from January 1, 2019 to December 31, 2019) was just awarded to states (October 2019) 10 months into the actual grant term. Our award was not a set amount, but rather a not to exceed amount. It is anticipated the final CY 2019 reimbursement request will be submitted in late March 2020 (PHMSA sets these moving deadlines each year), with actual payment not being received until mid-July 2020, which will be state FY 2021. Receiving reimbursement this late after the fact is what contributed to the Commission's finding, outlined above.

The Commission has been notified the CY 2018 PHMSA grant (Closed Dec. 31, 2018) is going to have a supplemental payment amount as well. However we do not have the total amount that will be available nor when we can anticipate receiving those funds. Again with the grant cycle and not one but two state fiscal years closed since those expenditures occurred, the Commission will not be able to match those expenditures and revenues for the same grant period.

As noted above, Commission staff are working with SCO, DFM and LSO auditors to establish, and document a consistent fiscal policy and procedures for processing future after-the-fact payments. We will be implementing a new reconciliation account to help with these late payments. This will continue to be an area that the Commission will monitor to ensure the reporting forms from the PHMSA payments align to the SCO's reports and identify each revenue and expenditure by grant year, regardless of the timing of payments.

Status: Uncorrected

Next Scheduled Review: The original report was issued November 5, 2019. We will contact the Commission to complete follow-up procedures and determine the status of the finding after March 31, 2021.

2017 MANAGEMENT REVIEW REPORT UNCORRECTED FINDINGS

IDAHO STATE DEPARTMENT OF AGRICULTURE (DEPARTMENT)

Finding 5

The Feed and Fertilizer Program has not reviewed tonnage reports since the implementation of the Feed, Fertilizer, and Soil & Plant Amendments System (FFS) in January of 2016.

Recommendation: We recommend that the Feed and Fertilizer Program ensure the review of tonnage reports are completed as required.

Management's View and Corrective Action Plan: We utilize the submitted tonnage reports of products distributed in Idaho as a way of ensuring proper and adequate registration and payment of fees. We agree that it is an important function that helps determine accuracy in reporting and paying fees. The overall volume of registrants and registered products for all programs has increased, and much of that distribution is from out of state distributors. Registrants and distributors are required to self-report these distributions.

Regarding the review of electronically submitted tonnage reports for fertilizer, controls have been put in place to review a sample of tonnage reports submitted online quarterly, in addition to the regular review of those tonnage reports received outside of the online submission system. These reviews consist of identifying discrepancies and missing information, as well as following up with registrants and distributors to rectify and correct any errors. During reviews, the most common issues identified include products that are duplicate reported by two different parties – the registrant as well as the distributor – or products that are reported that may not be required to do so. The program staff member tracks the reviews that are performed with notes regarding what was found in the sample.

Status: Partially Corrected

Auditor's Follow-up: The original report was issued September 12, 2019 and we contacted the Department in March, June, and August 2020 to complete procedures to determine progress on completing the corrective action plan provided by the Department. On November 16, 2020, we issued the Management Annual Follow-Up.

The electronically received tonnage reports for fertilizer and soil & plant amendments have been reviewed by the program specialist in the fertilizer and soil & plant amendment programs quarterly (January, April, July, and October) and at random to verify accuracy and compliance. These reviews have aided in identifying discrepancies and finding missing information in electronically submitted reports. When discrepancies or missing information have been found in these reviews, the program specialist tasked with these audits has followed up with customers to rectify errors and bring reports into compliance with submission requirements.

The Department was not able to provide sufficient supporting documentation to indicate the review on tonnage reports was performed. We reviewed the tonnage review tracking spreadsheet, which was created by the program specialist, and determined there was not sufficient supporting documentation to

prove the internal control was performed. There was no specific evidence that reviews were documented and the tonnage review tracking spreadsheet was not completed in a systematic fashion to ensure all tonnage reports were considered.

Next Scheduled Review: We will contact the Department again in November 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

IDAHO OFFICE OF DRUG POLICY (OFFICE)

Finding 1

Documentation is insufficient to support federal draws for the Strategic Prevention Framework program.

Recommendation: We recommend that the Office establish internal controls and procedures over federal draws to ensure adequate documentation is retained for each draw and amounts can be tied to expenditures paid or expected to be paid within the timeframe allowed by the federal program. We additionally recommend that the Office provide training to ensure that staff understand the requirements of the grant.

Management's View and Corrective Action Plan: Although the Strategic Prevention Framework grant has ended, the discretionary Partnership for Success (PFS) grant has been awarded to the Office of Drug Policy. Internally, ODP is utilizing several strategies to ensure this is no longer an issue in subsequent audits. These include:

- 1) Stephanie Pustejovsky, PFS Grant Director, will attend relevant trainings regarding grant management available through the Substance Abuse and Mental Health Services Administration and AGA.
- 2) Stephanie will review federal grant requirements through beta.samhsa.gov to ensure compliance with federal spending rules specific to the PFS grant.
- 3) The Grants 101 webinar will provide basic information about grants, including the responsibilities of recipients and key tasks that must be completed during the project period. This webinar will be most informative for administrative and program staff from organizations that were awarded a new grant in FY2018 and FY2019. It will also be relevant for new staff on existing grants who do not have extensive experience in grants management.
- 4) Stephanie is also taking training on the webinar, "Reporting Requirements" on April 11th, that will provide information about reports that need to be submitted to SAMHSA: performance and progress reports, FFRS, audits, and FAPIIS. Project staff members who would benefit from attending the webinar include: (1) Staff who are responsible for preparing progress and performance reports, (2) Staff who are responsible for preparing financial reports.
- 5) Stephanie will provide Melinda Smyser, Administrator of the Office of Drug Policy, a report of detailed transactions before drawing down funds. Transactions will occur prior to drawing down funds, and these drawdowns will not exceed the amount of funds already spent. Stephanie will collect a signed copy of this report from Melinda before drawing down funds. Stephanie will also keep a copy of this report to show dates of detailed transactions and drawdowns.

Status: Partially Corrected

Auditor's Follow-up: The original report was issued May 30, 2019 and we contacted the Office on September 25, 2019 to complete procedures to determine progress on completing the corrective action plan provided by the Office. On November 20, 2019, we issued the Management 90-Day Follow-Up.

The Office is in the process of developing a policy and procedure manual for federal draws. The current process includes the grant administrator pulling, reviewing, and signing a report of the federal expenditures for the month. This report is then reviewed jointly by the director and administrative assistant. The report is reviewed line by line to ensure that expenditures listed are appropriate for the grant and to verify the total being requested. The report cover sheet is then signed by the director. The report allows individual expenditures to be tied to the corresponding federal draw and demonstrates that funds are not being requested in advance of expenditures. We reviewed and verified that the August 30, 2019, federal draw report was in compliance with federal guidelines, internal controls were functioning appropriately, and individual expenditures could be tied to the specific draw.

The Office's newly implemented internal controls, as we reviewed for the completed report and federal draw from August 30, 2019, address the primary weaknesses identified in the finding. However, because the written policy manual has not yet been completed and only a single draw was available for review under the new system with current employees providing limited audit evidence, we are partially closing the finding.

Next Scheduled Review: We will contact the Office again in March 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

Finding 2

Inconsistencies and coding errors of federal expenditures creates unreliable data used by the Office and other agencies for financial reporting and decision-making.

Recommendation: We recommend that the Office provide training and guidance to individuals responsible for coding and reviewing financial transactions to ensure that transactions are consistently and appropriately coded.

Management's View and Corrective Action Plan: Training: The Office of Drug Policy staff will participate in the Internal Control Integrated Framework to make sure our organization is following all internal control procedures to ensure reliable financial reporting and compliance with applicable laws and regulations.

The ODP Administer already organized several meetings with staff and DFM (David Fulkerson and his staff) to outline the process for coding, reconciliations, authorizations and segregations of duties within the Office of Drug Policy.

The staff administrator will submit to ODP's grant Administrators a weekly Transaction Report so the Grant Administrators are able to reconcile their funding requests. On-going communication with DFM to verify coding discrepancies will take place monthly.

Status: Uncorrected

Auditor's Follow-up: The original report was issued May 30, 2019 and we contacted the Office on September 25, 2019 to complete procedures to determine progress on completing the corrective action plan provided by the Office. On November 20, 2019, we issued the Management 90-Day Follow-Up.

The Office holds monthly meetings with the Division of Financial Management (DFM) to ensure appropriate and consistent coding of transactions. The new administrative assistant works with grant administrators to review coding to ensure accuracy. The Office also went through its prior and current-year transactions with the DFM to identify and recode any previously miscoded transactions, as well as to identify any recurring issues. The Office director also reviews current coding more thoroughly and verifies any irregularities in transactions with staff and the DFM. The staff also participated in Internal Control Framework Training.

During our follow-up procedures, we noted 2 of the 19 sampled transactions had deviations related to consistent and accurate coding. The two items were coded as payments to subrecipients when they were actually made to a vendor for a good, not in a subgrant arrangement. As a result, this finding will remain open.

Next Scheduled Review: We will contact the Office again in March 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

IDAHO STATE HISTORICAL SOCIETY (ISHS)

Finding 1

Internal control weaknesses exist in federal grant accounting and program compliance.

Recommendation: We recommend that the ISHS implement internal controls that are adequate and documented to ensure compliance with federal program requirements. We further recommend that the ISHS take steps to ensure staff are knowledgeable of all federal compliance requirements.

Management's View and Corrective Action Plan: We concur. Staff turnover during the period under review created an internal control weakness in the review and approval process of federal reporting that has since been resolved. New procedures to meet Federal statute for the collection of a Dun & Bradstreet number from sub-recipients who are awarded Federal pass-through grants and a consistent method of calculation and application of indirect cost reimbursement have been implemented.

Status: Partially Corrected

Auditor's Follow-up: The original report was issued February 13, 2019 and we contacted the ISHS in June 2019 to complete procedures to determine progress on completing the corrective action plan provided by the ISHS. On September 4, 2019, we issued the Management 90-Day Follow-Up.

The ISHS has implemented controls and procedures to address the weaknesses in federal grant accounting and compliance. Federal grant reports are prepared by the grants manager and are submitted to the fiscal officer for review. The grant applications for the Idaho Board State & National Archival Partnership Grant (SNAP) and Historic Preservation Fund Grant (SHPO) have been revised to require a

Dun & Bradstreet (DUNS) number from all applicants. To ensure indirect cost reimbursement amounts are applied in a consistent manner, the ISHS has implemented a process where indirect costs are systematically expensed through the life of the grant.

We have reviewed the improved procedures and noted that the ISHS has implemented a review process for federal reports and has updated grant applications to obtain the DUNS number from subrecipients. However, during our review of indirect cost reimbursements we found that the ISHS had a systematic reimbursement process in place for the first half of fiscal year 2019, but due to staff changes mid-way through the year, indirect costs were not reimbursed in a systematic manner during the second half of fiscal year 2019.

Next Scheduled Review: We will contact the ISHS again in March 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

Finding 2

The ISHS has a growing cash balance in the Federal Fund 0348.

Recommendation: We recommend that the ISHS work with the SCO to transfer/spend the nonfederal balance in the Federal Fund 0348 as intended by the Legislature. Further, we recommend that the ISHS investigate the use of a borrowing limit with the DFM to properly manage the cash needs of federal grants.

Management's View and Corrective Action Plan: We concur with the findings that the cash balance in the Federal Fund has increased due to holding of indirect reimbursements in the Federal Fund that caused an increase over time. However the initial intent of the Federal Fund balance remains a need of the Agency to provide needed funds of federally funded programs of the State Historic Preservation Office due to six to nine month delays in National Park Service grant awards. Though a borrowing limit would be acceptable it seems counter to the original intent of the use of the \$181,453 and puts more burden on the State. Indirect in the Federal fund has an assigned grant code and as for the balance, we appreciate the recommendations of your team and will look to work with the SCO to set up a new fund to properly track ISHS indirect costs.

Status: Uncorrected

Auditor's Follow-up: The original report was issued February 13, 2019 and we contacted the ISHS in June 2019 to complete procedures to determine progress on completing the corrective action plan provided by the ISHS. On September 4, 2019, we issued the Management 90-Day Follow-Up.

The ISHS is currently working with the State Controller's Office (SCO), Division of Financial Management (DFM), and LSO Division of Budget & Policy to address the cash balance in Fund 0348. The ISHS intends to create a borrowing limit for Fund 0348 and will work with the DFM to submit the formal request. The ISHS is also planning to add Fund 0125 (Indirect Fund) to their financial structure. This will allow staff to identify which receipts are related to indirect costs (Fund 0125) and move them to the miscellaneous fund (Fund 0349). However, these changes have not been fully implemented at this time, so the finding remains open.

Next Scheduled Review: We will contact the ISHS again in March 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

IDAHO INDUSTRIAL COMMISSION (COMMISSION)

Finding 1

Estimates used to determine the allowance for doubtful accounts reported at yearend for restitution receivable have not been properly reviewed, resulting in consistently overstated doubtful account reporting.

Recommendation: We recommend that the Commission implement procedures to review prior year estimates in relation to actual results for the accounts receivable closing package.

Management's View and Corrective Action Plan: The Idaho Industrial Commission appreciates the thoroughness of LSO staff and accepts the recommendation from the Management Review. As discussed above, the agency did not perform an effective annual review of doubtful accounts and used default assumptions from program staff. As a result of the finding, the agency has conducted an in-depth review of its internal process related to Closing Package #17 (Accounts Receivable). To assist in providing more effective estimates, the data being used for the closing package has been reviewed and certified by program and fiscal staff. Reports have been developed by ITS in order to properly calculate and estimate all data required by the closing package. In addition to the new reporting structure, fiscal staff will review all the information with program staff prior to submitting the closing package.

To provide some background, the Crime Victims Compensation Program (CVCP) was established in 1986. The Commission officially started a restitution program in 1998, hired its first recovery officer in 2000, and began recording civil judgments in 2002. Previously, the Commission included all restitution collected and ordered going back to the program's inception, which predates computers. Because of the high probability of data loss, the agency data will be based on data beginning in 2002, when civil judgments began to be recorded and the program had an effective tracking capability. From 2002 to 2019, 66% (sixty-six percent) of all restitution has not been collected and is used as the allowance for uncollectible receivables. Every year, the agency will run the report from 6/30/2002 – 6/30 of the current closing package year to estimate a more proper uncollectible receivable allowance.

Status: Uncorrected

Auditor's Follow-up: The original report was issued September 26, 2019 and we contacted the Commission on February 25, 2019 to complete procedures to determine progress on completing the corrective action plan provided by the Commission. On April 15, 2020, we issued the Management 90-Day Follow-Up.

The Commission has implemented changes to address the overstatement in calculating the allowance for doubtful accounts on the accounts receivable closing package. We reviewed the submission of the fiscal year 2019 restitutions accounts receivable closing packages (Fund 0313).

To evaluate the changes made, we evaluated the methodology used to calculate the uncollectible rate, and we compared the Commission's estimated uncollectible percentages of the accounts receivable balance to the percentage of actual uncollected amounts using restitution collection amounts reported.

The Commission determined that the uncollectable amount of the accounts receivable balance was 66 percent. To calculate the uncollectible amount, the Commission used the average annual collection amount over three years divided by the total amount of collections over the same three years. Using this methodology, the Commission would consistently calculate an uncollectible amount of 66 percent. This methodology does not compare the historical rate of collections received directly to the accounts receivable balance. Additionally, the Commission does not compare the estimated doubtful accounts to actual uncollected receivables to assess the adequacy of the estimate, as required by standards.

We determined an uncollectable amount of 97 percent using actual collections reported during fiscal year 2019, which still results in an overstatement of the allowance for doubtful accounts by 31 percent. The changes made did not fully address the overstatement of doubtful accounts.

Next Scheduled Review: We will contact the Commission again in April 2021 to complete an annual follow-up review to determine if the corrective action plan has been fully completed and corrects the finding.

2018 INDIVIDUAL ENTITY OPINION AUDITS UNCORRECTED FINDINGS

SOUTH CENTRAL PUBLIC HEALTH DISTRICT (V) (DISTRICT)

Finding 2018-101

The District could not provide documentation to show internal controls were in place to ensure the accuracy and completeness of timesheets.

Type of Finding: Internal Control Deficiency

Recommendation: We recommend that the District design and implement internal controls to support the accuracy of timesheet data entered into I-Time in compliance with Office of the State Controller's Statewide Payroll Policy and maintain documentation to support that the controls are operating effectively.

Management's View and Corrective Action Plan: Our internal MAGIC system tracks all the required approvals for each individual employees' time coding and produces the timesheet for entry into the state Itime system. Upon completion of the entry into I-time, a report is run from MAGIC and used to review the entry into I-time. This report is then attached to the payroll. There is no way in the state system to document this checking process, but running that report is proof the review is occurring. To strengthen documentation, we have added a paper that the reviewer signs and dates to document that the review was completed, and this is then attached to the processed timesheets.

Auditor's Concluding Remarks: We thank the District for its cooperation and assistance throughout the audit. We would like to emphasize that the issue identified in this finding is the lack of documentation to confirm that the I-Time data entry was reviewed and any identified errors were resolved. I-time has user account logins and access controls, and retains the documentation of preparers and approvers for multiple functions, which include entering timesheet data. We appreciate the corrective action plan provided by the District to address the issue.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the District will be included in the next scheduled Individual Entity Audit Report for the District covering Fiscal Years 2019 and 2020 in the summary schedule of prior audit findings for the fiscal year ended June 30, 2019 and 2020. We plan to issue this report by December 2021.

Finding 2018-201

Internal controls over federal procurement, suspension, and debarment compliance are not adequately designed or implemented.

Type of Finding: Internal Control and Noncompliance

Recommendation: We recommend that the District design and implement internal controls to ensure compliance with State purchasing rules and federal procurement, suspension and debarment

requirements. We further recommend that the District retain documentation to demonstrate compliance with established procurement procedures.

Management's View and Corrective Action Plan: Our standard process for intaking a new vendor involves a check of the federal debarment list after receiving the new vendors W-9 and before forwarding it to the state for entry into STARS. Even though we were following the normal process, we did not document the process in the past. To strengthen the internal control, we will now print and attach the search results for each new vendor to show that we are completing the documentation.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the District will be included in the next scheduled Individual Entity Audit Report for the District covering Fiscal Years 2019 and 2020 in the summary schedule of prior audit findings for the fiscal year ended June 30, 2019 and 2020. We plan to issue this report by December 2021.

2017 INDIVIDUAL ENTITY OPINION AUDITS UNCORRECTED FINDINGS

SOUTHWEST DISTRICT HEALTH (III) (DISTRICT)

Finding 2017-101

Noncash expenditures were understated by \$95,146 on the Schedule of Expenditures of Federal Awards (SEFA).

Type of Finding: Significant Deficiency and SEFA Misstatement

Recommendation: We recommend that the District design and implement control procedures at a level of detail necessary to detect and prevent errors in the SEFA compilation.

Management's View and Corrective Action Plan: Southwest District Health's financial statements are reviewed by the preparer and reviewer in-house, and by a peer in another Health District. An error was made in the reporting of state-funded value of vaccine instead of federal-funded value. The error has been corrected. The Health District understands the importance of implementing the controls correctly and will ensure new staff members have adequate training to avoid future errors.

Status: Provided in the District Audit for Fiscal Years Ending June 30, 2018 and 2019

Follow Up: The external audit firm of Zwygart John & Associates CPAs, PLLC provided a summary report as part of their audit of fiscal years ended June 30, 2018 and 2019 addressing the prior audit finding issued by Legislative Services Office, Audit Division. Their report was issued on December 31, 2020 with the status update as follows:

Status: The District has put procedures in place to make sure that multiple individuals review the SEFA to confirm that amounts are stated correctly. We reviewed the SEFA and confirmed that multiple individuals signed off on their review. It was also noted that the noncash expenditures were tied to amounts provided by the Idaho Department of Health and Welfare. **This finding was closed and not reported in the current report.**

Finding 2017-201

The fiscal years 2016 and 2017 indirect cost rate proposals (ICRPs) contained errors that led to the under and over collection of indirect costs.

Type of Finding: Significant Deficiency and Noncompliance

Recommendation: We recommend that the District strengthen their internal controls over the indirect cost rate calculation and ensure that rates and allocation bases are applied correctly, according to the contracts and invoice billing, within the calculation spreadsheet.

Management's View and Corrective Action Plan: Southwest District Health has controls in place to prevent and/or detect errors in calculation of the indirect rate. At the time of this issue, there was inadequate oversight by the Financial Manager, and he is no longer with the Health District. The Health

District understands the importance of implementing the controls correctly and will ensure new staff members have adequate training to avoid future errors.

Status: Provided in the District’s Audit for Fiscal Years Ending June 30, 2018 and 2019

Follow Up: The external audit firm of Zwycart John & Associates CPAs, PLLC provided a summary report as part of their audit of fiscal years ended June 30, 2018 and 2019 addressing the prior audit finding issued by Legislative Services Office, Audit Division. Their report was issued on December 31, 2020 with the status update as follows:

Status: We reviewed the 2018 and 2019 ICRPs to confirm that amounts were correctly allocated. It was noted that the District has put in new procedures to make sure that multiple individuals are reviewing the ICRPs before it is submitted for approval. Based on our review no errors were identified in the 2018 and 2019 ICRPs. **This finding was closed and not reported in the current report.**

Finding 2017-202

The District could not provide documentation to support amounts reported to the Idaho Department of Health and Welfare (DHW) for the Maternal, Infant, and Early Childhood Home Visitation Program (MIECHV).

Type of Finding: Significant Deficiency

Recommendation: We recommend that the District develop and implement policies and procedures to retain documentation and submit reports timely in accordance with federal grant requirements.

Management’s View and Corrective Action Plan: The Program Manager for the Home Visitation Program changed during the audit period, and the incumbent had not received adequate training. At this time, the training has been completed.

Current Status: Provided in the District’s Audit for Fiscal Years Ending June 30, 2018 and 2019

Follow Up: The external audit firm of Zwycart John & Associates CPAs, PLLC provided a summary report as part of their audit of fiscal years ended June 30, 2018 and 2019 addressing the prior audit finding issued by Legislative Services Office, Audit Division. Their report was issued on December 31, 2020 with the status update as follows:

Status: The District has new personal in the positions that prepare, review, and submit these reports. A sample of the monthly and quarterly reports were randomly selected for review. All reports were tied to supporting documents with no issues noted. It was also seen that all reports had evidence that they were being reviewed. **This finding was closed and not reported in the current report.**

Finding 2017-203

Administrative costs charged to the Maternal, Infant, and Early Childhood Home Visitation Program (MIECHV) exceeded the allowed amount under federal earmarking requirements by \$27,588.

Type of Finding: Significant Deficiency and Noncompliance

Recommendation: We recommend that the District design and implement control procedures to monitor federal grant earmarking at a level of detail necessary to detect and prevent exceeding established limits.

Management's View and Corrective Action Plan: Southwest District Health has controls in place to prevent and/or detect errors in the calculation of invoices charged to programs. At the time of this issue, there was inadequate oversight by the Financial Manager, and he is no longer at the Health District. The Health District understands the importance of implementing the controls correctly and will ensure new staff members have adequate training to avoid future errors.

Status: Provided in the District's Audit for Fiscal Years Ending June 30, 2018 and 2019

Follow Up: The external audit firm of Zwygart John & Associates CPAs, PLLC provided a summary report as part of their audit of fiscal years ended June 30, 2018 and 2019 addressing the prior audit finding issued by Legislative Services Office, Audit Division. Their report was issued on December 31, 2020 with the status update as follows:

Status: The District worked with the granting agency for this grant. No further issues were seen. **This finding was closed and not reported in the current report.**

Finding 2017-204

Documentation was not available to support the allocation of direct costs to federal programs.

Type of Finding: Significant Deficiency and Noncompliance

Recommendation: We recommend that the Department maintain policies and procedures that ensure supporting documentation is appropriately retained and available for review. We also recommend that the District evaluate the reasonableness of the underlying methodology used when determining cost allocation rates.

Management's View and Corrective Action Plan: Southwest District Health has controls in place to retain adequate documentation to support the allocation of costs. At the time of this issue, there was inadequate oversight by the Financial Manager, and he is no longer at the Health District. The Health District understands the importance of implementing the controls correctly and will ensure new staff members have adequate training to avoid future errors.

Status: Provided in the District's Audit for Fiscal Years Ending June 30, 2018 and 2019

Follow Up: The external audit firm of Zwygart John & Associates CPAs, PLLC provided a summary report as part of their audit of fiscal years ended June 30, 2018 and 2019 addressing the prior audit finding issued by Legislative Services Office, Audit Division. Their report was issued on December 31, 2020 with the status update as follows:

Status: In reviewing the direct costs allocation for 2018 and 2019 we were able to obtain supporting documentation for how direct costs were being allocated. It was noted that budgeted expenses were being used as the basis for the allocation and that this was approved by the granting agencies.

2019 COMPREHENSIVE ANNUAL FINANCIAL REPORT UNCORRECTED FINDINGS

OFFICE OF THE STATE CONTROLLER (OFFICE)

Finding 2019-101

The Office's internal review process did not prevent or detect misstatements in the statewide Comprehensive Annual Financial Report (CAFR).

Recommendation: We recommend that the Office strengthen the review process over the compilation of the CAFR to ensure that the financial statements, note disclosures, and other information contained therein agree to the documentation that supports those amounts, including closing packages and outside audits.

Management's Views (Corrective Action Plan): The State Controller's Office acknowledges the misstatements and presentation errors identified by the auditors. Most errors were corrected prior to the issuance of the financial statements. The office will evaluate and make improvements to the internal review procedures and the related instructions for the compilation of the CAFR this spring and will create automated trend analysis and comparisons to identify variances and incorrect information.

Due to errors identified in financial information provided by component units, the office will communicate with the parties to ensure correct information is submitted with the auditor's signature prior to the first draft of the CAFR being submitted.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Internal Control Report, summary schedule of prior audit findings for the fiscal year ended June 30, 2020, with a planned issuance date in February 2021.

IDAHO DEPARTMENT OF HEALTH AND WELFARE (DEPARTMENT)

Finding 2019-102

The Department did not have a current evaluation of the adequacy of internal controls for a service organization responsible for processing \$230 million in pharmacy expenditure claims.

Recommendation: We recommend that the Department strengthen internal controls to ensure current SSAE No. 18 reports are received and reviewed for all significant service organizations. We further recommend that the Department review and improve, if necessary, contract monitoring terms to ensure that they receive the reports in a timely manner so as to not diminish the usefulness of the information provided.

Management's Views (Corrective Action Plan): The Department agrees with the finding as a control weakness. The Department will strengthen internal communications and controls. The Division of Medicaid Contract Managers will review critical deliverables, as outlined in each contract, with their

contract monitors to ensure contract monitoring activities are current and delivery of reports for review and acceptance are timely and within requirements.

DHW Internal Audit will include Contract Managers and the Division Audit Liaison on all correspondence to ensure audit deliverables and timelines are being fulfilled. Internal Audit will also continue to review and evaluate the Standards for Attestation Engagements ("SSAE") reports in a timely manner in accordance with our procedures.

These changes will ensure DHW Internal Audit and related external parties, to include Legislative Audit Services, receive requested information, and approve any adjustments to timelines.

The Division of Medicaid will add additional contract language during the next amendment(s) to include, the contractor will submit annual SSAE and System and Organization Controls ("SOC") reports to the Department within 15 days of the issued audited report.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Internal Control Report, summary schedule of prior audit findings for the fiscal year ended June 30, 2020, with a planned issuance date in February 2021.

Finding 2019-103

Capital assets in progress and capitalized intangible asset costs could be overstated and not in compliance with Governmental Accounting Standards Board Statement (GASB) Statement No. 51 requirements.

Recommendation: We recommend that the Department evaluate and modify their internal policy to ensure compliance with GASB Statement No. 51 guidelines when capitalizing costs of intangible assets related to development in progress and assets in production to reduce the risk of misstatements of intangible capital assets. We also recommend that the Department provide training to staff tasked with tracking these projects and making determinations about the nature of the expense to ensure accurate classification of the costs. Finally, we recommend that the Department review each of these intangible project and make appropriate adjustments to ensure compliance with GASB Statement No. 51 requirements.

Management's Views (Corrective Action Plan): The Department partially agrees with this finding. We agree with the noted condition that some of the expenditures charged to intangible assets in development included costs, like training, that were capitalized contrary to Governmental Accounting Standards Board ("GASB") Statement No. 51.10 and 51.14 and the Department's Financial Policy. The Bureau of Financial Services will strengthen its training, procedures, and documentation in order to ensure that costs are recorded in accordance with GASB Statement No. 51.

The Department disagrees with the condition that \$7,882,223 charged to the Ongoing Medicaid Modernization ("OMM") project did not meet the capitalization requirements of GASB Statement No. 51. While the title of the project in DHW's system indicates "ongoing", the OMM project includes an incremental approach that is intended to make substantial improvements to the Medicaid eligibility

system based on objectives and funding commitments that are established annually for each discrete initiative. The objective of the project is to avoid costly full-scale system replacement through incremental modernization improvements. Individual project deliverables are defined annually based on stakeholder needs, state and federal regulations, and emerging program requirements. The OMM Advanced Planning Documents (APDs), define incremental objectives, with estimated completion and release dates, for each individual discrete component, rather than the project as a whole. We believe the level of documentation performed for each component meets the standards set in GASB Statement No. 51. In the future, the Bureau will proactively communicate procedures to our audit partners on how the information concerning the nature of project costs is accumulated and distinguished for financial reporting. The Department will report adjustments to subsequent year's capital assets closing package, to incorporate accumulated cost and amortization of completed OMM components into the "asset in production" section of the report.

The Department disagrees with the condition that the \$6,855,423 in expenditures included for Medicaid Management Information System (MMIS) should have been expensed, rather than capitalized, since the software was substantially complete and operational in 2012. The charges to the MMIS project are reflective of system modifications with determined project objectives, funding commitments, and effort of achieving required levels of service capacity. Examples of some functionalities and efficiencies included in the reported outlays include automation of provider enrollment processes and implementation of system changes to support a new health plan. Based on the results of these activities, the Department deems the capitalization of the modification costs to be appropriate and consistent with GASB Statement No 51.15 which states that outlays associated with modification of software in operation should be capitalized if such modification results in an increase of functionality, efficiency, or extension of the useful life of the software.

Auditor's Concluding Remarks: We appreciate the Department's response; however, we would like to clarify that it remains unclear if the annual costs added to the OMM and MMIS projects increase functionality, increase efficiency, or extend the useful life of the software to qualify the costs for capitalization under GASB Statement No. 51.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Internal Control Report, summary schedule of prior audit findings for the fiscal year ended June 30, 2020, with a planned issuance date in February 2021.

IDAHO STATE TAX COMMISSION (COMMISSION)

Finding 2019-104

Evidence of review for sales tax distributions and reversal reconciliations was not maintained.

Recommendation: We recommend that the Commission ensure that internal control procedures are in place and consistently applied, and that they improve the documentation of control activities performed to ensure that reviews are completed and proper segregation of duties is maintained.

Management's Views (Corrective Action Plan): During the CAFR Audit, the Legislative Services Office discovered one finding; that the evidence of review for sales tax distributions and reversal reconciliations were not maintained. Regarding sales tax distributions, four end-of-month checklists did not have initials indicating that a review occurred. Data entry and review was done at the Financial Specialist Senior level. Moving forward, the Financial Specialist Principal or Financial Executive Officer will sign the End of Month checklist before it is filed to verify that a review was conducted by one of the Financial Specialist Seniors. The Financial Specialist Principal will be the primary contact in verifying that a review was conducted. The Financial Executive Officer will be the verifier in the Financial Specialist Principal's absence.

Regarding the review of reversal reconciliations, reversals and reconciliations were conducted by one individual. The Commission had personnel staffing shortfalls which contributed to this process. The Commission now has three active Financial Specialist Seniors that execute the day to day revenue accounting operations. Changes to workflow have been implemented and the individual who conducted the reversal process only reconciles the reversals while one of the other two employees enter in the reversal. All three employees are capable of entering and reconciling the reversal. If needed, one of the Financial Specialist Principals or the Financial Executive Officer can conduct the reconciliation.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Internal Control Report, summary schedule of prior audit findings for the fiscal year ended June 30, 2020, with a planned issuance date in February 2021.

IDAHO TRANSPORTATION DEPARTMENT (DEPARTMENT)

Finding 2019-105

The Department did not appropriately monitor the adequacy of internal controls for a service organization responsible for processing approximately \$15.2 million in receipts for International Registration Plan (IRP) fees.

Recommendation: We recommend that the Department improve policies and procedures to ensure current, and appropriate, SSAE No. 18 reports are received, reviewed, and evaluated for all significant service organizations.

Management's Views (Corrective Action Plan): The Idaho Transportation Department (ITD) will work with our providers of technology services to ensure that appropriate SSAE No. 18 reports are provided to ITD as part of their contracts by the end of Fiscal Year 2020. ITD will also train our staff on SSAE No. 18 reports and how to review and evaluate those reports to ensure that these systems provided to ITD are meeting the requirements for which they are intended.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Internal Control Report, summary schedule of prior audit findings for the fiscal year ended June 30, 2020, with a planned issuance date in February 2021.

2018 COMPREHENSIVE ANNUAL FINANCIAL REPORT UNCORRECTED FINDINGS

OFFICE OF THE STATE CONTROLLER (OFFICE)

Finding 2018-101

The Office's internal review process did not prevent or detect misstatements in the statewide CAFR.

Recommendation: We recommend that the Office strengthen the review process over the compilation of the CAFR to ensure that the financial statements, note disclosures, and other information contained therein agree to the documentation that supports those amounts, including closing packages and outside audits.

Management's View: The State Controller's Office acknowledges the immaterial misstatements and presentation errors identified by the auditors. Most errors were corrected prior to the issuance of the financial statements. The office will evaluate and make improvements to the internal review procedures and the related instructions for the compilation of the CAFR this spring.

Due to errors identified in financial information provided by state agencies, the office will conduct an evaluation to determine where greater risk may be present. Additional reviews and checks will be conducted on this information to ensure reporting errors are eliminated prior to inclusion in the statewide financial report. The office will put emphasis on these areas of increased risk during the annual financial reporting trainings provided to state agencies.

The office will continue to search out training opportunities for implementing new accounting standards, specifically trainings on the complex reporting requirements related to pension and other postemployment benefits (OPEB). Additionally, the office will work with the agencies who administer the state's pension and OPEB plans to better understand how to apply generally accepted accounting principles to these plans.

Lastly, the office will add a new step in the internal review procedures to include a check of links within the reporting software to ensure amounts display correctly within the financial report.

Status: Partially Corrected

Corrective Action Taken in Fiscal Year 2019: Our team attended professional development training during the year. The team continues to attend trainings to stay current on governmental accounting standards and will continue to seek out additional trainings.

Our team has utilized our reporting software to identify possible errors, and we have implemented an upgrade to the software, which allowed us to remove one layer of linking complexity. Our team met with the Department of Administration to discuss other post-employment benefit information required to be reported in the financial statements and agreed on the information the Department provides to SCO for reporting.

Our team identified common errors reported by agencies in the prior year and documented them as part of our annual agency risk assessment. At the beginning of financial statement preparation and again after closing packages were submitted, our team reviewed the risk assessment and identified agencies that may be higher risk. The common errors were also discussed during our annual training to the agencies.

Our team evaluated and improved internal review procedures for the CAFR compilation by improving the closing package platform to include a new review feature. This allows the SCO reviewer and users to easily see that closing packages have been reviewed by at least one reviewer. The Office continues to have entries of \$5 million or more, as well as unusual or uncommon entries to be reviewed before being processed.

Reason for Recurrence in Fiscal Year 2019 as Reported by Management: The Office implemented corrective actions provided on the prior year corrective action plan, however, staffing changes and review process changes still resulted in errors going undetected. As a result, the Office is working to improve the review process as discussed in our current year corrective action plan.

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Internal Control Report, summary schedule of prior audit findings for the fiscal year ended June 30, 2020, with a planned issuance date in February 2021.

2019 SINGLE AUDIT REPORT UNCORRECTED FINDINGS

IDAHO STATE DEPARTMENT OF AGRICULTURE (DEPARTMENT)

Finding 2019-201

The Department did not perform subrecipient risk assessments, ensure subrecipient audits were received, or perform subrecipient monitoring procedures as required for the Specialty Crop Block Grant.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department design and implement appropriate procedures to ensure compliance with pass-through entity requirements, including documenting risk assessment, obtaining and reviewing required audits from subrecipients, and ensuring subrecipients comply with all pass-through entity requirements.

Management's Views (Corrective Action Plan): The Idaho State Department of Agriculture (ISDA) accepts this finding and will design and implement internal controls and procedures to comply with 2 CFR 200 and all applicable subparts included in the regulations. ISDA will also create tracking forms that document evaluations of each subrecipient's risk of non-compliance and ensure that the subrecipients were audited by June 30, 2020. ISDA will review all required audit reports from pass through entities and subrecipients and document any identified risks on grant related findings. ISDA will also ensure that all pass-through entities also comply with obtaining, reviewing and identifying any risks identified from findings of subrecipients in compliance with 2 CFR 200 and all applicable subparts included in the regulations by June 30, 2020. ISDA will implement these internal controls and procedures on the current grants and the new grants that will be awarded this summer will have these procedures in place at part of the award and distribution process. A risk assessment checklist has already been developed and implemented and steps to obtain audits and document the review of the obtained audits will be included to the checklist included and tracked for each grant recipient. Training and implementation of these same steps for all pass-through entities on subrecipient monitoring will also be completed after internal implementation.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

IDAHO DEPARTMENT OF FISH AND GAME (DEPARTMENT)

Finding 2019-202

Purchases were made with Lower Snake River Compensation Plan grant funds for \$746,709 from three vendors without obtaining bids or a documented exemption, which is not in compliance with federal and State procurement rules.

Type of Finding: Significant Deficiency, Material Noncompliance

Recommendation: We recommend that the Department design and implement controls to ensure compliance with federal and State procurement rules.

Management's Views (Corrective Action Plan): In reviewing this finding, the Department believed it had an exemption in place from the Division of Purchasing for the fish food it purchased for the Lower Snake River Compensation Plan (LSRCP) grant program in 2019. Unfortunately, we were unable to locate and provide the written documentation to support the exemption.

In October of 2019, prior to the commencement of the audit, the Department worked with the Division of Purchasing to secure its fish food exemption for Fiscal Year 2020. This new exemption was approved, finalized, and documented in October of 2019.

In summary, the Department concurs with the finding to the extent that we were unable to produce the supporting documentation for the 2019 fish food exemption. The Department has already resolved this issue for 2020 and is in the process of reviewing its purchasing procedures to ensure that documentation is properly retained for any future bidding exemptions that we receive from the Division of Purchasing.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

FINDING 2019-203

Internal controls over the review of performance reports for the Lower Snake River Compensation Plan and Pacific Coast Salmon Recovery grants are not sufficiently documented.

Type of Finding: Significant Deficiency

Recommendation: We recommend that the Department design and implement internal controls over the review of performance reports that will ensure accuracy and compliance with federal requirements.

Management's View: The Department reviewed its procedures and agrees with the auditors' finding that the performance reports for the Pacific Coast Salmon Recovery Fund (PCSRF) and Lower Snake River Compensation Plan (LSRCP) grant programs were reviewed and approved by management, but that documentation of such review was not consistently generated and retained. In the case of PCSRF, the performance reports were reviewed within a federal online grant reporting system. However, we later discovered that the reporting system did not adequately document that the review had occurred.

The Department is evaluating its documentation processes, and will implement appropriate procedural changes to ensure that we are capturing and retaining evidence documenting the management review of performance reports for these programs. We anticipate these changes will be implemented during Fiscal Year 2021.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

IDAHO DEPARTMENT OF HEALTH AND WELFARE (DEPARTMENT)

Finding 2019-204

The Department did not meet the minimum earmarking requirements for the Crime Victim Assistance grant that was finalized during State fiscal year 2019 grant.

Type of Finding: Material Weakness, Material Noncompliance

Recommendation: We recommend that the Department develop and implement internal control procedures to ensure the correct allocation of funds to priority victim categories in compliance with federal grant requirements.

Management's View: The Council on Domestic Violence and Victim Assistance ("Council") concurs with the finding. The Council developed policy and procedures to ensure VOCA funds are disbursed in accordance with the priority category funding requirement. The policy and procedures are available and will be provided upon request. While the Council did ensure the VOCA priority categories were met for FY2020 grant allocations, the policy and procedure were not approved by the Council until December 6, 2020. The policies and procedures will be implemented for the state fiscal year 2021 grant cycle and will be implemented with each subsequent funding cycle.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-205

Subrecipient eligibility is not adequately documented or reviewed for compliance with federal requirements of the Crime Victim Assistance program.

Type of Finding: Material Weakness, Noncompliance

Recommendation: We recommend that the Department implement internal control procedures to ensure an adequate review and determination of subrecipient eligibility is completed and documented in compliance with federal grant requirements.

Management's View: The Council concurs with the finding. The Council developed policy and procedures to ensure eligibility requirements are reviewed and the process is documented to be compliant with federal requirements. The policy and procedures and the Eligibility Checklist are available and will be provided upon request. The policy will be implemented for the FY2021 grant cycle and implemented with each subsequent funding cycle.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-206

Subrecipient monitoring procedures are not adequate to ensure compliance with federal requirements for the Crime Victim Assistance program.

Type of Finding: Material Weakness, Material Noncompliance

Recommendation: We recommend that the Department implement procedures to ensure compliance with all of the requirements of a pass-through entity. We also recommend that the Department design and implement effective internal control procedures to ensure subrecipient monitoring activities are complete and appropriate.

Management's View: The Council concurs with the finding. The Council has enhanced its monitoring procedures and are available upon request. The monitoring procedures are effective as of March 6, 2020. Council Grant Managers will follow the policy and procedure outlined to monitor subrecipients receiving Council funds.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-207

The Crime Victims Assistance grant was charged \$35,902 of expenditures that were for unallowable activities and lacked appropriate supporting documentation.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department strengthen internal controls over the processing of reimbursement requests to ensure reimbursements are adequately supported and for allowable activities.

Management's View: The Council concurs with the finding. The Council strengthened its monitoring policies to ensure financial reimbursements submitted are accurate, allowable, and supported. A copy of the policy is available and will be provided upon request. The policies were approved by the Council on December 6, 2019; however, Council staff has been adhering to the policies since September 2019.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-208

Special reports and performance reports required for the Crime Victim Assistance grant were not reviewed for accuracy, contained errors, and were submitted after the due date.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department implement, strengthen, and document internal controls to ensure compliance with federal grant reporting requirements.

Management's View: The Council concurs with the finding. The Council has developed policies and procedures to ensure that data is reviewed for accuracy and submitted timely. The policy and procedures are available and will be provided upon request. The policy was approved December 6, 2019. Due to Council staff shortages, the policy will be effective at the next VOCA quarterly due date (April 15, 2020) however, the Council employees will retroactively review and approve data submitted for FY2020.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-209

The Bureau of Facility Standards within the Department of Health and Welfare (Department) failed to complete health and safety surveys of long-term care facilities in a timely manner to ensure compliance with the Medicaid program.

Type of Finding: Noncompliance

Recommendation: We recommend that the Department ensure that provider health and safety surveys are completed in 15-month timeframe required by the Uniform Guidance 42 CFR 448.308(a) and the Idaho State Medicaid Plan.

Management's View: The Department agrees with this finding. As indicated in the legislative auditor's comments about the cause of this finding, the Bureau of Facility Standards within the Department's Licensing and Certification Division attempts to ensure all facilities are surveyed within a period of time ranging from 12 to 15 months from the previous survey. There are times, however, that limited resources combined with the necessity to prioritize unexpected follow-up surveys or complaint investigations can occasionally result in surveys being completed beyond the date anticipated to maintain compliance.

We have taken several steps to improve performance in this area. The goal of the steps we have taken is to find alternative ways to get report review and other survey-related activities accomplished so we free as much surveyor time as possible to concentrate on conducting the on-site surveys.

- The Department maintains a contract with Healthcare Management Solutions to provide Survey Minimum Qualifications Tested (SMQT) survey staff to help supplement the bureau's survey teams with contracted surveyors. The Centers for Medicare and Medicaid Services (CMS) requires that all staff conducting federal certification surveys on behalf of CMS are SMQT-qualified. SMQT consists of courses and a test that surveyors must pass in order to survey on behalf of CMS.
- We hired a part-time supervisor who is assisting with the review of survey reports and providing additional help to the Long-Term Care (LTC) Supervisors.
- We continue to work with staff and, with the assistance of CMS Seattle survey staff, are exploring methods to improve efficiency on survey with the hope of completing surveys in less time without compromising the quality of the survey.
- We hired a part-time, former LTC supervisor, with extensive experience, assisting with Plan of Correction review and the performance of phone/mail follow-ups to free SMQT qualified survey staff to survey.
- We hired two part-time RNs to handle the Certified Nurse Aid abuse case work to free SMQT qualified survey staff to survey.
- We are cross training two surveyors from another program to assist with complaint investigations and revisit surveys to help us complete regular recertification surveys on time when unexpected complaints or follow-up surveys occur.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-210

Two federal reimbursement requests were submitted for the Crime Victim Assistance program for a total of \$92,294 in excess of immediate cash needs as identified on the supporting documentation.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department implement or strengthen the cash draw control procedures to ensure that draws are accurate and compliant with federal requirements.

Management's View: The Department disagrees with this finding. The Department believes the internal controls established and maintained do provide reasonable assurance that the Department complies with federal award requirements. This is demonstrated by the fact that the errors referenced, were detected and corrected. Further, the Department disputes the questioned cost amount as the funds that were pre-drawn in error have already been returned. This is stated in the Condition above.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

IDAHO POTATO COMMISSION (COMMISSION)

Finding 2019-211

The Commission is not performing subrecipient risk assessments, monitoring subrecipient activities, or reviewing subrecipient audits as required for the Specialty Crop Block Grant program.

Type of Finding: Material Weakness, Noncompliance

Recommendation: We recommend that the Commission design and implement procedures to ensure compliance with pass-through entity requirements, including documenting risk assessment, obtaining required audits from subrecipients, and performing other required monitoring procedures.

Management's View: In reviewing the finding, Idaho Potato Commission agrees there is not a risk assessment, or monitoring of activities, or review of subrecipient audit reviews.

Idaho Potato Commission received a risk assessment report and questionnaire from Idaho State Department of Agriculture that we will be implementing at the start of each project prior to rewarding the grant. This will review the institutions size and complexity of the program, prior compliance and experience, their management systems, and single audits. At this time the terms and conditions of each individual grant will be discussed and have a written agreement signed between University of Idaho and Idaho Potato Commission. The Industry Relations Director will go through the forms with the University of Idaho researcher in person to get the answers. These forms and agreements will be placed in each grants file to be reviewed when needed.

We are implementing a procedure regarding the review process of the quarterly and annual reports and checks on the progress of the project. We will originally have it sent to the legal/finance assistant for review and finalized by the Industry Relations Director.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-212

The Commission does not have procedures in place to ensure that subrecipients are complying with the cost principles for federal awards for the Specialty Crop Block Grant program.

Type of Finding: Material Weakness

Recommendation: We recommend that the Commission design and implement procedures to detect and prevent reimbursement of unallowable costs.

Management's View: In reviewing the finding, we agree Idaho Potato Commission needs to strengthen the internal control in reviewing the expenditures to ensure that the costs are in compliance with the cost principles for federal awards in CFR 200.

To ensure this, the Legal/Finance Assistant will review each receipt along with the cost principles and terms and conditions for each grant. Any questions or concerns regarding any expenditures will be relayed back to University of Idaho for better explanations or corrections. After corrections, the backup and ledger will be further reviewed by the Industry Relations Director who will sign off on the agreement to send University of Idaho payment and finalized documents to Idaho State Department of Agriculture for reimbursement.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-213

The Commission does not have procedures in place to ensure that subrecipients are not suspended or debarred from participation in federal grants prior to entering into a subaward contract.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Commission design and implement procedures to ensure that subrecipients are checked for suspension or debarment prior to entering into a subaward contract.

Management's View: Idaho Potato Commission has reviewed the findings and agrees there is no documentation stating the Commission verified that the University of Idaho was not suspended or debarred prior to entering into a subaward contract.

Idaho Potato Commission will use the website SAM.gov for a printed document stating they are active and show the expiration date for the file. This will ensure compliance with the suspension and debarment.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

OFFICE OF SPECIES CONSERVATION (OFFICE)

Finding 2019-214

The Office of Species Conservation did not comply with State procurement guidelines or appropriation laws by paying subgrantee vendors \$681,043 directly on behalf of another State agency during fiscal years 2018 and 2019.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Office discontinue making payments on behalf of their subgrantees for which they have not contracted with the vendor nor monitored the contract for compliance with the grant agreement as a way to circumvent appropriation limitations. We further recommend that the Office implement policies to ensure compliance with State procurement requirements.

Management's View: In order to ensure that OSC "discontinue[s] making payments on behalf of their subgrantees for which they have not contracted with the vendor nor monitored the contract for compliance", OSC will establish communications and processes that comply with 2 CFR 200.303, 317, 318, and Idaho Code Sections 67-3516(1), 67-5711 C.

OSC will ensure adequate training in State procurement practices, Internal Controls, and Uniform Guidance under 2 CFR 200 related to the management of grant pass through funds is provided to all relevant staff.

OSC will continue to evaluate all payment requests to ensure adherence to State procurement policies and Federal Uniform Guidance as noted in the codes listed above. This process is currently being done through an internal control process which requires oversight by the Financial Officer and Administrator, with Legal Counsel guidance as needed, into any requests from other agencies and vendors. OSC will neither process nor pay for any invoices that are outside the scope of its own contracts.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-215

Required procedures for ensuring the Office does not enter into a covered transaction with a suspended or debarred subrecipient or vendor were not documented sufficiently to demonstrate compliance for a portion of the fiscal year.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: A corrective action plan has already been implemented by the Office. We recommend that the Office continue to follow new procedures to ensure sufficient documentation is maintained to comply with suspension and debarment requirements.

Management's View: In March 2019, OSC implemented a SAM status check through www.sam.gov for each subrecipient. The status and expiration date are recorded in a spreadsheet and timestamped PDFs to document these actions are saved to a DUNS folder. While a SAM status check was done in the past, saving a timestamped PDF is a confirmation of this practice and provides documentation of the timing of the check.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

IDAHO TRANSPORTATION DEPARTMENT (DEPARTMENT)

Finding 2019-216

Internal control procedures are not designed or implemented effectively to ensure compliance with the suspension and debarment requirements of the Federal Highway Administration (FHWA) Research and Development (R&D) grant.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department strengthen internal controls over suspension and debarment by implementing control policies and procedures to verify that vendors are eligible to enter into agreements with the Department and that they are not suspended or debarred prior to entering into covered transactions.

Management's View: The Idaho Transportation Department (ITD) concurs with the audit finding and recommendation. ITD has updated the Research Program Manual to include both the policy and procedure to ensure that all Research & Development grants are checked against the federal database "System for Awards Management" (SAM). This information will be retained in the contract file for that entity in ProjectWise.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

IDAHO DEPARTMENT OF WATER RESOURCES (DEPARTMENT)

Finding 2019-217

The Schedule of Expenditures of Federal Awards (SEFA) was understated by \$775,322 for the Pacific Coast Salmon Recovery grant.

Type of Finding: Significant Deficiency

Recommendation: We recommend that the Department work to obtain a better understanding of the reporting requirements for federal funds and establish policies and procedures to ensure federal dollars spent by the Department are accurately reported.

Management's View: Idaho Department of Water Resources (IDWR) received an update memo regarding this finding on March 9, 2020. After receiving the update memo, IDWR reviewed all open federal awards to verify all expenditures are recorded or tracked through spreadsheets and reconciled with the State Controller's Office (SCO) monthly reports. Prior to submitting the Schedule of Expenditures of Federal Awards (SEFA) IDWR's fiscal staff will create a memo requesting all federal award managers verify purchases that were made using federal funds.

Federal funds transferred to the Idaho Water Resource Board (IWRB) Revolving Development Fund will be tracked on the monthly IWRB balance sheets to ensure compliance with federal fund reporting requirements.

IDWR will include the understatement of \$775,322 in FY 2019 on the FY 2020 SEFA and include a note disclosing the misstatement on the FY 2019 SEFA.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

Finding 2019-218

Internal controls over the review of performance reports for the Pacific Coast Salmon Recovery grant are not sufficiently documented.

Type of Finding: Significant Deficiency

Recommendation: We recommend that the Department design and implement internal controls to improve the documentation of the review of performance reports.

Management's View: IDWR will implement the following processes as agency controls for reporting performance/progress for grant awards from the Pacific Coast Salmon Recovery Fund and for all federal awards:

- Award manager creates a draft version of the performance/progress report.
- Award manager emails the draft version to the manager's supervisor for review.
- Supervisor includes edits and offers comments on the draft version.
- Supervisor emails the draft version back to the award manager.
- Award manager incorporates edits and comments from supervisor.
- Award manager completes the performance report and sends it on to the awarding agency for review. Copy of email is sent to supervisor.

- Award manager notifies their supervisor that the awarding agency has reviewed and accepted the performance report.

This review process will be implemented for all federal awards requiring performance/progress reports submitted to the awarding agency.

Status: Uncorrected

Next Scheduled Review: The status of this finding and completion of corrective action taken by the Department will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020, with a planned issuance date in spring 2021.

2018 SINGLE AUDIT REPORT UNCORRECTED FINDINGS

IDAHO DEPARTMENT OF FISH AND GAME (DEPARTMENT)

Finding 2018-204

Deficiencies in internal control allowed errors to go undetected in the performance reports submitted for the Pacific Coast Salmon Recovery program.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department strengthen the design and effectiveness of controls over performance reporting to ensure compliance with those requirements. We further recommend that the Department retain documentation to provide evidence that a review was completed prior to submitting the performance reports to the grantor.

Management's Views (Corrective Action Plan): In reviewing this finding, the Department believes that the financial data submitted on the final financial billings was accurate; but, we also agree that it did differ from the financial data that was submitted on the final performance reports.

The Department is reviewing our performance reporting process and procedures to determine how best to eliminate discrepancies and resolve any issues between our final performance reports and our final financial billings that are submitted to the Office of Species Conservation (Office). We will also be implementing a procedure to ensure that we capture and retain documentation supporting our review process for the performance reports submitted to the Office.

Status: Partially Corrected

The Department's progress completing corrective action for this finding was reviewed as part of the fiscal year 2019 Single Audit Report. The Summary Schedule of Prior Audit Findings provided by the Office of the State Controller reported the status of this finding.

Corrective Action Taken in Fiscal Year 2019: The Department reviewed their performance reporting process and procedures for reporting on the Pacific Coast Salmon Recovery program to the Office of Species Conservation (OSC). They have settled on a final process that is designed to verify that the financial data on the performance report matches the financial data on the associated financial report.

Reason for Recurrence in Fiscal Year 2019 as Reported by Management: Since we have not closed this grant since the finding was issued, we have listed the finding as partially corrected.

Next Scheduled Review: This finding will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020. Expected issuance of this report is spring 2021.

2017 SINGLE AUDIT REPORT UNCORRECTED FINDINGS

IDAHO TRANSPORTATION DEPARTMENT (DEPARTMENT)

Finding 2017-211

Internal control policies and procedures did not ensure compliance with the suspension and debarment requirements of the Highway Planning and Construction program.

Type of Finding: Significant Deficiency, Noncompliance

Recommendation: We recommend that the Department reinforce its existing control policies and procedures to ensure they are performed consistently for all contracts and agreements required by the FHWA to reduce the risk of entering into a covered transaction with a suspended or debarred vendor.

Management's View: ITD's Contracting Services section is responsible for advertising and awarding the majority of the federal-aid construction contracts for ITD, LHTAC, and ACHD. Prior to award of a federal-aid contract, Contracting Services will verify compliance with suspension and debarment requirements and will document this verification on the Contract Award Checklist. Part of this verification will be to utilize the System for Award Management (SAM) Exclusions as recommended by the audit.

As mentioned previously for Item 1, each federal-aid contract includes the FHWA-1273, Section X. Certification Regarding Debarment. Suspension. Ineligibility and Voluntary Exclusion. By signing and submitting a proposal, the contractor certifies that they are not presently debarred, suspended, or proposed for debarment and that they will include this same clause in contracts with subcontractors (lower tiered participants).

As an added precaution, at the award of each contract, Contracting Services staff will post the Contract Award Checklist, including the date reviewed in the Contracts and Plans folder in Project Wise.

In some cases LHTAC, ACHD, Cities, Counties, Highway Districts, or ITD's Business and Supply Management (BSM) section may also award federal-aid construction contracts independently of ITD's Contracting Services section. Through Stewardship & Oversight Agreements, State/Local Agreements, and other applicable ITD procedure manuals. ITD will require that federal-aid contracts include the FHWA-1273 provisions and that the SAM website be checked prior to award of the contract.

Status: Partially Corrected

The Department's progress completing corrective action for this finding was reviewed as part of the fiscal year 2018 and 2019 Single Audit Reports. The Summary Schedule of Prior Audit Findings provided by the Office of the State Controller reported the status of this finding in each of those reports.

Corrective Action Taken in Fiscal Year 2018: ITD's Contracting Services section is responsible for advertising and awarding the majority of the federal-aid construction contracts for ITD, LHTAC, and ACHD. Prior to award of a federal-aid contract, Contracting Services will verify compliance with

suspension and debarment requirements and will document this verification on the Contract Award Checklist. Part of this verification will be to utilize the System for Award Management (SAM) Exclusions as recommended by the audit.

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Reason for Recurrence in Fiscal Year 2018 as Reported by Management: This finding was addressed in May 2018, the end of State fiscal year. Due to the timing, the finding would not have been fully corrected for State Fiscal Year 2018.

Corrective Action Taken in Fiscal Year 2019: ITD's Contracting Services section is responsible for advertising and awarding the majority of the federal-aid construction contracts for ITD, LHTAC, and ACHD. Prior to award of a federal-aid contract, Contracting Services will verify compliance with suspension and debarment requirements and will document this verification on the Contract Award Checklist. Part of this verification will be to utilize the System for Award Management (SAM) Exclusions as recommended by the audit.

As mentioned previously for Item 1, each federal-aid contract includes the FHWA-1273, Section X. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion. By signing and submitting a proposal, the contractor certifies that they are not presently debarred, suspended, or proposed for debarment and that they will include this same clause in contracts with subcontractors (lower tiered participants).

As an added precaution, at the award of each contract, Contracting Services staff will post the Contract Award Checklist, including the date reviewed in the Contracts and Plans folder in Project Wise.

In some cases LHTAC, ACHD, Cities, Counties, Highway Districts, or ITD's Business and Supply Management (BSM) section may also award federal-aid construction contracts independently of ITD's Contracting Services section. Through Stewardship & Oversight Agreements, State/Local Agreements, and other applicable ITD procedure manuals, ITD will require that federal-aid contracts include the FHWA-1273 provisions and that the SAM website be checked prior to award of the contract. ITD's intent is that within 90 days, these will be working as reported.

Reason for Recurrence in Fiscal Year 2019 as Reported by Management: Corrective actions were implemented in May 2018. Due to the timing, there were likely FY18 contracts that did not utilize the new policies and procedures implemented near the end of the fiscal year.

Next Scheduled Review: This finding will be included in the Single Audit Report, Summary Schedule of Prior Audit Findings for the fiscal year ended June 30, 2020. Expected issuance of this report is spring 2021.