CLARK SCHAEFER HACKETT
BUSINESS ADVISORS

GREENE COUNTY COMBINED HEALTH DISTRICT
GREENE COUNTY

SINGLE AUDIT

FOR THE YEAR ENDED DECEMBER 31, 2024

OHIO AUDITOR OF STATE
KEITH FABER

65 East State Street
Columbus, Ohio 43215
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800-282-0370

Board of Health
Greene County Combined Health District
360 Wilson Drive
Xenia, Ohio 45385

We have reviewed the *Independent Auditors' Report* of the Greene County Combined Health District, prepared by Clark, Schaefer, Hackett & Co., for the audit period January 1, 2024 through December 31, 2024. Based upon this review, we have accepted these reports in lieu of the audit required by Section 117.11, Revised Code. The Auditor of State did not audit the accompanying financial statements and, accordingly, we are unable to express, and do not express an opinion on them.

Our review was made in reference to the applicable sections of legislative criteria, as reflected by the Ohio Constitution, and the Revised Code, policies, procedures and guidelines of the Auditor of State, regulations and grant requirements. The Greene County Combined Health District is responsible for compliance with these laws and regulations.

KEITH FABER
Ohio Auditor of State

Tiffany L Ridenbaugh

Tiffany L Ridenbaugh, CPA, CFE, CGFM
Chief Deputy Auditor

July 15, 2025

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CLARK SCHAEFER HACKETT
BUSINESS ADVISORS

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INDEPENDENT AUDITORS' REPORT

Greene County Combined Health District
Board of Health
360 Wilson Drive
Xenia, Ohio 45385

Report on the Audit of the Financial Statements

Opinions
We have audited the cash basis financial statements of the governmental activities, each major fund and the aggregate remaining fund information of the Greene County Combined Health District (the "Health District"), as of and for the year ended December 31, 2024, and related notes to the financial statements, which collectively comprise the Health District's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective cash basis financial position of the governmental activities, each major fund, and the aggregate remaining fund information of the Health District, as of December 31, 2024, and the respective changes in cash-basis financial position and the respective budgetary comparison for the General, Clinical Health Services and Environmental Health funds for the year then ended in accordance with the cash-basis of accounting described in Note 2.

Basis for Opinions
We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*). Our responsibilities under those standards are further described in the *Auditors' Responsibilities for the Audit of the Financial Statements* section of our report. We are required to be independent of the Health District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Emphasis of Matter - Accounting Basis
We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinions are not modified with respect to this matter.

Responsibilities of Management for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with the cash basis of accounting described in Note 2, and for determining that the cash basis of accounting is an acceptable basis for preparation of the financial statements in the circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we

- exercise professional judgment and maintain professional skepticism throughout the audit.

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health District's internal control. Accordingly, no such opinion is expressed.

- evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplementary Information
Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the Health District's basic financial statements. The Schedule of Expenditures of Federal Awards as required by *Title 2 U.S. Code of Federal Regulations Part 200*, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for the purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Schedule of Expenditures of Federal Awards is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole on the basis of accounting described in Note 2.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 15, 2025, on our consideration of the Health District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Health District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health District's internal control over financial reporting and compliance.

Clark, Schaefer, Hackett & Co.

Springfield, Ohio
May 15, 2025

Greene County Combined Health District
Greene County
Statement of Net Position - Cash Basis
For the Year Ended December 31, 2024

	Governmental Activities
Assets	
Equity in Pooled Cash and Cash Equivalents	$ 12,587,020
Net Position	
Restricted for:	
Public Health Grants and Services	1,419,647
Unrestricted	11,167,373
Total Net Position	$ 12,587,020

See accompanying notes to the basic financial statements.

Greene County Combined Health District
Greene County
Statement of Activities - Cash Basis
For the Year Ended December 31, 2024

	Cash Disbursements	Program Cash Receipts: Charges for Services and Sales	Program Cash Receipts: Operating Grants and Contributions	Net (Disbursements) Receipts and Changes in Net Position: Governmental Activities
Governmental Activities				
Current:				
Public Health Services	$ 6,971,852	$ 1,769,689	$ 2,902,853	$ (2,299,310)
Capital Outlay	204,739	-	-	(204,739)
Total Governmental Activities	$ 7,176,591	$ 1,769,689	$ 2,902,853	(2,504,049)
General Receipts:				
Property Taxes Levied for General Purposes				3,135,091
Grants/Entitlements not Restricted to Specific Programs				843,987
Rental Income				46,176
Miscellaneous				73,096
Total General Receipts				4,098,350
Change in Net Position				1,594,301
Net Position Beginning of Year				10,992,719
Net Position End of Year				$ 12,587,020

See accompanying notes to the basic financial statements.

Greene County Combined Health District
Greene County
Statement of Assets and Fund Balances - Cash Basis
Governmental Funds
For the Year Ended December 31, 2024

	General Fund	Clinical Health Services Fund	Environmental Health Fund	Nonmajor Governmental Funds	Total Governmental Funds
Assets					
Equity in Pooled Cash and Cash Equivalents	$ 5,663,794	$ 2,651,664	$ 1,763,479	$ 2,508,083	$ 12,587,020
Fund Balances					
Restricted	$ -	$ -	$ -	$ 1,419,647	$ 1,419,647
Committed	-	2,651,664	1,763,479	1,088,436	5,503,579
Assigned	63,758	-	-	-	63,758
Unassigned	5,600,036	-	-	-	5,600,036
Total Fund Balances	$ 5,663,794	$ 2,651,664	$ 1,763,479	$ 2,508,083	$ 12,587,020

See accompanying notes to the basic financial statements.

Greene County Combined Health District
Greene County
Statement of Receipts, Disbursements and Changes in Fund Balances - Cash Basis
For the Year Ended December 31, 2024

	General Fund	Clinical Health Services Fund	*(Formerly nonmajor)* Environmental Health Fund	*(Formerly major)* Building Fund	Nonmajor Governmental Funds	Total Governmental Funds
Cash Receipts						
Property Taxes	$ 3,135,091	$ -	$ -		$ -	$ 3,135,091
Charges for Services	443,072	-	-		6,401	449,473
Fines, Licenses and Permits	-	-	26,046		1,294,170	1,320,216
Intergovernmental:						
Apportionments	346,603	-	-		-	346,603
Grants	464,244	1,339,868	19,478		1,543,011	3,366,601
Other	33,140	191	-		305	33,636
Rental Income/ Receipts	8,396	-	-		37,780	46,176
Reimbursements	41,855	20,040	-		2,500	64,395
Miscellaneous	2,182	-	-		6,519	8,701
Total Cash Receipts	4,474,583	1,360,099	45,524		2,890,686	8,770,892
Cash Disbursements						
Current:						
Health:						
Personal Services	1,555,816	1,102,704	387,528		2,326,252	5,372,300
Materials & Supplies	142,105	119,528	5,492		67,527	334,652
Contractual Services	300,528	58,937	5,440		77,309	442,214
Other	258,692	143,287	4,914		72,336	479,229
Remittance to State	123,079	-	-		220,378	343,457
Capital Outlay	69,665	-	7,948		127,126	204,739
Total Cash Disbursements	2,449,885	1,424,456	411,322		2,890,928	7,176,591
Excess of Receipts Over (Under) Disbursements	2,024,698	(64,357)	(365,798)		(242)	1,594,301
Other Financing Sources (Uses)						
Transfers In	-	1,650,865	2,044,532		1,000,000	4,695,397
Transfers Out	(4,695,397)	-	-		-	(4,695,397)
Total Other Financing Sources (Uses)	(4,695,397)	1,650,865	2,044,532		1,000,000	-
Net Change in Fund Cash Balances	(2,670,699)	1,586,508	1,678,734		999,758	1,594,301
Fund Balance Beginning of Year, As Previously Reported	8,334,493	1,065,156	-	50,656	1,542,414	10,992,719
Adjustment - change in major funds	-	-	84,745	(50,656)	(34,089)	-
Fund Balances Beginning of Year, As Adjusted	8,334,493	1,065,156	84,745		1,508,325	10,992,719
Fund Balances End of Year	$ 5,663,794	$ 2,651,664	$ 1,763,479		$ 2,508,083	$ 12,587,020

See accompanying notes to the basic financial statements.

Greene County Combined Health District
Greene County
Statement of Receipts, Disbursements and Changes
In Fund Balance - Budget and Actual - Budget Basis
General Fund
For the Year Ended December 31, 2024

	Budgeted Amounts			Variance with Final Budget Positive
	Original	Final	Actual	(Negative)
Receipts				
Property Taxes	$ 3,002,900	$ 3,002,900	$ 3,135,091	$ 132,191
Charges for Services	473,000	473,000	443,072	(29,928)
Intergovernmental:				
Apportionments	354,000	354,000	346,603	(7,397)
Grants	396,000	396,000	464,244	68,244
Other	121,970	121,970	33,140	(88,830)
Rental Income/ Receipts	-	-	8,396	8,396
Reimbursements	75,000	75,000	41,855	(33,145)
Miscellaneous	166,000	166,000	2,182	(163,818)
Total Receipts	4,588,870	4,588,870	4,474,583	(114,287)
Disbursements				
Current:				
Health:				
Personal Services	1,559,228	1,578,845	1,555,816	23,029
Materials & Supplies	104,007	164,811	151,916	12,895
Contractual Services	232,910	351,001	322,543	28,458
Other	248,756	287,743	271,048	16,695
Remittance to State	158,582	164,731	142,655	22,076
Capital Outlay	47,500	76,635	69,665	6,970
Total Disbursements	2,350,983	2,623,766	2,513,643	110,123
Excess of Receipts Over (Under) Disbursements	2,237,887	1,965,104	1,960,940	(4,164)
Other Financing Uses				
Transfers Out	(460,309)	(4,695,397)	(4,695,397)	-
Total Other Financing Uses	(460,309)	(4,695,397)	(4,695,397)	-
Net Change in Fund Balance	1,777,578	(2,730,293)	(2,734,457)	(4,164)
Unencumbered Fund Balance Beginning of Year	8,269,788	8,269,788	8,269,788	-
Prior Year Encumbrances Appropriated	64,705	64,705	64,705	-
Unencumbered Fund Balance End of Year	$ 10,112,071	$ 5,604,200	$ 5,600,036	$ (4,164)

See accompanying notes to the basic financial statements.

Greene County Combined Health District
Greene County
Statement of Receipts, Disbursements and Changes
In Fund Balance - Budget and Actual - Budget Basis
Clinical Health Services Fund
For the Year Ended December 31, 2024

	Budgeted Amounts			Variance with Final Budget Positive (Negative)
	Original	Final	Actual	
Receipts				
Intergovernmental:				
Grants	$ 1,004,000	$ 1,004,000	$ 1,339,868	$ 335,868
Other	55,000	55,000	191	(54,809)
Reimbursements	-	-	20,040	20,040
Total Receipts	1,059,000	1,059,000	1,360,099	301,099
Disbursements				
Current:				
Health:				
Personal Services	1,116,118	1,143,834	1,102,704	41,130
Materials & Supplies	87,091	124,696	120,959	3,737
Contractual Services	52,854	63,868	60,181	3,687
Other	70,105	150,369	145,801	4,568
Capital Outlay	5,000	500	-	500
Total Disbursements	1,331,168	1,483,267	1,429,645	53,622
Excess of Receipts Over (Under) Disbursements	(272,168)	(424,267)	(69,546)	354,721
Other Financing Sources				
Transfers In	-	-	1,650,865	1,650,865
Total Other Financing Sources	-	-	1,650,865	1,650,865
Net Change in Fund Balance	(272,168)	(424,267)	1,581,319	2,005,586
Unencumbered Fund Balance Beginning of Year	1,030,186	1,030,186	1,030,186	-
Prior Year Encumbrances Appropriated	34,970	34,970	34,970	-
Unencumbered Fund Balance End of Year	$ 792,988	$ 640,889	$ 2,646,475	$ 2,005,586

See accompanying notes to the basic financial statements.

Greene County Combined Health District
Greene County
Statement of Receipts, Disbursements and Changes
In Fund Balance - Budget and Actual - Budget Basis
Environmental Health Fund
For the Year Ended December 31, 2024

	Budgeted Amounts			Variance with Final Budget Positive
	Original	Final	Actual	(Negative)
Receipts				
Fines, Licenses and Permits	$ 20,000	$ 20,000	$ 26,046	$ 6,046
Intergovernmental:				
Grants	11,000	11,000	19,478	8,478
Total Receipts	31,000	31,000	45,524	14,524
Disbursements				
Current:				
Health:				
Personal Services	396,291	400,731	387,529	13,202
Materials & Supplies	4,233	8,944	5,759	3,185
Contractual Services	2,559	6,173	5,581	592
Other	2,150	6,473	5,032	1,441
Capital Outlay	-	78,764	31,441	47,323
Total Disbursements	405,233	501,085	435,342	65,743
Excess of Receipts Over (Under) Disbursements	(374,233)	(470,085)	(389,818)	80,267
Other Financing Sources				
Transfers In	475,309	475,309	2,044,532	1,569,223
Total Other Financing Sources	475,309	475,309	2,044,532	1,569,223
Net Change in Fund Balance	101,076	5,224	1,654,714	1,649,490
Unencumbered Fund Balance Beginning of Year	84,528	84,528	84,528	-
Prior Year Encumbrances Appropriated	217	217	217	-
Unencumbered Fund Balance End of Year	$ 185,821	$ 89,969	$ 1,739,459	$ 1,649,490

See accompanying notes to the basic financial statements.

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Note 1 – Reporting Entity

The Greene County Combined Health District (the "Health District"), is a body corporate and politic established to exercise the rights and privileges conveyed to it by the constitution and laws of the State of Ohio. A thirteen-member Board of Health governs the Health District. The Board appoints a health commissioner and all employees of the Health District.

The reporting entity is composed of the primary government, component units, and other organizations that are included to ensure the financial statements of the Health District are not misleading.

Primary Government

The primary government consists of all funds, departments, boards and agencies that are not legally separate from the Health District. The Health District's services include communicable disease investigations, immunization clinics, inspections, public health nursing services, the issuance of health-related licenses and permits, and emergency response planning.

The Health District's management believes these financial statements present all activities for which the Health District is financially accountable.

Note 2 – Summary of Significant Accounting Policies

As discussed further in the "Basis of Accounting" section of this note, these financial statements are presented on a cash basis of accounting. This cash basis of accounting differs from accounting principles generally accepted in the United States of America (GAAP). Generally accepted accounting principles include all relevant Governmental Accounting Standards Board (GASB) pronouncements, which have been applied to the extent they are applicable to the cash basis of accounting. Following are the more significant of the Health District's accounting policies.

Basis of Presentation

The Health District's basic financial statements consist of government-wide financial statements, including a statement of net position and a statement of activities, and fund financial statements which provide a more detailed level of financial information.

Government-Wide Financial Statements - The statement of net position and the statement of activities display information about the Health District as a whole. These statements include the financial activities of the primary government. The statements distinguish between those activities of the Health District that are governmental in nature and those that are considered business-type activities. Governmental activities generally are financed through taxes, intergovernmental receipts or other nonexchange transactions. Business-type activities are financed in whole or in part by fees charged to external parties for goods or services. The Health District has no business-type activities.

The statement of net position presents the cash balance of the governmental activities of the Health District at year end. The statement of activities compares disbursements and program receipts for each program or function of the Health District's governmental activities. Disbursements are reported by function. A function is a group of related activities designed to accomplish a major service or regulatory program for which the Health District is responsible. Program receipts include charges paid by the recipient of the goods or services offered by the program, grants and contributions that are restricted to meeting the operational or capital requirements of a particular program, and receipts of interest earned on grants that are required to be used to support a particular program. Receipts which are not classified as program receipts are presented as general receipts of the Health District, with certain limited exceptions.

Note 2 – Summary of Significant Accounting Policies - (Continued)

The comparison of direct disbursements with program receipts identifies the extent to which each governmental program is self-financing on a cash basis or draws from the general receipts of the Health District.

Fund Financial Statements - During the year, the Health District segregates transactions related to certain Health District functions or activities in separate funds in order to aid financial management and to demonstrate legal compliance. Fund financial statements are designed to present financial information of the Health District at this more detailed level. The focus of governmental fund financial statements is on major funds. Each major fund is presented in a separate column. Nonmajor funds are aggregated and presented in a single column.

Fund Accounting

The Health District uses funds to maintain its financial records during the year. A fund is defined as a fiscal and accounting entity with a self-balancing set of accounts. The Health District does not have any proprietary or fiduciary funds.

Governmental Funds - Governmental funds are those through which most governmental functions of the Health District are financed. The following are the Health District's major governmental funds:

> ***General*** - The general fund accounts for and reports all financial resources not accounted for and reported in another fund. The general fund balance is available to the Health District for any purpose provided it is expended or transferred according to the general laws of Ohio.
>
> ***Clinic Health Services*** - The Clinic Health Services fund is used to account for revenue received and expended for the following activities: children with Medical Handicaps (CMH), health supervision, health education, communicable disease program and other population-based programs.
>
> ***Environmental Health*** - The Environmental Health fund is used to account for revenue received and expended on activities that prevent or reduce the risks from environmental hazards like the following: prevent disease or injury associated with food, water, sewage, plumbing, animals, vectors, and infectious and solid waste.

The other governmental funds of the Health District account for and report grants and other resources whose use is restricted, committed or assigned to a particular purpose.

For 2024, the Health District's Environmental Health fund presentation was adjusted from non-major to major due to meeting the qualitative threshold for a major fund. The Health District's Building fund presentation was adjusted from major to non-major due to no longer meeting the qualitative threshold for a major fund. These changes are separately displayed in the financial statements.

Basis of Accounting

The Health District's financial statements are prepared using the cash basis of accounting. Receipts are recorded in the Health District's financial records and reported in the financial statements when cash is received rather than when earned and disbursements are recorded when cash is paid rather than when a liability is incurred.

Note 2 – Summary of Significant Accounting Policies - (Continued)

As a result of the use of this cash basis of accounting, certain assets and their related revenues (such as accounts receivable and revenue for billed or provided services not yet collected) and certain liabilities and their related expenses (such as accounts payable and expenses for goods or services received but not yet paid, and accrued expenses and liabilities) are not recorded in these financial statements.

Budgetary Process

All funds are legally required to be budgeted and appropriated. The major documents prepared are the tax budget, the certificate of estimated resources, and the appropriations resolution, all of which are prepared on the budgetary basis of accounting. The tax budget demonstrates a need for existing or increased tax rates. The certificate of estimated resources establishes a limit on the amount the Board of Health may appropriate. The appropriations resolution is the Board of Health's authorization to spend resources and sets annual limits on disbursements plus encumbrances at the level of control selected by the Board of Health. The legal level of control has been established by the Board of Health at the fund, department, and object level for all funds.

ORC Section 5705.28(C)(1) requires the Health District to file an estimate of contemplated revenue and expenses with the municipalities and townships within the Health District by about June 1 (forty-five days prior to July 15). The County Auditor cannot allocate property taxes from the municipalities and townships within the Health District if the filing has not been made.

ORC Section 3709.28 establishes budgetary requirements for the Health District, which are similar to ORC Chapter 5705 budgetary requirements. On or about the first Monday of April, the Health District must adopt an itemized appropriation measure. The appropriation measure, together with an itemized estimate of revenues to be collected during the next fiscal year, shall be certified to the county budget commission. Subject to estimated resources, the Board of Health may, by resolution, transfer appropriations from one appropriation item to another, reduce or increase any item, create new items, and make additional appropriations or reduce the total appropriation. Such appropriation modifications shall be certified to the county budget commission for approval.

The amounts reported as the original budgeted amounts on the budgetary statements reflect the amounts on the certificate of estimated resources in effect when the original appropriations were adopted. The amounts reported as the final budgeted amounts on the budgetary statements reflect the amounts on the amended certificate of estimated resources in effect at the time final appropriations were passed by the Board of Health.

The appropriations resolution is subject to amendment throughout the year with the restriction that appropriations cannot exceed estimated resources. The amounts reported as the original budget reflect the first appropriation resolution that covered the entire year, including amounts automatically carried forward from prior years. The amount reported as the final budgeted amounts represents the final appropriations passed by the Board of Health during the year.

Cash and Investments

The County Treasurer is the custodian for the Health District's cash and investments. The County's cash and investment pool holds the Health District's cash and investments, which are reported at the County Treasurer's carrying amount. Deposits and investments disclosures for the County as a whole may be obtained from the County by contacting the Greene County Auditor, 69 Greene Street, Xenia, Ohio 45385 or (937) 562- 5065.

Note 2 – Summary of Significant Accounting Policies - (Continued)

Inventory and Prepaid Items

The Health District reports disbursements for inventory and prepaid items when paid. These items are not reflected as assets in the accompanying financial statements.

Capital Assets

Acquisitions of property, plant and equipment are recorded as disbursements when paid. These items are not reflected as assets in the accompanying financial statements.

Accumulated Leave

For 2024, GASB Statement No. 101, *Compensated Absences,* was effective. GASB 101 defines a compensated absence as leave for which employees may receive cash payments when the leave is used for time off or receive cash payments for unused leave upon termination of employment. These payments could occur during employment or upon termination of employment. Compensated absences generally do not have a set payment schedule.

Health District employees earn sick, personal, and vacation time that can be used for time off. In certain circumstances, such as upon leaving employment or retirement, employees are entitled to cash payments for unused leave.

This GASB pronouncement had no effect on beginning net position/fund balance as unpaid leave is not reflected as a liability under the Health District's cash basis of accounting.

Employer Contributions to Cost-Sharing Pension Plans

The Health District recognizes the disbursement for employer contributions to cost-sharing pension plans when they are paid. As described in Notes 8 and 9, the employer contributions include portions for pension benefits and for other postemployment benefits (OPEB).

Long-Term Obligations

The Health District's cash basis financial statements do not report liabilities for long-term obligations. Proceeds of debt are reported when cash is received and principal and interest payments are reported when paid. Since recording a capital asset (including the intangible right to use) when entering into a lease, SBITAs, or financed purchase transaction is not the result of a cash transaction, neither an other financing source nor a capital outlay expenditure is reported at inception. Lease payments, SBITA payments, and financed purchase payments are reported when paid.

Leases and SBITAs

The Health District is the lessee (as defined by GASB 87) in various leases related to equipment under noncancelable leases. Lease receivables/payables are not reflected under the Health District's cash basis of accounting. Lease revenue/disbursements are recognized when they are received/paid.

The Health District has entered into noncancelable Subscription-Based Information Technology Arrangements (SBITA) contracts (as defined by GASB 96) for several types of software including contracts related to financial systems, data storage, and various other software. Subscription assets/liabilities are not reflected under the Health District's cash basis of accounting. Subscription disbursements are recognized when they are paid.

Note 2 – Summary of Significant Accounting Policies - (Continued)

Net Position

Net position is reported as restricted when there are limitations imposed on their use through external restrictions imposed by creditors, grantors, or laws or regulations of other governments. The Health District's policy is to first apply restricted resources when an expense is incurred for purposes for which both restricted and unrestricted resources are available.

Fund Balance

Fund balance is divided into five classifications based primarily on the extent to which the Health District is bound to observe constraints imposed upon the use of the resources in the governmental funds. The classifications are as follows:

Nonspendable - The nonspendable fund balance category includes amounts that cannot be spent because they are not in spendable form, or are legally or contractually required to be maintained intact. The "not in spendable form" criterion includes items that are not expected to be converted to cash. It also includes the long-term amount of interfund loans.

Restricted - Fund balance is reported as restricted when constraints placed on the use of resources are either externally imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments; or is imposed by law through constitutional provisions.

Committed - The committed fund balance classification includes amounts that can be used only for the specific purposes imposed by formal action (resolution) of the Board of Health. Those committed amounts cannot be used for any other purpose unless the Board of Health removes or changes the specified use by taking the same type of action (resolution) it employed to previously commit those amounts. Committed fund balance also incorporates contractual obligations to the extent that existing resources in the fund have been specifically committed for use in satisfying those contractual requirements.

Assigned - Amounts in the assigned fund balance classification are intended to be used by the Health District for specific purposes but do not meet the criteria to be classified as restricted or committed. In governmental funds other than the general fund, assigned fund balance represents the remaining amount that is not restricted or committed. In the general fund, assigned amounts represent intended uses established by the Board of Health or a Health District official delegated that authority by resolution, or by State Statute.

Unassigned - Unassigned fund balance is the residual classification for the general fund and includes amounts not contained in the other classifications. In other governmental funds, the unassigned classification is used only to report a deficit balance.

The Health District applies restricted resources first when expenditures are incurred for purposes for which either restricted or unrestricted (committed, assigned, and unassigned) amounts are available. Similarly, within unrestricted fund balance, committed amounts are reduced first followed by assigned, and then unassigned amounts when expenditures are incurred for purposes for which amounts in any of the unrestricted fund balance classifications could be used.

Note 2 – Summary of Significant Accounting Policies - (Continued)

Internal Activity

Internal allocations of overhead expenses from one function to another or within the same function are eliminated on the Statement of Activities. Payments for interfund services provided and used are not eliminated.

Exchange transactions between funds are reported as receipts in the seller funds and as disbursements in the purchaser funds. Subsidies from one fund to another without a requirement for repayment are reported as interfund transfers. Interfund transfers are reported as other financing sources/uses in governmental funds and after nonoperating receipts/disbursements in proprietary funds. Repayments from funds responsible for particular disbursements to the funds that initially paid for them are not presented in the financial statements.

New Accounting Pronouncements

For 2024, GASB Statement No. 100, *Accounting Changes and Error Corrections* was effective. The financial statement presentation was modified to reflect a change in the reporting entity. See the *Accumulated Leave* section of Note 2 for discussion of the implementation of GASB Statement No. 101, *Compensated Absences*.

Note 3 – Budgetary Basis of Accounting

The budgetary basis as provided by law is based upon accounting for certain transactions on the basis of cash receipts, disbursements, and encumbrances. The Statement of Receipts, Disbursements and Changes in Fund Balance – Budget and Actual – Budget Basis presented for the general fund and clinic health services fund are prepared on the budgetary basis to provide a meaningful comparison of actual results with the budget.

The difference(s) between the budgetary basis and the cash basis are as follows:

1. Outstanding year end encumbrances are treated as cash disbursements (budgetary basis) rather than as restricted, committed or assigned fund balance (cash basis).

Adjustments necessary to convert the results of operations at the end of the year on the budget basis to the cash basis are as follows:

	General Fund	Clinic Health Services Fund	Environmental Health Fund
Cash basis	$ (2,670,699)	$ 1,586,508	$ 1,678,734
Less: encumbrances	(63,758)	(5,189)	(24,020)
Budget-basis	$ (2,734,457)	$ 1,581,319	$ 1,654,714

Note 4 – Deposits and Investments

As required by the Ohio Revised Code, the Greene County Treasurer is custodian for the District's deposits. The County's deposit and investment pool holds the District's assets, valued at the Treasurer's reported carrying amount.

Note 5 - Taxes

Property Taxes

Property taxes include amounts levied against all real and public utility property located in the Health District. Property tax revenue received during 2024 for real and public utility property taxes represents collections of 2023 taxes.

2024 real property taxes are levied after October 1, 2024, on the assessed value as of January 1, 2024, the lien date. Assessed values are established by State law at 35 percent of appraised market value. 2024 real property taxes are collected in and intended to finance 2025.

Real property taxes are payable annually or semi-annually. If paid annually, payment is due December 31; if paid semi-annually, the first payment is due December 31, with the remainder payable by June 20. Under certain circumstances, State statute permits later payment dates to be established.

Public utility tangible personal property currently is assessed at varying percentages of true value; public utility real property is assessed at 35 percent of true value. 2024 public utility property taxes which became a lien December 31, 2023, are levied after October 1, 2024, and are collected in 2025 with real property taxes.

The full tax rate for all Health District operations for the year ended December 31, 2024, was $0.80 per $1,000 of assessed value. The assessed values of real property and public utility tangible property upon which 2024 property tax receipts were based are as follows:

	Tax Year 2023/ Collection Year 2024
Real property	$5,990,055,230
Public utility personal property	198,426,700
Total assessed valuation	$6,188,481,930

The County Treasurer collects property taxes on behalf of all taxing districts in the County, including the Health District. The County Auditor periodically remits to the Health District its portion of the taxes collected.

Note 6 – Transfers

During 2024, the following transfers were made:

Transfers from General Fund to:	
Clinical Health Services Fund	$ 1,650,865
Environmental Health Fund	2,044,532
Nonmajor Governmental Fund	1,000,000
Total	$ 4,695,397

The above mentioned Transfers From/To were used to move receipts from the fund that statute or budget requires to collect them to the fund that statute or budget requires to expend them; and to use unrestricted receipts collected in the General Fund to finance various programs accounted for in other funds in accordance with budgetary authorizations.

Note 7 – Risk Management

Risk Pool Membership

The Health District is exposed to various risks of property and casualty losses.

The Health District is a member of the Public Entities Pool of Ohio (The Pool). The Pool assumes the risk of loss up to the limits of the Health District's policy. The Pool covers the following risks:

- General liability and casualty
- Public official's liability
- Cyber
- Law enforcement liability
- Automobile liability
- Vehicles
- Property
- Equipment breakdown

The Pool reported the following summary of assets and actuarially-measured liabilities available to pay those liabilities as of December 31:

	2023 (latest available)
Cash and investments	$ 43,996,442
Actuarial liabilities	$ 19,743,401

Workers' Compensation coverage is provided by the State of Ohio. The Health District pays the State Workers' Compensation System a premium based on a rate per $100 of salaries. This rate is calculated based on accident history and administrative costs.

The Health District belongs to the Public Entities Pool of Ohio (PEP), a risk-sharing pool available to Ohio local governments. PEP provides property and casualty coverage for its members. York Insurance Services Group, Inc. (York) functions as the administrator of PEP and provides underwriting, claims, loss control, risk management, and reinsurance services for PEP. PEP is a member of the American Public Entity Excess Pool (APEEP), which is also administered by York. Member governments pay annual contributions to fund PEP. PEP pays judgments, settlements and other expenses resulting from covered claims that exceed the members' deductibles.

After one year of membership, a member may withdraw on the anniversary of the date of joining PEP, if the member notifies PEP in writing 60 days prior to the anniversary date. Upon withdrawal, members are eligible for a full or partial refund of their capital contributions, minus the subsequent year's contribution. Withdrawing members have no other future obligation to PEP. Also upon withdrawal, payments for all casualty claims and claim expenses become the sole responsibility of the withdrawing member, regardless of whether a claim occurred or was reported prior to the withdrawal

Note 8 – Defined Benefit Pension Plans

The Statewide retirement systems provide both pension benefits and other postemployment benefits (OPEB).

Plan Description – Ohio Public Employees Retirement System (OPERS)

Plan Description **–** Health District employees participate in the Ohio Public Employees Retirement System (OPERS). OPERS is a cost-sharing, multiple employer public employee retirement system which administers three separate pension plans. The traditional pension plan is a cost-sharing, multiple-employer defined benefit pension plan. The member-directed plan is a defined contribution plan and the combined plan is a combination cost-sharing, multiple-employer defined benefit/defined contribution pension plan. Effective January 1, 2022, new members may no longer select the Combined Plan, and current members may no longer make a plan change to this plan. Participating employers are divided into state, local, law enforcement and public safety divisions. While members in the state and local divisions may participate in all three plans, law enforcement and public safety divisions exist only within the traditional plan.

OPERS provides retirement, disability, survivor and death benefits, and annual cost of living adjustments to members of the traditional and combined plans. Authority to establish and amend benefits is provided by Chapter 145 of the Ohio Revised Code. OPERS issues a stand-alone financial report that includes financial statements, required supplementary information and detailed information about OPERS' fiduciary net position that may be obtained by visiting https://www.opers.org/financial/reports.shtml, by writing to the Ohio Public Employees Retirement System, 277 East Town Street, Columbus, Ohio 43215-4642, or by calling 800-222-7377.

Senate Bill (SB) 343 was enacted into law with an effective date of January 7, 2013. In the legislation, members in the traditional and combined plans were categorized into three groups with varying provisions of the law applicable to each group. The following table provides age and service requirements for retirement and the retirement formula applied to final average salary (FAS) for the three member groups under the traditional and combined plans as per the reduced benefits adopted by SB 343 (see OPERS Annual Comprehensive Financial Report referenced above for additional information, including requirements for reduced and unreduced benefits):

Group A Eligible to retire prior to January 7, 2013 or five years after January 7, 2013	**Group B** 20 years of service credit prior to January 7, 2013 or eligible to retire ten years after January 7, 2013	**Group C** Members not in other Groups and members hired on or after January 7, 2013
State and Local	**State and Local**	**State and Local**
Age and Service Requirements: Age 60 with 60 months of service credit or Age 55 with 25 years of service credit	**Age and Service Requirements:** Age 60 with 60 months of service credit or Age 55 with 25 years of service credit	**Age and Service Requirements:** Age 57 with 25 years of service credit or Age 62 with 5 years of service credit
Traditional Plan Formula: 2.2% of FAS multiplied by years of service for the first 30 years and 2.5% for service years in excess of 30	**Traditional Plan Formula:** 2.2% of FAS multiplied by years of service for the first 30 years and 2.5% for service years in excess of 30	**Traditional Plan Formula:** 2.2% of FAS multiplied by years of service for the first 35 years and 2.5% for service years in excess of 35
Combined Plan Formula: 1% of FAS multiplied by years of service for the first 30 years and 1.25% for service years in excess of 30	**Combined Plan Formula:** 1% of FAS multiplied by years of service for the first 30 years and 1.25% for service years in excess of 30	**Combined Plan Formula:** 1% of FAS multiplied by years of service for the first 35 years and 1.25% for service years in excess of 35

Note 8 – Defined Benefit Pension Plans – (Continued)

Traditional plan state and local members who retire before meeting the age-and-years of service credit requirement for unreduced benefits receive a percentage reduction in the benefit amount. The amount of a member's pension benefit vests at retirement.

Law enforcement and public safety members who retire before meeting the age-and-years of service credit requirement for unreduced benefits receive a percentage reduction in the benefit amount.

Combined plan members retiring before age 65 with less than 30 years of service credit receive a percentage reduction in benefit.

Final average Salary (FAS) represents the average of the three highest years of earnings over a member's career for Groups A and B. Group C is based on the average of the five highest years of earnings over a member's career.

When a traditional plan benefit recipient has received benefits for 12 months, the member is eligible for an annual cost of living adjustment (COLA). This COLA is calculated on the member's original base retirement benefit at the date of retirement and is not compounded. Members retiring under the combined plan receive a cost–of–living adjustment on the defined benefit portion of their pension benefit. For those who retired prior to January 7, 2013, the cost-of-living adjustment is 3 percent. For those retiring on or after January 7, 2013, beginning in calendar year 2019, the adjustment is based on the average percentage increase in the Consumer Price Index, capped at 3 percent.

Defined contribution plan benefits are established in the plan documents, which may be amended by the Board. Member-directed plan and combined plan members who have met the retirement eligibility requirements may apply for retirement benefits. The amount available for defined contribution benefits in the combined plan consists of the member's contributions plus or minus the investment gains or losses resulting from the member's investment selections. Combined plan members wishing to receive benefits must meet the requirements for both the defined benefit and defined contribution plans. Member-directed participants must have attained the age of 55, have money on deposit in the defined contribution plan and have terminated public service to apply for retirement benefits. The amount available for defined contribution benefits in the member-directed plan consists of the members' contributions, vested employer contributions and investment gains or losses resulting from the members' investment selections. Employer contributions and associated investment earnings vest over a five-year period, at a rate of 20 percent each year. At retirement, members may select one of several distribution options for payment of the vested balance in their individual OPERS accounts. Options include the annuitization of the benefit (which includes joint and survivor options and will continue to be administered by OPERS), partial lump-sum payments (subject to limitations), a rollover of the vested account balance to another financial institution, receipt of entire account balance, net of taxes withheld, or a combination of these options. When members choose to annuitize their defined contribution benefit, the annuitized portion of the benefit is reclassified to a defined benefit.

Note 8 – Defined Benefit Pension Plans – (Continued)

Funding Policy - The Ohio Revised Code (ORC) provides statutory authority for member and employer contributions as follows:

	State and Local	
	Traditional	Combined
2024 Statutory Maximum Contribution Rates		
Employer	14.0 %	14.0 %
Employee *	10.0 %	10.0 %
2024 Actual Contribution Rates		
Employer:		
Pension **	14.0 %	12.0 %
Post-employment Health Care Benefits **	0.0	2.0
Total Employer	14.0 %	14.0 %
Employee	10.0 %	10.0 %

* Member contributions within the combined plan are not used to fund the defined benefit retirement allowance.

** These pension and employer health care rates are for the traditional and combined plans. The employer contributions rate for the member-directed plan is allocated 4 percent for health care with the remainder going to pension; however, effective July 1, 2022, a portion of the health care rate is funded with reserves.

Employer contribution rates are actuarially determined and are expressed as a percentage of covered payroll.

For 2024, the Health District's contractually required contribution was $495,202 for the traditional plan, $19,299 for the combined plan and $22,152 for the member-directed plan.

Note 9 – Postemployment Benefits

Ohio Public Employees Retirement System

Plan Description – The Ohio Public Employees Retirement System (OPERS) administers three separate pension plans: the traditional pension plan, a cost-sharing, multiple-employer defined benefit pension plan; the member-directed plan, a defined contribution plan; and the combined plan, a cost-sharing, multiple-employer defined benefit pension plan that has elements of both a defined benefit and defined contribution plan.

Note 9 – Postemployment Benefits – (Continued)

OPERS maintains a cost-sharing, multiple-employer defined benefit post-employment health care trust. The 115 Health Care Trust (115 Trust or Health Care Trust) was established in 2014, under Section 115 of the Internal Revenue Code (IRC). The purpose of the 115 Trust is to fund health care for the Traditional Pension, Combined and Member-Directed plans. The Ohio Revised Code permits, but does not require, OPERS to provide health care to its eligible benefit recipients. Authority to establish and amend health care coverage is provided to the Board in Chapter 145 of the Ohio Revised Code. Retirees in the Traditional Pension and Combined plans may have an allowance deposited into a health reimbursement arrangement (HRA) account to be used toward the health care program of their choice and other eligible expenses. An OPERS vendor is available to assist with the selection of a health care program.

With one exception, OPERS-provided health care coverage is neither guaranteed nor statutorily required. Ohio law currently requires Medicare Part A equivalent coverage or Medicare Part A premium reimbursement for eligible retirees and their eligible dependents.

OPERS offers a health reimbursement arrangement (HRA) allowance to benefit recipients meeting certain age and service credit requirements. The HRA is an account funded by OPERS that provides tax free reimbursement for qualified medical expenses such as monthly post-tax insurance premiums, deductibles, co-insurance, and co-pays incurred by eligible benefit recipients and their dependents.

OPERS members enrolled in the Traditional Pension Plan or Combined Plan retiring with an effective date of January 1, 2022, or after must meet the following health care eligibility requirements to receive an HRA allowance:

Age 65 or older Retirees Minimum of 20 years of qualifying service credit

Age 60 to 64 Retirees Based on the following age-and-service criteria:

Group A 30 years of total service with at least 20 years of qualified health care service credit;

Group B 31 years of total service credit with at least 20 years of qualified health care service credit;

Group C 32 years of total service cred with at least 20 years of qualified health care service credit.

Age 59 or younger Based on the following age-and-service criteria:

Group A 30 years of qualified health care service credit;

Group B 32 years of qualified health care service credit at any age or 31 years of qualified heath care service credit and at least age 52;

Group C 32 years of qualified health care service credit and at least age 55.

Note 9 – Postemployment Benefits – (Continued)

Retirees who do not meet the requirement for coverage as a non-Medicare participant can become eligible for coverage at age 65 if they have at least 20 years of qualifying service.

Members with a retirement date prior to January 1, 2022, who were eligible to participate in the OPERS health care program will continue to be eligible after January 1, 2022, as summarized in the following table:

Group A	Group B	Group C
Age and Service Requirements	**Age and Service Requirements**	**Age and Service Requirements**
December 1, 2014 or Prior	***December 1, 2014 or Prior***	***December 1, 2014 or Prior***
Any Age with 10 years of service credit	Any Age with 10 years of service credit	Any Age with 10 years of service credit
January 1, 2015 through December 31, 2021	***January 1, 2015 through December 31, 2021***	***January 1, 2015 through December 31, 2021***
Age 60 with 20 years of service credit or Any Age with 30 years of service credit	Age 52 with 31 years of service credit or Age 60 with 20 years of service credit or Any Age with 32 years of service credit	Age 55 with 32 years of service credit or Age 60 with 20 years of service credit

See the Age and Service Retirement section of the OPERS ACFR for a description of Groups A, B and C.

Eligible retirees may receive a monthly HRA allowance for reimbursement of health care coverage premiums and other qualified medical expenses. Monthly allowances, based on years of service and the age at which the retiree first enrolled in OPERS coverage, are provided to eligible retirees, and are deposited into their HRA account.

The base allowance is determined by OPERS and is currently $1,200 per month for non-Medicare retirees and $350 per month for Medicare retirees. The retiree receives a percentage of the base allowance, calculated based on years of qualifying service credit and age when the retiree first enrolled in OPERS health care. Monthly allowances range between 51 percent and 90 percent of the base allowance for both non-Medicare and Medicare retirees.

Retirees will have access to the OPERS Connector, which is a relationship with a vendor selected by OPERS to assist retirees participating in the health care program. The OPERS Connector may assist retirees in selecting and enrolling in the appropriate health care plan.

When members become Medicare-eligible, recipients enrolled in OPERS health care programs must enroll in Medicare Part A (hospitalization) and Medicare Part B (medical).

OPERS reimburses retirees who are not eligible for premium-free Medicare Part A (hospitalization) for their Part A premiums as well as any applicable surcharges (late-enrollment fees). Retirees within this group must enroll in Medicare Part A and select medical coverage, and may select prescription coverage, through the OPERS Connector. OPERS also will reimburse 50 percent of the Medicare Part A premium and any applicable surcharges for eligible spouses. Proof of enrollment in Medicare Part A and confirmation that the retiree is not receiving reimbursement or payment from another source must be submitted. The premium reimbursement is added to the monthly pension benefit.

Note 9 – Postemployment Benefits – (Continued)

Participants in the Member-Directed Plan have access to the Connector and have a separate health care funding mechanism. A portion of employer contributions for these participants is allocated to a retiree medical account (RMA). Members who elect the Member-Directed Plan after July 1, 2015, will vest in the RMA over 15 years at a rate of 10 percent each year starting with the sixth year of participation. Members who elected the Member-Directed Plan prior to July 1, 2015, vest in the RMA over a five-year period at a rate of 20 percent per year. Upon separation or retirement, participants may use vested RMA funds for reimbursement of qualified medical expenses.

Disclosures for the health care plan are presented separately in the OPERS financial report. Interested parties may obtain a copy by visiting https://www.opers.org/financial/reports.shtml, by writing to OPERS, 277 East Town Street, Columbus, Ohio 43215-4642, or by calling (614) 222-5601 or 800-222-7377.

Funding Policy - The Ohio Revised Code provides the statutory authority allowing public employers to fund postemployment health care through their contributions to OPERS. When funding is approved by OPERS Board of Trustees, a portion of each employer's contribution to OPERS is set aside to fund OPERS health care plans. Beginning in 2018, OPERS no longer allocated a portion of its employer contributions to health care for the traditional plan.

Employer contribution rates are expressed as a percentage of the earnable salary of active members. For fiscal year 2024, state and local employers contributed at a rate of 14.0 percent of earnable salary. These are the maximum employer contribution rates permitted by the Ohio Revised Code. Active member contributions do not fund health care.

Each year, the OPERS Board determines the portion of the employer contribution rate that will be set aside to fund health care plans. For 2024, OPERS did not allocate any employer contribution to health care for members in the Traditional Pension Plan. Beginning July 1, 2022, there was a two percent allocation to health care for the Combined Plan which has continued through 2024. The OPERS Board is also authorized to establish rules for the retiree or their surviving beneficiaries to pay a portion of the health care provided. Payment amounts vary depending on the number of covered dependents and the coverage selected. The employer contribution as a percentage of covered payroll deposited into the RMA for participants in the member-directed plan for 2024 was 4.0 percent. Effective July 1, 2022, a portion of the health care rate was funded with reserves which has continued through 2024.

Employer contribution rates are actuarially determined and are expressed as a percentage of covered payroll. The Health District's contractually required contribution was $12,078 for the year 2024.

Note 10 – Contingent Liabilities

Amounts grantor agencies pay to the Health District are subject to audit and adjustment by the grantor, principally the federal government. Grantors may require refunding any disallowed costs. Management cannot presently determine amounts grantors may disallow. However, based on prior experience, management believes any refunds would be immaterial.

Note 11 – Fund Balances

The constraints placed on the fund balance for the major governmental funds and all other governmental funds are presented below:

Fund balance	General Fund	Clinic Health Services Fund	Environmental Health Fund	Nonmajor Governmental Funds	Total Governmental Funds
Restricted:					
Solid waste program	$ -	$ -	$ -	$ 85,114	$ 85,114
Water program	-	-	-	13,807	13,807
Swimming pool program	-	-	-	17,085	17,085
Food service program	-	-	-	148,754	148,754
Recreation vehicles	-	-	-	3,014	3,014
Help Me Grow	-	-	-	421,863	421,863
MCHP	-	-	-	5,577	5,577
WIC administration	-	-	-	122,872	122,872
PHEP	-	-	-	206,573	206,573
Tuberculosis	-	-	-	39,022	39,022
Safe communities	-	-	-	30,203	30,203
Health District sewage	-	-	-	35,007	35,007
Health District plumbing	-	-	-	209,138	209,138
Naloxone infrastructure	-	-	-	81,618	81,618
Total Restricted	-	-	-	1,419,647	1,419,647
Committed:					
Clinic health services	-	2,651,664	-	-	2,651,664
Environmental health	-	-	1,763,479	-	1,763,479
Building maintenance	-	-	-	1,088,436	1,088,436
Total Committed	-	2,651,664	1,763,479	1,088,436	5,503,579
Assigned:					
Other purposes -encumbrances	63,758	-	-	-	63,758
Total Assigned	63,758	-	-	-	63,758
Unassigned	5,600,036	-	-	-	5,600,036
Total Fund Balances	$ 5,663,794	$ 2,651,664	$ 1,763,479	$ 2,508,083	$ 12,587,020

The Health District has established a budget stabilization fund in the amount of $3,000,000 for the purpose of continuing operations during emergency situations. This amount is included in the unassigned fund balance of the general fund.

GREENE COUNTY COMBINED HEALTH DISTRICT
GREENE COUNTY

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2024

FEDERAL GRANTOR *Pass Through Grantor* Program / Cluster Title	Assistance Listing Number	Pass Through Entity Identifying Number	Total Federal Expenditures
U.S. DEPARTMENT OF AGRICULTURE			
Passed Through Ohio Department of Health			
Special Supplemental Nutrition Program for Women, Infants, and Children	10.557	02910011WA1724	390,781
		02910011WA1825	75,273
Total Special Supplemental Nutrition Program for Women, Infants, and Children			466,054
Total U.S. Department of Agriculture			**466,054**
U.S. DEPARTMENT OF EDUCATION			
Passed Through Greene County Family and Children First Council			
Special Education - Grants for Infants and Families	84.181	H181A220024	91,472
		H181A230024	243,102
Total Special Education - Grants for Infants and Families			334,574
Total U.S. Department of Education			**334,574**
U.S. DEPARTMENT OF TRANSPORTATION			
Passed Through Ohio Department of Public Safety			
Highway Safety Cluster:			
State and Community Highway Safety	20.600	SC-2024-Greene County Combined He-00018	34,398
		SC-2025-Greene County Combined He-00035	4,549
Total Highway Safety Cluster			38,947
Total U.S. Department of Transportation			**38,947**
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Passed Through Ohio Department of Health			
Opioid STR	93.788	02910014IH0224	157,000
National and State Tobacco Control Program	93.387	02910014TU1024	61,442
		02910014TU1125	11,300
Total National and State Tobacco Control Program			72,742
Public Health Emergency Preparedness	93.069	02910012PH1524	49,953
		02910012PH0125	37,769
Total Public Health Emergency Preparedness			87,722
COVID-19 Epidemiology and Laboratory Capacity for Infectious Diseases	93.323	02910012EO0223	145,678
State Physical Activity and Nutrition (SPAN)	93.439	NU58DP006505	25,000
Centers for Disease Control and Prevention Collaboration with Academia to Strengthen Public Health	93.967	02910012WF0223	288,689
Grants to States for Operation of State Offices of Rural Health	93.913	5 H95RH00133-33-00	25,000
Preventive Health and Health Services Block Grant	93.991	02910014CC0125	8,248
Passed Through Public Health Dayton and Montgomery County			
HIV Prevention Activities Health Department Based	93.940	05710012HP1522	17,091
		05710012HP1623	28,925
Total HIV Prevention Activities Health Department Based			46,016
Passed Through the National Association of County and City Health Officials			
Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health	93.421	6NU38OT000306-05-01	111,991
		6NU38OT000306-05-05	22,250
		6NU38OT000306-04-01	10,000
Total Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health			144,241
Medical Reserve Corps Small Grant Program	93.008	6HITEP200045-03-03	5,000
Total U.S. Department of Health and Human Services			**1,005,336**
Total Expenditures of Federal Awards			**1,844,911**

The accompanying notes are an integral part of this schedule.

GREENE COUNTY COMBINED HEALTH DISTRICT
GREENE COUNTY

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
2 CFR 200.510(B)(6)
FOR THE YEAR ENDED DECEMBER 31, 2024

NOTE A – BASIS OF PRESENTATION

The accompanying Schedule of Expenditures of Federal Awards (the "Schedule") includes the federal award activity of Greene County Combined Health District (the "Health District") under programs of the federal government for the year ended December 31, 2024. The information on this Schedule is prepared in accordance with the requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of the Health District, it is not intended to and does not present the financial position or changes in net position of the Health District.

NOTE B – SIGNIFICANT ACCOUNTING POLICIES

Expenditures reported on the Schedule are reported on the cash basis of accounting. Such expenditures are recognized following the cost principles contained in Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, wherein certain types of expenditures may or may not be allowable or may be limited as to reimbursement.

NOTE C – INDIRECT COST RATE

The Health District has elected not to use the 10-percent de minimis indirect cost rate as allowed under the Uniform Guidance.

NOTE D – MATCHING REQUIREMENTS

Certain Federal programs require that the Health District to contribute non-Federal funds (matching funds) to support the Federally funded programs. The Health District has complied with the matching requirements. The expenditure of non-Federal matching funds is not included on the Schedule.

NOTE E – COMMINGLING

Federal monies are comingled with other state and local revenues for the following programs:

- Special Education – Grants for Infants and Families (ALN #84.181)

When reporting expenditures on this Schedule, the Health District assumes it expends federal monies first.

NOTE F – MEDICAID ADMINISTRATIVE CLAIMING

The Health District received Medicaid Administrative Claiming (MAC) reimbursements (ALN #93.767 and #93.778) from the Ohio Department of Health (ODH). Based on the agreement between ODH and the Health District, MAC reimbursements disbursed by ODH to the District are not considered federal dollars. In 2024, the Health District received $191,923 of MAC reimbursements from ODH. These monies are not reported on the Health District's Schedule.

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INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Greene County Combined Health District
Board of Health
360 Wilson Drive
Xenia, Ohio 45385

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of the Greene County Combined Health District (the "Health District"), as of and for the year ended December 31, 2024, and the related notes to the financial statements, which collectively comprise the Health District's basic financial statements, and have issued our report thereon dated May 15, 2025, wherein we noted the Health District reported on the cash basis of accounting.

Report on Internal Control Over Financial Reporting
In planning and performing our audit of the financial statements, we considered the Health District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health District's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters
As part of obtaining reasonable assurance about whether the Health District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Health District's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health District's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Clark, Schaefer, Hackett & Co.

Springfield, Ohio
May 15, 2025

CLARK SCHAEFER HACKETT
BUSINESS ADVISORS

14 East Main Street, Suite 500, Springfield, Ohio 45502
P: 937.399.2000 | F: 937.399.5433

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

Greene County Combined Health District
Board of Health
360 Wilson Drive
Xenia, Ohio 45385

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited the Greene County Combined Health District's (the "the Health District") compliance with the types of compliance requirements identified as subject to audit in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Health District's major federal programs for the year ended December 31, 2024. The Health District's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

In our opinion, the Health District complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2024.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditors' Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the Health District and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major federal program. Our audit does not provide a legal determination of Health District's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to the Health District's federal programs.

Auditors' Responsibilities for the Audit of Compliance
Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the Health District's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the Health District's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we

- exercise professional judgment and maintain professional skepticism throughout the audit.

- identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the Health District's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.

- obtain an understanding of the Health District's s internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of the Health District's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance
A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A sig*nificant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditors' Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

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

Clark, Schaefer, Hackett & Co.

Springfield, Ohio
May 15, 2025

Section I – Summary of Auditors' Results

Financial Statements

Type of auditors' report issued:	Unmodified
Internal control over financial reporting:	
• Material weakness(es) identified?	No
• Significant deficiency(ies) identified not considered to be material weakness(es)?	None reported
Noncompliance material to financial statements noted?	No

Federal Awards

Internal control over major programs:	
• Material weakness(es) identified?	No
• Significant deficiency(ies) identified not considered to be material weakness(es)?	None reported
Type of auditors' report issued on compliance for major programs:	Unmodified
Any audit findings that are required to be reported in accordance with 2 CFR 200.516(a)?	No
Identification of major programs:	
ALN 10.557 – Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
ALN 84.181 – Special Education - Grants for Infants and Families	
Dollar threshold to distinguish between Type A and Type B programs:	$750,000
Auditee qualified as low-risk auditee?	No

Section II – Financial Statement Findings

None noted

Section III – Federal Awards Findings and Questioned Costs

None noted

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OHIO AUDITOR OF STATE
KEITH FABER

GREENE COUNTY COMBINED HEALTH DISTRICT

GREENE COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

This is a true and correct copy of the report, which is required to be filed pursuant to Section 117.26, Revised Code, and which is filed in the Office of the Ohio Auditor of State in Columbus, Ohio.

Certified for Release 7/29/2025

65 East State Street, Columbus, Ohio 43215
Phone: 614-466-4514 or 800-282-0370