

Financing Public Health Services in Marion County:

A Review of Relevant Data and Targeted Recommendations to Assist Decision-making

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I. Executive Summary

In early 2014, Marion Public Health (MPH) requested research support from Kent State University's Center for Public Policy and Health (KSU-CPPH) on issues related to local shares of funding support for local public health services, the funding split between the City of Marion and Marion County, and best-practices related to carryover fund balance management. The agency also requested external recommendations concerning the latter two issues to help facilitate productive discussions and resolution of those issues by appropriate decision-makers in Marion County. Local officials from Marion County -- including MPH professionals -- are currently working through these issues as they continue to transition to a single consolidated health agency in response to a voter approved referendum.

We used multiple data sources to help us respond to the research needs identified by MPH. We obtained Local Health District (LHD) financial information on a national level from the National Association of City and County Health Officials (NACHHO). Financial information and population data relating to Ohio's LHDs was gathered from the Ohio Department of Health's Annual Financial Report (AFR) database for 2012. We also implemented a survey of health officials with LHDs that had consolidated from 1999-2012. We also reviewed available consolidation contracts from a sample of LHDs that had consolidated since 2001. And finally, we reached out to a small sample of nationally accredited health departments for information on how they address local public health funding needs.

We compared Marion County's total expenditures and local revenues on a per capita basis with several benchmark populations of LHDs. These benchmark populations include comparable national health departments, Ohio's population of local departments, and recently consolidated Ohio health departments. We found that Marion County's local government contribution for public health services to be close to the average of the benchmark populations investigated.

In Ohio, local jurisdictions are given liberties in determining how to finance their local public health services. Not surprisingly, therefore, we found substantial variations among recently consolidated health districts regarding the manner in which city and county shares of local public health costs are determined and distributed. We found that there appear to be at least three different mechanisms for determining city shares of local public health services among the recently consolidated health departments in the state. First, a number of jurisdictions determined city shares based on an established proportion of assessed property valuation. Others appear to rely on negotiated fixed dollar amounts to determine the costs to the consolidating cities of receiving public health services from the new and consolidated county LHD. And finally, one county uses a per capita payment arrangement to determine the amount of funding to be supplied by the two cities merged to its consolidated health department.

We also found that the majority of the recently consolidated departments are characterized by the consolidation of a relatively small city jurisdiction with a larger county department. In most of these cases, the cities tend to contribute revenue to the health department at levels that are at or below their share of the population. However, two cases of relatively recent consolidation -- Toledo-Lucas County and Akron-Summit County -- are analogous to the Marion case because the cities represent large proportions of the population served by the newly consolidated LHD. In both of these cases, the cities pay their population-based proportionate share of expenses, or more.

Our investigation into carryover practices found that national organizations advise governments to maintain carryover balances to address a variety of issues, including unexpected needs for expenditures. The Government Finance Officers Association (GFOA), in particular makes recommendations regarding reserve funding balances for government entities. Through our survey of recently consolidated LHDs in Ohio, we learned that certain Ohio LHDs are aware of these recommendations and have sought to develop practices consistent with them. We also learned that

reported carryover funds in Ohio vary widely, from -1.6% to 122.6%, and that MPH's level of carryover balance in unrestricted funds is not near either of these extreme values.

Based on the results of our research regarding city and county shares to MPH and carryover management practices, we have developed the recommendations below for consideration by decision-makers in Marion County. We offer them as suggestions that we hope will facilitate productive dialogue and resolutions of remaining issues associated with the consolidation of health departments in Marion County.

Our recommendations for consideration that are related to city and county shares to Marion Public Health include:

1. Marion County should define a new method of determining the city and county shares of locally provided LHD revenues that are based on population shares within Marion County. This kind of population indicator reflects both health needs and the benefits likely to be received from health related services.
2. MPH should separate out the services provided exclusively to the City of Marion and not to the rest of the county. The full costs of these "city only" services should be paid by the City of Marion.
3. The transition to a population-based calculation of the city/county shares should take place over the period of two or three years to ease impacts on individual jurisdictions.
4. MPH officials should convene a group of respected citizens who, as a collectivity, have equal ties to the city and the outlying areas of the county to review the funding source changes made two years after they are fully implemented (e.g., within five years of initial implementation).

Our recommendations related to carryover management practices are:

1. The MPH should establish a written policy for managing its General Fund balances.
2. The MPH should join other LHDs in Ohio in drawing useful guidance from the GFOA's 2009 "Best Practices" document. Based on our investigations, we believe that establishing ongoing carryover balances of at least 25% of total health department expenditures is a reasonable starting point for discussion.
3. The MPH may also want consider a staged process of policy responses to differing fund balances as is done in the City of Tallmadge, Ohio (see Appendix 2). Decisions on policy responses may also affect threshold fund balances incorporated into the written policy referenced in 1 and 2 above.

The recommendations above represent informed suggestions that we believe can provide a useful starting point for discussions to resolve issues associated with City-County shares and carryover fund management practices in Marion County. It is our hope that citizens and stakeholders in Marion County find these recommendations to be useful as they seek to provide a firmer foundation for ongoing efforts to improve the health of their citizens.

II. Introduction

In January 2014, Marion Public Health (MPH) expressed interest in receiving research assistance on several issues. These issues included the spectrum of local tax support for public health services provided by Local Health Departments (LHDs), city-county shares of local public health financing contributions from recently consolidated Ohio LHDs, and appropriate practices for managing carryover fund balances at the end of each fiscal year. MPH also sought recommendations regarding appropriate splits for city and county shares of funds for local public health services in Marion County and next steps for managing carryover balances in the Marion Combined General Local Health District.

After discussing these issues with MPH leadership, the Center for Public Policy and Health at Kent State University (KSU-CPPH) agreed to assist the department by providing the requested research assistance and making external recommendations. As result, KSU-CPPH agreed to develop this report in order to address three questions provided by MPH:

1. Where does MPH currently fall within the spectrum of tax support per capita per annum across Ohio or other comparable situations nationally?
2. How does the city to county ratio of tax support for MPH (currently 68:32, unadjusted for population size) compare with the funding ratios in similar city/county health districts in Ohio and other accredited local health districts of similar size? What is an appropriate payer mix (proportion) between the City of Marion and Marion County for the delivery of public health services?
3. Based on current budget and liabilities (e.g. retirement payouts, grant forwards) what is an appropriate range of end-of-year cash balance to assure no disruption of services results from an insufficient end of year cash balance?

In providing this report to MPH, we seek to provide useful responses to all three of these questions.

In more general terms, this report seeks to accomplish three purposes. First, and most obviously, we seek to provide useful information on: 1) locally provided support for public health services in Ohio and elsewhere; 2) city-county shares of local public health funding for recently consolidated LHDs in Ohio, and; 3) carryover practices for local public health organizations. Second, we seek to provide recommendations for MPH, its governing entities, and its component jurisdictions to consider regarding both appropriate city-county shares of local public health service costs and carryover fund management balance practices. When viewed in larger context, however, we believe that the most important purpose of this report is to offer information for officials in Marion County to use in establishing financing approaches that solidify MPH's financing practices, develop a foundation for ongoing support from key stakeholders, and build momentum toward more effective public health efforts in Marion County.

III. Background

Marion County – like many other counties in Ohio and throughout the nation -- faces significant public health challenges. Just recently, the Robert Wood Johnson Foundation, in cooperation with the University of Wisconsin – Madison, released its annual county health rankings for 2013 (University of Wisconsin – Madison, 2013). These rankings are compiled each year, and they provide insight regarding the extent and nature of public health problems faced by citizens and jurisdictions throughout Ohio and the rest of the United States. In this set of rankings, Marion County ranks 66th out of 88 Ohio counties regarding its overall health outcomes, and it ranked among the lower half of counties in Ohio for all

outcomes measured, including length of life (50th), Quality of Life (80th), health behaviors (82nd), Clinical Care (55th), Physical Environment (87th), and Socioeconomic Factors (80th).

Until several years ago, two separate LHDs in Marion County sought to address these significant public health challenges. However, in January of 2010, the Marion County Health Department merged with the City of Marion Health Department as a result of a ballot initiative championed by the League of Women Voters and the local Chamber of Commerce. This merger has created opportunities for leaders in Marion County to develop more coordinated, effective, and efficient approaches to addressing public health challenges and improving the health and lives of citizens throughout Marion County.

The merger was made official through a contract signed by the county's District Advisory Council and the City of Marion, and the new and consolidated county-wide department has since been rebranded, "Marion Public Health". A funding split between the city and county portions of the jurisdiction was established in the contract with the city paying 68% and the county paying 32% of the established "inter-governmental revenue" amount. This contribution split appears to have been determined by the proportion of overall spending levels in place in each of the two Marion County LHDs in 2008.

The consolidation of the two health districts in Marion County was not an isolated event. In Ohio, there were a total of 21 voluntary¹ health department consolidations between 1999 and 2013. This figure includes both full health district mergers, as was the case in Marion County, and cases where city health jurisdictions contract with county health departments to provide public health services within their jurisdictions. In a recent study of health department consolidation in Ohio, we found that county and city health departments typically seek to save money and improve services through consolidation (Morris et al., 2013). The county health officials we interviewed for this statewide study also noted that they believed their consolidations, for the most part, achieved their cost saving and service improvement goals.

MPH now appears to be working through some of the "growing pains" associated with the implementation of its consolidation. At the same time, the newly consolidated MPH is seeking to improve its efforts to address the significant public health challenges facing Marion County. To aid the government jurisdictions and public health stakeholders in Marion County, along with the County's citizens and MPH itself, we identified data and methods through which we could respond to the questions posed by MPH and stakeholders in Marion County.

IV. Data and Methods

As noted above, this report is concerned with addressing three questions. This section highlights the data and methods used to address each of the three questions highlighted above.

1. **Question 1:** Where does MPH fall within the spectrum of tax support per capita per annum across Ohio or other comparable situations nationally?

To answer this question we relied on data from several different sources. We used data and information from a KSU-CPPH consolidation study (Morris et al., 2013), LHD profile data from the National Association of County and City Health Officials (NACCHO, 2013), and Annual Financial Report (AFR) data from the Ohio Department of Health (ODH, 2013). We also contacted accredited

¹ We have excluded "involuntary" consolidations from this figure. "Involuntary" consolidations typically occur when a city loses population and falls below the 5,000 person threshold for continuation of a city health district under Ohio law.

LHDs to improve our understanding of ways in which local governments contributed to their revenues for carrying out public health services.

We used the Morris et al, 2013 study to identify recently consolidated LHDs in Ohio, and to guide us toward relevant data and information for this study. The Morris et al (2013) analysis involved interviewing a sample of senior county health officials whose departments had consolidated, or entered into a contract for public health services with a city health department from 2001 – 2012, about their perceptions regarding the motivations and impacts associated with their health department consolidation experience. The report also featured a longitudinal statistical analysis of AFR data.

The NACCHO data provides profile information on local health departments from around the country, including information on total expenditures and local funding shares. NACCHO develops a report that describes the population of local health departments nationally every three years. NACCHO's 2013 Profile included 2,532 local health departments in its study population (NACCHO, 2013). All departments received a basic questionnaire, and a sample of the study population received a more in-depth set of profile questions. In the end, NACCHO received a 79% response rate (NACCHO, 2013). The data collected covered a variety of topics, including funding, workforce, health assessment and planning, accreditation, health impact assessments, jurisdictions and governance, and others. From this data source, we drew information on 147 LHDs nationally that are comparable to MPH in terms of governance arrangements (local vs. state), the provision of primary care services, and population served.

The AFR data include self-reported financial data from all of Ohio's LHDs. The Ohio Administrative Code Section 3701-06-3 requires LHDs to meet certain minimum standards in order to receive state subsidy funds. One of these standards is the submission of a completed annual financial report to ODH by March first of each year. To facilitate submission of these data, the ODH has developed a secure online application that enables LHDs to report their annual revenue and expenditure data from local, state and federal sources in a prescribed form, using guidance provided by ODH. In 2012, ODH asked LHDs to use the 2011 guidance to inform their submittal of this information. The Health Commissioner and county or city auditor serving as fiscal agent for the LHD approves the report prior to its submission to ODH. The AFR process enables one to develop a statewide picture of the financial capacities and practices of LHDs in Ohio. KSU-CPPH obtained a relational ACCESS database containing AFR reports from Ohio's 125 local health districts for fiscal/calendar year 2012 from ODH, and extracted information to Excel format, for use in this analysis.

And finally, from among the 31 health departments accredited to date by the Public Health Accreditation Board (PHAB), we identified six LHDs in Ohio and other states with locally based public health systems. Two of these LHDs are in Ohio. Four of the accredited LHDs are in Wisconsin and Illinois, both of which have locally based public health systems and similar local government units to Ohio. We were able to compile data on the two accredited Ohio LHDs – Summit County Public Health (SCPH) and the Licking County Health Department (LCHD) – through the procedures described above. We made phone calls to four accredited health department in Ohio and Wisconsin, and we were able to get responses to our questions about local government shares of public health revenues from two of them by the time we submitted the initial draft of this report on March 31, 2014.

To answer Question 1 above, we used population and financial data from the sources above to calculate per capita expenditures, per capita local shares, and the percent of revenue from local shares for a national sample of similar LHDs, all LHDs in Ohio, Ohio LHDs that consolidated between 1999 and 2013, and a small sample of PHAB accredited LHDs. The results of these investigations are outlined in the Findings section below.

2. **Question 2:** How does the city to county ratio of tax support for MPH (currently 68:32, unadjusted for population size) compare with the funding ratios in similar city/county health districts in Ohio and other accredited local health districts of similar size? What is an appropriate payer mix (proportion) between the City of Marion and Marion County for the delivery of public health services across Marion County?

This question required us to explore how other consolidated health departments split the share of funding support between city and countywide portions of their jurisdictions. We used ODH AFR data submitted by Ohio's LHDs (described above), service and consolidation contract information provided to us by LHDs in 2013 as we prepared the Morris et al (2013) report, and – importantly - a survey of senior county officials from consolidated health departments in Ohio to provide information for use in our analysis.

We used the AFR dataset to collect information on revenues from local government sources that flow to LHDs in Ohio, including total local revenues, inside millage², and levy revenue for 2012. The AFR dataset also yielded information on LHD expenditures and populations served by each LHD.

We also reviewed consolidation contracts from a number of Ohio LHD consolidations³. As a part of the Morris et al. (2013) project, we collected contracts from 15 of the 20 consolidations in that report's universe (including the contract merging the City of Marion and the Marion County LHDs). For this project, we also reviewed the 2013 Portage County-Ravenna consolidation contract. From these contracts, we extracted information on the amount of money paid to the county health department by the city jurisdiction and – to the extent available – information on how that amount was calculated as well.

We also developed a survey for this project to collect information on city and countywide shares of local revenue and other relevant information. Because it is directed toward public officials, the survey was exempted by the KSU Institutional Review Board (IRB) in February 2014. The protocol we followed to solicit participation from LHD officials and collect needed information was as follows:

- 1) We developed a survey template and piloted its use with two county LHD financial officials.
- 2) After receiving feedback from the officials who piloted the early version of the survey, we made needed changes and finalized the survey instrument.
- 3) Members of the KSU-CPPH research team then reached out to Health Commissioners and leaders from the departments that made up our sample of 20 recently consolidated city-county LHDs (1999-2013) that could be productively compared with MPH to seek their assistance and cooperation with the project. We asked for contact information for each department's senior finance staff (CFO or Finance Directors, typically) and, if given permission, we reached out to the finance staff person with a copy of the survey for completion. Our team used emails and phone call reminders to Health Commissioners and financial staff as necessary during the process.
- 4) Upon receiving the surveys from the departments, KSU-CPPH staff complied, summarized, and analyzed the data contained in the questionnaires. Where appropriate, we sought and obtained clarifying information from the officials responding to our inquiries. The survey focused on the issues of city and countywide shares of local revenue and carryover management practices (described below). As of March 25, 2014, we had received completed (or partially completed) questionnaires from 12 of the 20 (60%) consolidated health departments, other than Marion County.

² Inside millage is the "non-voted" portion of local property tax revenue that is divided and distributed by a county's Auditor to its political subdivisions.

³ This sample included contracts for consolidation carried out under both Ohio Revised Code (ORC) 3709.07 (full merger) and ORC 3709.08 (contracted services without full health district merger).

We identified alternative approaches for determining city and county funding shares in Ohio by reviewing and summarizing information from the consolidation contracts we had collected, and supplementing that information with information from the completed surveys and other sources. We estimated city and county shares of local public expenditures using data from the surveys and the 2012 AFR data described above.

In reviewing the data on city shares of local government revenues, it is important to note that the use of property tax-based estimates of local revenues and alternative estimates of total “local revenue” yield slightly different estimates of total city shares of local public health revenues. We use two methods of comparing the City of Marion’s local share with the local shares of other consolidated cities. As we investigated the data we found that there were two categories of consolidations. The first type of consolidation involved cities that made up a small percentage of the overall population. The second type involved cities that made up large portions of the overall county population. We found that Marion County’s situation fell into this second category and we were able to obtain more detailed financial data from the three cases with larger cities.

We used the following estimates for the consolidations featuring smaller cities. The property tax based estimates are most comparable to the situation in Marion County, where “intergovernmental shares” appear to have been originally determined based on LHD expenditures which were drawn from inside millage. To arrive at the property tax assessment based city shares of local government revenues, we sum the AFR figures for inside millage and general⁴ public health levies.

However, some of the consolidations investigated finance local shares of public health services in ways that do not directly involve property tax revenues, so these jurisdictions should probably not be compared on the basis of property tax based local government revenues alone. We thus also compare city shares of local revenues on the basis of total local revenue. In this context, though, it is important to note that “total local revenue” figures may not always be comparable across jurisdictions. The 2011 guidance provided for use in 2012 by ODH specified “local revenue” as a component of these shares, and some jurisdictions – including Marion County – may have included non-governmental local revenues in the figures they submitted. Other jurisdictions, however, may have interpreted these revenues to include only local government revenues because this qualification was explicitly included in the ODH guidance in both the year before 2011 (2010) and the most recent (2014) guidance. In addition, it is worth noting that the “total local revenue” figure may also include local revenues from adjacent local governments (counties, for example) that procure services from the recently consolidated LHD jurisdictions in our sample. Thus for the smaller cities in our sample, we present city share information in comparison to both “Total Local Revenues” and “Property Tax Assessment” based revenues such as inside millage and local public health levies.

For the consolidations involving larger cities, we obtained additional information from the LHD officials we surveyed on the amount of revenue provided from all political subdivisions to their county health departments. This figure does not contain any other type of local revenue, such as special contracts or fees. We were thus able to calculate a rather accurate percent city share estimate by using the cities’ contributions to the health district and the revenue from all political subdivisions.

The data and information we collected on financing approaches in consolidation contracts and city-county shares of local government revenues are presented in the Findings Section (IV). Our recommendations regarding potential changes in city-county shares in Marion County are provided in the Recommendations Section (V).

⁴ For example, we excluded special purpose levies, such as the Tuberculosis levy used in Mahoning County, from our “general” public health levy calculations.

Question 3: Based on current budget and liabilities what is an appropriate range of end-of-year cash balance to assure no disruption of services results from an insufficient end of year cash balance?

The final question we address relates to managing carryover funds. We relied on AFR data, our survey of recently consolidated LHDs, and a review of best practices from national public sector financing and health organizations to inform this analysis. We also drew information from general purpose local government practices and a March 2014 ODH directive on fund balances to inform our work in this area.

The AFR dataset yielded total carryover balances that LHDs reported to ODH for 2012, as well as expenditure information needed for calculating the ratio of carryover funds to total expenditures. It is important to recognize, however, that MPH included both restricted and unrestricted funds in its reported carryover balance, and we report only the portion of these carryover funds that it deems unrestricted⁵. This is because restricted funds, by definition, are unlikely to be available to support unanticipated needs which may be appropriately addressed by carryover fund balances.

The portion of our survey of recently consolidated LHDs that focuses on identifying current Ohio LHD carryover management practices included questions relating to retirement related payments occurring in 2012, practices for managing carryover funds, and reliance on externally provided “best practices”. We use the responses received from senior financial officials from other Ohio LHDs to inform our findings and recommendations, where appropriate.

We also reviewed best practice information from national and local sources. A number of organizations such as the Public Health Accreditation Board (PHAB), the International City Management Association (ICMA), the Government Finance Officers Association (GFOA), and others call for sound financial practices, planning, and reasonable fund balance levels. In addition, in an effort to understand how carryover balances may be managed in practice by government organizations other than Ohio LHDs, we searched for relevant practices currently in use by other local governments. We found one particularly useful example in Tallmadge Ohio, and the ordinances it uses to guide its practices are provided in Appendix 2.

Our findings regarding carryover fund balances and recommendations relating to their management are provided in Sections IV and V of this report.

⁵ The ODH guidance for completion of AFRs in 2012 suggests that LHDs report carryover as “the total of unobligated and unspent funds from the previous year”. While other interpretations are possible, we believe that LHDs typically interpret this guidance to mean that the funds must be *both* unobligated and unspent to appear in this reporting category. Thus, we believe it is likely that most reporting LHDs excluded restricted funds from their carryover balances because these funds would be interpreted to be obligated to the purpose which defines the restrictions on the fund (solid waste fund, etc.). To the extent that LHDs interpret these figures differently than we do, the figures reported in the AFR may not be fully comparable. Further research in this area is thus appropriate. However, in making recommendations on fund balances, the GFOA focuses on unrestricted funds, so it seems appropriate to focus on unrestricted funds if one seeks to follow their guidance in developing minimum fund balance policies and practices.

V. FINDINGS

The findings associated with our investigations are summarized below, and they are organized around the three questions posed by MPH at the outset of this project.

Local Government Share of Local Public Health Expenditures: Where Does MPH Fit?

To assess the local share of LHD revenues paid by Marion County local governments to support local public health services, we compare Marion County's total expenditures and local revenues on a per capita basis with several benchmark populations. To add another dimension to the analysis, we also compare MPH with benchmark LHDs based on the proportion of total LHD revenue that is derived from local sources. The benchmark populations assessed include comparable LHDs nationally, other LHDs in Ohio, recently consolidation LHDs in Ohio, and a small sample of PHAB accredited LHDs.

Table 1 compares MPH's local revenue generation to similar LHDs on a national basis for the 2013 calendar year. These similar LHDs include those that are locally governed and which do not offer ongoing clinical services, while serving populations of between 50,000 and 99,999 persons. All of these parameters appear to match the situation in Marion County.

Table 1

Local Revenue: Comparing MPH to Comparable LHD's*, Nationally**			
	Total Expenditures, Per Capita	Local Revenue, Per Capita	Local Revenue, as a % of Total Revenue
Range	\$2.62-\$151.19	\$0-\$57.02	0-100%
Average (mean)	\$31.69	\$11.53	40.4%
Marion Public Health	\$29.54	\$13.63	28.3%
Source: 2013 National Association of County and City Health Officials (NACCHO) survey of LHDs.			
*The sample of comparable LHDs consists of a nationwide sample of LHDs that are: 1) locally governed; 2) not providing primary care, behavioral health, or home health services, and; 3) serve between 50,000 and 99,999 persons.			
** Sample size (N) = 147.			

The findings in Table 1 show that MPH lies toward the center of the national distribution with regard to all three of the comparisons that are presented. MPH spent \$29.54 per capita on public health services in 2013, slightly less than the \$31.69 national average. Its per capita local revenues in that year, \$13.63, were slightly above the \$11.53 national average. And, the proportion of total revenue derived from local sources, 28.3%, was about 12% below the 40.4% national average. Overall these figures, suggest that MPH lies toward the middle of the distribution of comparable LHDs nationally with regard to both overall expenditures and the extent to which local governments contribute to the revenue base supporting local public health services.

We find a similar situation when we compare MPH to the other 124 LHDs in Ohio. Table 2 compares MPH to Ohio LHDs generally with regard to its total expenditures per capita, local revenues per capita, and the proportion of total revenue accounted for by local government contributions.

Table 2

Local Revenue: Comparing MPH to Other LHDs, in Ohio			
	Total Expenditures, Per Capita	Local Revenue, Per Capita	Local Revenue, as a % of Total Revenue
Range	\$4.30-\$209.74	\$0-\$68.92	0% - 84.66%
Average (mean)	\$37.92	\$14.72	33.16%
Marion Public Health	\$29.41	\$13.57	28.25%
Source: 2012 Annual Financial Report Data (submitted by Ohio LHDs to ODH in 2013)			
*Sample size (N) = 125			

The data in Table 2 reveal that MPH again appears to be roughly in the middle of the distribution of LHDs with regard to both expenditures and the extent to which local governments contribute revenue to support local public health services. With regard to total expenditures, MPH's \$29.41 per capita expenditure figure lies slightly below the average for LHDs in Ohio. With regard to local revenue, MPH's \$13.57 per capita figure lies slightly below the Ohio average of \$14.72 per capita. In addition, MPH's local revenues reflect 28.25% of total revenue, a figure that is slightly below the Ohio average.

Table 3 compares MPH to other recently consolidated LHDs in Ohio with respect to total per capita expenditures, local revenue contributions per capita, and the proportion of total revenue derived from local jurisdictions during the 2012 year. The universe of LHDs addressed here includes the 14 Ohio county-level LHDs that were involved in consolidations with city LHDs since 1999⁶. Perhaps not surprisingly, these LHDs spend slightly less per capita on public health than the national and overall Ohio benchmark LHD populations discussed above.

Even so, as the findings in Table 3 show, MPH spends close to the same amount per capita as the average recently consolidated Ohio LHD, and local jurisdictions in Marion County contribute a bit more per capita for local public health services than the average recently consolidated Ohio LHD. In interpreting these figures, however, it is useful to remember that this group of LHDs is likely to have taken conscious steps to control costs and expenditures in recent years. As a result, it should not be surprising that MPH's figures are slightly above the average in this context. Even so, the overall MPH figures remain in the middle portion of the overall distribution, even among this more frugal group of Ohio LHDs.

Table 3

Local Revenue: Comparing MPH to Other Recently Consolidated Ohio LHDs			
	Total Expenditures, Per Capita	Local Revenue, Per Capita	Local Revenue, as a % of Total Revenue
Range	\$15.19-\$45.07	\$4.64-\$22.12	14.14% - 37.27%
Average (mean)	\$29.06	\$10.50	26.72%
Marion Public Health	\$29.41	\$13.57	28.25%
Source: 2012 Annual Financial Report Data (submitted by Ohio LHDs to ODH in 2013)			
*Sample size (N) = 14 counties, including Marion County, that were involved in the 20 City-County LHD consolidations between 1999 and 2012.			

⁶ While our count suggests that there have been 21 city-county LHD consolidations in Ohio since 1999, these consolidations have involved only 15 county LHDs, including Portage County in 2013.

Table 4 compares local shares of revenue for MPH with local shares of revenue for a small sample of LHDs that have achieved PHAB accreditation. While the per capita local government share of public health revenues in Marion County is lower than the average for the accredited health departments in this sample, it is higher than three of the four LHDs in the sample. It is worth noting, however, that these three health departments, like MPH, do not provide primary care services, but serve substantially larger populations than does MPH, so this finding may very well be explained by economies of scale in the delivery of public health services (Santerre, 2009). This interpretation is also supported by the fact that Polk County, Wisconsin, which is a bit smaller than Marion County in terms of population, has a local share of per capita revenues that is substantially higher than MPH. When the population control is removed from these figures and we assess local revenue as a percentage of total revenue, we encounter similar – although not identical -- findings. MPH again shows higher local shares than the three larger departments, but lower shares than Polk County, Wisconsin, the smaller department. Without the control for population, MPH shows a slightly higher than average overall share of total revenue. Overall, however, these data, once again, appear to suggest that Marion County lies toward the middle range of LHDs with regard to its local contributions to public health revenues.

Table 4
Local Revenue: Comparing MPH to Accredited LHDs

Local Health Department (LHD)	Population	Local Share of Revenues Per Capita	Local Revenue, as a % of Total Revenue
Accredited LHDs			
Summit County, OH	543,072	\$12.59	26.7%
Licking County, OH	157,762	\$10.50	26.3%
Kenosha County, WI	167,757	\$9.85	21.6%
Polk County, WI	43,476	\$23.79	33.1%
Average Accredited LHD		\$14.18	26.9%
Marion County, OH	66,501	\$13.57	28.25%
Sources: 2012 AFR data for Ohio LHDs and personal phone calls to LHD leaders in Polk and Kenosha Counties.			

Overall, the data compiled and presented above suggest that MPH is neither a “big spender” for public health, nor is it “at the bottom of the barrel” in terms of its public health expenditures and local contributions for public health services. To the contrary, as the figures above suggest, MPH generally lies toward the center of the overall distribution of LHDs in terms of its overall public health expenditures and local contributions in comparison to the benchmark populations investigated here.

City-Countywide Shares of Local Revenue Contributions for Local Public Health Services

Ohio law allows local communities latitude in determining how to finance local public health services. Not surprisingly, we found substantial variations among recently consolidated health districts regarding the manner in which city and county shares of local public health costs are determined and distributed. The consolidation contracts we reviewed revealed variations in the ways in which recently consolidated LHDs determine city shares of public health costs. At the same time, data from the AFRs and our survey of recently consolidated LHDs revealed significant variations in the proportion of local government revenues that are provided by the cities involved in these consolidations. In general, however, most of the cities with small proportions of the total population in the county provided rather

small shares. By contrast, the cities with large proportions of their county's populations – Akron in Summit County, Toledo in Lucas County, and Marion in Marion County – pay relatively large city shares.

Our reviews of contracts for consolidated services revealed three mechanisms for determining city shares of local public health services. First, a number of jurisdictions determined city shares based on an established proportion of assessed property valuation. Eight of the 15 (53%) contracts for consolidated services determined city shares using this kind of mechanism. Most of these contracts (6 of 8, or 75%) relied on an established rate of inside millage to determine the city shares. However, two consolidated jurisdictions – Clark-New Carlisle and Portage-Ravenna – based their city shares on established proportions or millage rates of an enacted public health levy. In all of these cases, however, the actual amount of contribution made by the cities involved in the consolidation is determined based on the assessed valuation of property within their borders – a measure of their ability to pay for public health services.

Second, some of the contracts appear to rely on negotiated fixed dollar amounts to determine the costs to the consolidating cities of receiving public health services from the new and consolidated county LHD. Five of the 15 (33%) contracts we reviewed included fixed dollar amounts that did not specifically reference assessed valuations as the determinant of the dollar amount included in the contract. However, through our survey of consolidated LHDs, we later found that at least one of these five consolidations, the Hamilton County – Indian Hill consolidation, used an established assessed valuation rate based on inside millage to determine the fixed dollar amount. In addition, just this past year, the City of Akron moved away from a fixed dollar amount mechanism to a more dynamic approach that ties Akron's payments to the assessed valuation based payments made by other jurisdictions in Summit County.

And finally, 2 of the 15 consolidation contracts (13%) – both of which involved Franklin County Public Health (FCPH) – used a per capita payment arrangement to determine the amount of funding to be supplied by the cities merged to the consolidated health department. This approach is applied to all cities in Franklin County. As a result, the cities of Bexley and Pickerington pay a similar per capita rate of about \$5.60 (in 2012) to the FCPH to support the cost of their local public health services. Thus, Franklin County operates a two-tiered system for determining jurisdictional shares – one for cities based on per-capita income and one for villages and townships that is based on assessed property valuations. This appears to have created potential difficulties as villages gain populations sufficient to become cities and change the basis of their contributions. In 2010, for example, when New Albany gained population sufficient to become a city, it saw a reduction of about 50% in its contribution for local public health services – presumably because its share of assessed valuation was high relative to its share of the county's population. This two-tiered system could thus contribute to a perception of inequity across different types of jurisdictions in the financing of local public health services for Franklin County. Table 5 summarizes our findings from reviewing the fifteen consolidation contracts that we were able to access.

Table 5

**A Review of Available Ohio LHD Consolidation Contracts:
Mechanisms for Determining City Shares & Related Notes**

Consolidation	Mechanism Determining City Share	Year of Consolidation	Year of Contract Reviewed by KSU-CPPH	Amount of Payment &/or Other Notable Features of the Contract
Clark-New Carlisle	Assessed Valuation – PH Levy	2005	2004	Payment equals the city’s 1 mil human services levy.
Portage-Ravenna	Assessed Valuation-PH Levy	2013	2013	\$30k +, one-half year implementation for 2013.
Cuyahoga-Lakewood	Assessed Valuation – Inside Millage	2008	2008	\$228,777
Mahoning-Campbell	Assessed Valuation – Inside Millage	2003	2003	“amount determined by a rate of inside millage equal to the rate paid by other political subdivisions in the general health district.”
Mahoning-Struthers	Assessed Valuation-Inside Millage	2009	2012	“amount determined by a rate of inside millage equal to the rate paid by other political subdivisions comprising the general health district.”
Summit-Barberton	Assessed Valuation-Inside Millage	2010	2010	“apportionment on the basis of taxable valuations among each political subdivision”
Summit-Norton	Assessed Valuation-Inside Millage	2009	2009	“apportionment on the basis of taxable valuations among each political subdivision”
Hamilton-Reading	Assessed Valuation-Inside Millage	2003	2012	\$10,990.80, and future year payments shall be made on the same basis as the assessment to Townships and Villages.
Hamilton-Indian Hill	Fixed dollar amount	2006	2012	\$39,662.19, according to the CFO, this figure actually based on assessed valuation.
Crawford-Bucyrus	Fixed dollar amount	2002	2001	\$174,000, plus subsidies & other funds to Bucyrus for PH services. Amount to be reduced by PH levy collected on property.
Fairfield-Lancaster	Fixed dollar amount	2002	2011	\$247,000 – with additional charges for nuisance abatements.
Licking-Newark	Fixed dollar amount	2008	2012	\$788,000. Proceeds from levies may be used to reduce this amount. Newark may continue general fund payments above this amount.
Summit-Akron	Fixed dollar amount	2011	2010	Not to exceed \$5.337M in 2011, but with addition of a one-time \$150,000 payment. Subsequent revision reported by the CFO created a contract amount of 1.25 times total property taxes assessed to all other jurisdictions, effective in 2014.
Franklin-Bexley	Per-capita payment	2007	2007	Per capita rate of \$5.13, not to exceed \$67,993 in 2007. Extra charge for nuisance abatements. County receives state subsidy funds for Bexley.
Franklin-Pickerington	Per-capita payment	2010	2010	Per capita rate of \$5.73, not to exceed \$81,142 for 2010. Extra charge for nuisance abatements.
Source(s): Reviews of 15 consolidation contracts involving city and county LHDs in Ohio between 1999 and 2013, with supplemental information provided from the survey of recently consolidated LHDs, discussions with their Health Commissioners, and other sources.				

Notably, while we did not have an opportunity to review the Lucas-Toledo consolidation contract prior to developing this table, we were able to review it at a later point in time. Based on that review, it appears that the original consolidation contract involved multiple cities and apportioned percentage contributions of “intergovernmental revenue” to support local health services among the cities involved. It also included a provision to enable reviews of these cost allocations periodically.

Our data and analyses also reveal significant variations across recent Ohio LHD consolidations with respect to the proportion of local government revenues to the consolidated LHD that are provided by the city that participated in the consolidation. Table 6 overviews city-shares of local government revenues based on both total local revenues and property tax based government revenues reported in AFRs for cases of consolidation featuring cities that make up less than 10% of the overall county population. It also benchmarks those figures against the city shares of the population receiving LHD services, as this is one useful way to think about the variations in city-shares of local public health revenues. Table 7 highlights city-shares of local government revenues based total revenue from all political subdivisions within the county (townships, cities, villages) for consolidations featuring cities with 40% or more of the overall county population.

As shown in Table 6, nine of the 11 recently LHDs that consolidated between 2001 and 2012⁷ are characterized by the consolidation of a relatively small city into a larger County Health District. Indeed, in these 9 cases, the cities that have consolidated their health departments have 10% or less of the population served by the recently combined LHDs. Notably, only one of these cities -- Indian Hill in Hamilton County -- appears to contribute a share of total local revenues *and* property tax based local revenue that is larger than their proportionate share of the population. Only one additional city -- the City of Norton in Summit County -- appears to contribute a share of revenue from property tax-based sources that exceeds its share of the population. In both of these cases, this may occur because the city's contribution is determined by the value of its assessed property, which may be disproportionately higher than the other communities in their counties.

⁷ This sample excludes Portage County which consolidated operations with Ravenna in 2013.

Table 6

**City Shares of Local Public Health Revenue
for Consolidations Involving Cities with <10% of County Populations**

Consolidation	Local Revenue, from:			City Share of Local Revenue, Based On:		City population as a % of County population
	All Local Sources**	Property Tax Assessments: Public Health Levies & Inside Millage	Major City Involved in the Consolidation	% Local Revenue – All Local Sources	% of Local Revenue - Property Tax Assessments	
Hamilton-Indian Hill	\$2,164,326	\$488,313	\$39,662	1.8%	8.1%	1.3%
Summit-Norton	\$6,839,173	\$3,230,675	\$91,483	1.3%	2.8%	2.2%
Clark-New Carlisle	\$3,058,555	\$2,200,134	\$58,980	1.9%	2.7%	4.1%
Belmont-Martin's Ferry*	\$320,000*	\$271,869	\$18,301	5.7%	6.7%	9.8%
Franklin-Bexley	\$2,792,691	0	\$74,816	2.7%	NA	3.1%
Franklin-Pickerington	\$2,792,691	0	\$104,807	3.8%	NA	4.4%
Mahoning-Campbell**	\$1,442,926**	\$884,343**	\$18,587	1.3%	2.1%	4.8%
Mahoning-Struthers**	\$1,442,926**	\$884,343**	\$29,660	2.1%	3.4%	6.8%
Summit-Barberton	\$6,839,173	\$3,230,675	\$135,163	2%	4.2%	5.1%
Marion-Marion	\$902,359	\$658,863	\$447,638	49.6%	67.9%	53.1%

Sources: AFR Data for calendar year 2012 from ODH and a survey of recently consolidated LHDs. Portage County not included. Some data from Marion were obtained through follow up phone conversations with its financial officer.

* On its AFR for 2012, the Belmont LHD reported total local expenditures of \$374,248. However, the Belmont LHD Financial Officer reported to us that only \$320,000 of these funds were provided by local government bodies. Because that figure more closely represents the concept we are trying to measure, we use that figure here.

** Mahoning County's figures exclude its levy for Tuberculosis-related services.

*** "All local sources" includes contributions from cities, villages, townships, special contracts and potentially other local funding sources, except where indicated otherwise.

The two remaining cases of consolidation in our sample of recently consolidated LHDs – Lucas County-Toledo and Summit County-Akron – are ones in which the consolidating cities represent large proportions of the populations served by the newly consolidated LHD, 64.3% (Toledo) and 40% (Akron), respectively. These two cases, along with the Marion County case, are highlighted in Table 7. In both of these cases, we find that the cities pay their population-based proportionate share of expenses or more. Toledo pays about 69% of the total local revenue provided to the Lucas County LHD, an amount roughly equal to its share of the Lucas County population. In 2012, Akron provided 55% of the local revenues

received by the consolidated LHD in Summit County, even though Akron’s population represents only 40% of those served by the SCPH. Notably, our survey revealed that Akron and SCPH have now updated their contract and have used 125% of inside millage payments from other Summit County jurisdictions figure as the basis for Akron’s future payments for public health services.

Overall, the information and data we found suggest that recently consolidated LHDs in Ohio have chosen a range of ways to share the local costs of public health services, and there is also substantial variation in the proportionate shares provided by the city parties to LHD consolidations. In general, in the two counties where cities represent large portions of the population, the cities tend to take on local tax burdens that are equal to, or exceed, their shares of the population served by the consolidated department. Notably, and as indicated in Table 7, this latter situation is similar to the situation in Marion County, where the City of Marion represents about 53% of the population and pays about 68% of the property tax based revenue.

Table 7

City Shares of Local Public Health Revenue for Consolidations Involving Cities with 40% or More of the County Population				
Consolidation	All Local Subdivision Revenue*	Revenue from Major City Involved in the Consolidations	% Major city share of local subdivision revenue	City population as a % of County population
Summit-Akron	\$7,251,485**	\$4,020,810**	55.4%	40%
Lucas-Toledo	\$3,229,366	\$2,236,335	69%	64.3%
Marion-Marion	\$658,863	\$447,638	67.9%	53.1%

Sources: AFR Data for calendar year 2012 from ODH and a survey of recently consolidated LHDs. Some data from Akron, Marion, and Toledo information were obtained through follow up phone conversations with those departments’ financial officers.

****“All local subdivision revenue” includes tax and contract revenue from all local government jurisdictions (Townships, Villages, Cities) within the county. It does not include other sources of local revenue.**

****This figure for Akron was the total amount owed for 2012, not the AFR reported amount (\$3,181,881), which was the amount that SCPH actually received from Akron in 2012. This latter figure includes final 2011 payment, but excludes final amount paid for 2012.**

Fund Balance Carryover Practices among LHDs in Ohio

Our investigation of carryover practices reveals variations in carryover fund balances among Ohio LHDs, in terms of both total amounts carried over and carryover funds as a proportion of total annual expenditures. At the same time, our survey also reveals variable carryover management practices and a range of reported 2012 retirement payout levels among recently consolidated Ohio LHDs. Finally, our investigation of best practices for fund balance management (which includes carryover practices) reveals both guidance from national organizations and examples of practices that may be of use to Marion County and LHDs in Ohio. We discuss each of these sets of findings in turn.

Reported Carryover Fund Balances for Ohio LHDs

The 2012 AFRs revealed a wide range of reported carryover balances in 2012, both in terms of total dollars carried over and in terms of the percentage of annual expenditures those dollars represent. Total expenditures across LHDs in Ohio varied from \$27,686 in Belpre to \$43,305,775 in the City of Columbus. Total carryover amounts also varied widely, from - \$19,881 in Jackson County to \$7,207,111 in Delaware County. These same variations were evident when one views carryover as a percentage of annual expenditures in the year reported, as these percentages varied from - 1.6% to 122.6%. Summary data reflecting these variations are provided in Table 8.

Table 8

Carryover Reported in the 2012 AFR: Comparing Marion Public Health to Other Ohio LHDs*			
	Total Expenditures	Carryover Reported	Carryover as a % of Total Expenditures
Range	\$27,686 - \$43,305,775	\$-19,880.82 - \$7,207,111	-1.60% - 122.6%
Average (mean)	\$3,498,048	\$871,472.27	30.04%
Marion Public Health	\$1,955,625	\$443,143**	22.66%
Source: 2012 Annual Financial Report Data (submitted by Ohio LHDs to ODH in 2013)			
*Sample size (N) = 125			
** This figure was provided by MPH staff, and it includes only carryover fund balances designated by MPH as <i>unrestricted</i>, which are most relevant for understanding carryover practices associated with general revenues provided by local governments. The actual amount reported by MPH in its 2012 AFR is slightly over \$1 million, but this amount includes unspent balances in restricted funds. Because they are in restricted funds, these additional funds may not be readily available to meet needs associated with forward funding grants, making retirement payouts, or meeting unanticipated needs.			

Variations are also evident when one looks at the data provided by 13 County LHDs (excluding Marion County) in our sample which have experienced consolidations between 1999 and 2012. Among these LHDs, total reported 2012 expenditures varied between about \$1.5 and \$21 million. Reported carryover balances ranged from \$150,547 to more than \$5 million. Among this group of LHDs, carryover funds as a percentage of 2012 annual expenditures ranged from about 8.5% to about 53.5%. Summary data are shown in Table 9.

Table 9

**Carryover Reported in the 2012 AFR:
Comparing Marion Public Health to Other Recently Consolidated Ohio LHDs***

	Total Expenditures	Carryover Reported	Carryover as a % of Total Expenditures
Range	\$1.5M - \$21M	\$150,547 - \$5,041,328	8.54% - 53.54%
Average (mean)	\$6,900,633.50	\$1,872,719.53	26.76%
Marion Public Health	\$1,955,625	\$443,143**	22.66%

Source: 2012 Annual Financial Report Data (submitted by Ohio LHDs to ODH in 2013)

***Sample size (N) = 13, excluding MPH. The summary figures are based data submitted by the 13 recently consolidated county LHDs, excluding Marion County and Portage County.**

**** This figure was provided by MPH staff, and it includes only carryover fund balances designated by MPH as *unrestricted*. These balances are most relevant for understanding carryover practices associated with general revenues provided by local governments. The actual amount reported in by MPH in its 2012 AFR is slightly over \$1 million, but this amount includes unspent balances in restricted funds. Because they are in restricted funds, these additional funds may not be readily available to meet needs associated with forward funding grants, making retirement payouts, or meeting unanticipated needs.**

In comparison to other recently consolidated LHDs in Ohio, MPH’s expenditures, carryover funds, and carryover funds as a percentage of total expenditures (as reported above) appear lower than the averages reported for recently consolidated LHDs. Future efforts to improve our understanding of how other LHDs report carryover funds in the AFRs would increase our confidence in these findings⁸.

Carryover Fund Balance Management Practices Among Recently Consolidated County LHDs

Our survey of recently consolidated LHDs regarding their carryover practices revealed a range of insights. None of the reporting LHDs indicated that they operate according to a written policy regarding carryover balances, but they did reveal a range of ongoing practices.

While most of our survey respondents said they did not use industry best practices to guide their management of carryover balances, several did point toward practices that they viewed to be appropriate in their situations as LHDs in Ohio – and some of these practices are based on national guidance. Hamilton County reported that it seeks to maintain end of year fund balances that total at least 25% of annual expenditures. In addition, both Summit County and Lucas County – two of the larger LHDs in our sample – indicated that they draw guidance from practices outlined by the Government Finance Officers Association (GFOA).

We also asked the officials who responded to our survey to describe how they ensure that their carryover balances are sufficient and the steps they take to calculate those balances. The responding CFO’s reported using a range of fund balance management approaches. Clark County reported that they created an “Accrued Liability Fund” in 2001, and that they have analyzed potential payouts over the next ten years and are contributing appropriately to this fund to cover the cost of future liabilities. Other LHDs pointed out that they accounted for expected liabilities within their ongoing budgetary practices. For example, Hamilton County reported that its budgeting process requires a forward look to budget retirements and other known liabilities, while Lucas County also budgets for potential retirements in its annual appropriations process. Portage County reported that it plans to carryover funds sufficient to cover potential payouts, plus enough to cover operating costs for the Department for the first quarter of each

⁸ Indeed, as mentioned in footnote 5 in the data and methods section of this report, future research in this area may very well be appropriate.

year. In short, while the specific approaches vary, most of the LHD's responding to our survey reported that they go through some ongoing processes to estimate likely obligations, and they also reserve funds to cover operating expenses and/or emergencies in the event these funds are needed.

We also asked the respondents to our survey to report on the amount of funds that they disbursed in 2012 to cover costs associated with employee retirements (unpaid vacation and sick leave, compensatory time, etc.). The amounts reported ranged from \$15,257 to \$204,919. The average payment was \$84,286.

“Best Practices” for Public Sector Fund Balance Management: Guidance and an Example from Ohio

While – as noted above – our investigation did not identify any single widely used best practice among Ohio LHDs, we did find that a number of national public health and government finance organizations provide guidance on best practices for government financial accounting generally, and fund balance policies in particular. We also uncovered guidance regarding different ways in which these policies may be established. The discussions that follow identify national, state, and local organizations that seek to assist public health and/or other government organizations in managing their finances effectively, define ways to establish an-end-of year fund balance policy, and summarize several recommendations regarding minimum fund balances that are provided by the Government Finance Officers Association.

Key National Organizations and the Need for Fund Balance Policies:

We identified a number of organizations that call for sound financial practices in public health organizations and governments more generally. The Public Health Accreditation Board (PHAB), for example, suggests a “corrective action plan that shows compliance with funding requirement(s)....” (PHAB, 2013). PHAB and other public sector organizations, such as the International City Management Association (ICMA), the Government Finance Officers Association (GFOA), join in this call for sound financial practices and supplement it with more specific calls for planning and reasonable fund balance levels. These public sector-oriented organizations typically call for reasonable fund balances to provide fiscal stability. While these goals are important, they do little to contribute to a definitive standard. How much of a fund balance is recommended? Is 10%, 20%, or 30% a reasonable fund balance level? Should the balance be calculated as a percentage of revenues, expenditures, or an adjusted revenue or expenditure figure?

These questions are difficult enough, but the answers to them are further complicated by the uneven stream of revenue sources that often characterizes LHD finances. For example, some revenues are distributed periodically through the year rather than on a smooth and regular basis. As a result, some financial resources are often needed to “carry” the entity forward in anticipation of a later infusion of cash. This need to “carry forward” funding may apply to grants provided by federal and state governments, which constitute a significant portion of LHD revenues. Indeed, we understand from ODH that it is changing its grant fund distribution plans and is now asking LHDs to ensure that they have 90 days (25%) of initial funding to ensure no interruptions in services associated with their grants.

This problem is also evident for public bodies that rely on property tax distributions, which may be received late in the first quarter of a calendar year, and adopt a budget that is based on a 12 month cycle from January 1st to December 31st. This infusion of revenue may not be realized until the entity is several months into its 12 month budget year. In this case a fund balance is needed to financially cover the costs of key operations for the first several months of the year.

When one combines these questions with the complexity of fund accounting that is required in the public sector, the answers to questions regarding appropriate carryover balances outlined above becomes even more difficult. Resources may be readily available in a fund resulting from a federal or state grant, but these resources cannot be comingled with general resources that are used for general operations. Such grant money must be separate and distinct from general operating resources to insure the appropriate use of such resources to the grant agency. Similar segmentations of funds may also result in other accounts for restricted purposes that should not be comingled with other funds in order to ensure that the health purposes they are intended to accomplish can have the resources needed to make continuing progress toward the purposes for which the funds were established.

While we did not find a set of answers to these complex questions that are specifically focused on Ohio LHDs, we did find useful guidance from national public finance organizations such as the Governmental Accounting and Standards Board (GASB) and the GFOA. The GASB, for example, issued its Statement No. 54, *Fund Balance Reporting and Governmental Fund Type Definitions* that recognizes five types of fund balances and argues for an ongoing fund balance policy. The GASB's five-fold classification is provided to insure an understanding of the concept of government "funds" and creates a common language for communication between policy makers and the public. The GFOA recognizes the GASB definitions, and argues for maintaining adequate funds to mitigate current and future risks and to ensure stable tax rates. It also advocates for a formal fund balance policy. Its statements in these areas are quoted below, as released in GFOA's 2009 document on appropriate government fund balances.

“Accountants distinguish up to five separate categories of fund balance, based on the extent to which the government is bound to honor constraints on the specific purposes for which amounts can be spent: *nonspendable fund balance, restricted fund balance, committed fund balance, assigned fund balance, and unassigned fund balance.* The total of the last three categories, which include only resources without a constraint on spending or for which the constraint on spending is imposed by the government itself termed *unrestricted fund balance* (GFOA, 2009).”

“It is essential that governments maintain adequate levels of fund balance to mitigate current and future risks (e.g. revenue shortfalls and unanticipated expenditures) and to ensure stable tax rates. Fund balance levels are a crucial consideration, too, in long-term financial planning (GFOA, 2009).”

GFOA “recommends that governments establish a formal policy on the level of unrestricted fund balance that should be maintained in the general fund (GFOA, 2009).”

Based on research conducted to aid in the development of this report, there appear to be three fundamental approaches to the development of fund balance policies. First is the development of the policy as part of a strategic planning process. Second, is the effort to develop a policy based on forecasted revenue, and it may seek to establish “rainy day” funds to guard against revenue shortfalls. The third, and most popular, approach is to base a policy on expenditure levels. The expenditure approach is one suggestion of the GFOA. This standard is directly tied to the budgeting process. When one dollar is removed from a budget, exactly one dollar is added to the fund balance. This direct connection makes budget decisions abundantly clear.

The GFOA also recommends that governments, regardless of size, maintain unrestricted fund balance in their general fund of not less than two months (or almost 17%) of regular general fund operating expenditures. It is important to emphasize, however, that this is a *minimum* recommended general fund balance. The GFOA also explicitly recognizes that “a government’s particular situation often may require a level of unrestricted fund balance in the general fund significantly in excess of this recommended minimum level” (GFOA, 2009). It also suggests that the predictability of revenues and the

volatility of expenditures may give rise to a need for higher minimum unrestricted fund balances (GFOA, 2009). Because Ohio LHDs receive a substantial proportion of their revenues from external sources that are subject to change, it seems evident that a minimum fund balance in excess of 17% is likely to be appropriate for most LHDs in Ohio.

One Ohio local government that has followed an expenditure approach to setting minimum fund balances, as per GFOA Best Practice recommendations, is the City of Tallmadge. We provide a more detailed description of how the City of Tallmadge has managed its fund balances to enable readers to understand key elements of a system that might be considered for MPH and other LHDs in Ohio.

Tallmadge Approach

Tallmadge, Ohio (a community of 17,000 to the east of Akron) has a proactive fund balance policy. Funds are classified into 3 categories. Major funds in category 1, such as the City's general fund, water fund, and sewer fund require a minimum 25% reserve of the adjusted operating appropriation. The adjusted appropriation is the total appropriation including transfers for bond retirements and pension. However, other transfers and capital appropriation are removed in the adjustment. The result is an appropriation figure that represents ongoing commitments of the City such as personnel costs and general operating expenses.

A financial management system is established that includes monthly monitoring and a Financial Review Committee has been created. If it is forecasted that the budget will only have a reserve between 20%-25%, a Financial Action Plan is implemented. This system calls for the Director of Administration to attempt to return the minimum 25% balance.

If the reserve falls to the 15-20% range, further actions are specified including: hiring freezes, elimination of non-union wage increases, requests for wage concessions from union members, limitation on contractual services, and other actions. The Director of Administration is required to prepare a 2 year budget projection and the Financial Review Committee suggests revenue enhancement possibilities. If the reserve falls to 10%-15% the City is considered in a fiscal alert which calls for an action plan. The further reduction of the balance is not considered an acceptable part of such a plan. If the reserve falls below 10% the City is considered in fiscal crisis. Levies are considered, capital purchases are held to a minimum or stopped, and mandatory reduction of staffing is required.

Category 2 funds such as the Fire/EMS fund and Street Maintenance fund require an 8.5% reserve and have the same type of financial management system.

The Tallmadge plan has been in existence for a number of years and was last amended in 2005. The City, through close management under these policies, was able to accurately forecast the loss of revenues from the 2008 recession and took immediate action to suspend the street paving program and freeze capital expenditures. Through use of this plan and an active collaboration effort, the City increased its general fund balance to over \$6,000,000, which is approximately 40% of the adjusted appropriation in 2014.

In summary, relevant national organizations do advise that local government organizations follow reasonable and pre-designated plans and policies for managing carryover balances. There are several ways to go about establishing these policies, including developing carryover balance based on strategic planning process, establishing "rainy day" funds by separating pre-established proportions of revenue into separate funds, and by managing unrestricted fund balances in ways that ensure carryover funds equaling 17% or more of annual operating expenses. The GFOA also suggests that the 17% figure should be considered a minimum. The City of Tallmadge has used a variation on this approach in ways that have

yielded financial stability in recent years, when many other public sector organizations have struggled to cope with financial uncertainties.

While we did not find written carryover management policies among the recently consolidated LHDs we surveyed (see discussion in the previous subsection), we did find several LHDs that referenced the GFOA guidance, and we found others who sought to manage their carryover balances in ways that are consistent with it. In this sense, the GFOA approach appears to be as close to a best practice that is available. While it is targeted toward general purpose local governments, its principles appear to be applicable to LHDs in Ohio.

VI. Recommendations

Decisions regarding the shares of local government funding provided by various jurisdictions to support public health services, and appropriate fund balance policies, are governed by local communities. However, there are times when recommendations from external parties can help facilitate productive discussions regarding these kinds of issues. It is in this spirit that we offer the recommendations below. Our hope is that the local government jurisdictions in Marion County, along with stakeholders with interests in the health of the county's citizenry, can use our recommendations to assist the recently consolidated MPH in stabilizing its resource flows and in providing a solid financial foundation for needed long-term public health improvement efforts.

Recommendations Regarding City and County Shares to Marion Public Health

While the current shares of intergovernmental revenue support provided by the City of Marion and other jurisdictions in Marion County were established through a contractual arrangement, they appear to be unsustainable over the long term. This is because they enshrine a set of expenditure levels from 2008 into ongoing practice, without providing for equitable adjustments in contribution levels over time. As a result, leaders of local jurisdictions are likely to question – perhaps continually -- whether their citizens are being treated equitably. Over the long term, this kind of ongoing skepticism will draw attention and resources away from public health services and diminish MPH's ability to deliver needed public health services effectively and efficiently.

Our review of city-county funding share arrangements in other recently consolidated LHDs in Ohio reveals that the vast majority have grounded their city-county funding shares with indicators of either a need for health services (typically, based on population) or indicators of ability to pay (typically assessed property valuations). The Akron-Summit County and the Toledo-Lucas County consolidations appear to have moved beyond initial funding arrangements to arrangements based on more dynamic indicators of underlying needs and payment capabilities. It is time for Marion County to do the same, and we offer more specific suggestions below.

5. Marion County should define a new method of determining the city and county shares of locally provided LHD revenues that is based on population shares within Marion County. This kind of population indicator reflects both health needs and the benefits likely to be received from health related services.
 - a. Using a population-based method for determining city and county shares approximates the need for and utilization of public health services. Calculating city and countywide shares of “intergovernmental revenue” flowing to MPH on a per capita basis would also reduce funding burdens on the City of Marion, which is currently paying a higher share of the local government contribution (68%) than its share of the jurisdiction's overall

population (53%) would warrant⁹. This method also creates a forward-looking mechanism for allocating funds that can keep pace with changes in public health needs across MPH's population over time.¹⁰

6. MPH should separate out the services provided exclusively to the City of Marion and not to the rest of the county. The full costs of these “city only” services should be paid by the City of Marion.
 - a. Currently, the costs of these “City-only” services appear to be comingled in the “intergovernmental revenue” figure that is supported by both the city and the outlying Marion County jurisdictions. This yields a potential for confusion regarding what jurisdictions are paying for what services. Placing the cost burden of these “City-only” services on the jurisdiction receiving the services is also likely to improve the perceived equity of the funding arrangements employed over time. In the end, this change may also relieve financial pressures on outlying areas, which may see an increase in their share of the funding as a result of the switch to a population-based calculation.
7. The transition to a population-based calculation of the city/county shares should take place over the period of two or three years to ease impacts on individual jurisdictions.
 - a. Implementing a gradual process for changing city-county cost shares would ease financial adjustments associated with a new arrangement, and provide time for the jurisdictions to fully implement to the changes recommended above.
8. MPH officials should convene a group of respected citizens who, as a collectivity, have equal ties to the city and the outlying areas of the county to review the funding source changes made two years after they are fully implemented (e.g., within five years of initial implementation).
 - a. After the new city-county shares arrangement is defined and fully implemented, it makes sense to take stock of how well it is actually working. Given the fact that the consolidation and the creation of MPH was a citizen-led endeavor, enabling members of the general public to assess the new funding arrangement and recommend any changes they deem appropriate should help build support and trust in both the new funding arrangement and the still young and recently consolidated MPH.

⁹ If one removes the expenditures focused only on the City of Marion from this figure, the City's proportion of general local government contribution appears to drop a percentage point or two to 66% or 67%.

¹⁰ If MPH and Marion County officials decide to proceed with this population-based approach, they could also consider taking steps to guard against the kinds of potential impacts that were discussed earlier in relation to Franklin County, which draws revenue differently based on the type of jurisdiction (cities vs. villages and townships). This potential problem of perceived equity across jurisdictional types does not appear likely to develop in the near term in Marion County because there are no villages that even approach the 5,000 person threshold for becoming cities in Ohio. However, potential future problems could be alleviated by limiting the scope of population-based financing to the funding split between the City of Marion and all other jurisdictions, with financing from all of the smaller jurisdictions being based on ability to pay (eg. property tax valuations). Because the City of Marion represents more than half of the Marion County population, it is different than other Marion County jurisdictions and there is therefore some rationale to structure its financial contributions differently than other jurisdictions.

Recommendations Regarding Fund Balance Management Practices and Carryover

Based on our review of existing data on MPH's carryover amounts and practices, and our understanding of both the GFOA's recommended "best practices" and successful practices we have identified in other jurisdictions, we make the following recommendations:

4. The MPH should establish a written policy for managing its General Fund balances.
 - a. While it is clear from our research that not all LHD's in Ohio have established formal written fund balance policies, a number of them do appear to use ongoing "best practices" in this area. In general, these practices involve systematically identifying future liabilities and establishing ongoing plans and practices to ensure that they can meet these liabilities. While the current practices regarding the management of carryover do not appear to have resulted in any significant problems to date, it seems clear that the recently consolidated MPH is undergoing a period of growth and transition that involves new staff, altered governing arrangements, and questions regarding the use of unspent funds provided by local jurisdictions that benefit from the MPH's services. In this context, we believe that the process of developing a written policy would be useful in both developing common understandings regarding ongoing practices and in creating a mechanism for enabling stable and effective use of organizational resources.
5. The MPH should join other LHDs in Ohio in drawing useful guidance from the GFOA's 2009 "Best Practices" document (see appendix).
 - a. While the GFOA document focuses most specifically on "General Purpose" governments, it also recognizes explicitly that governments differ in their characteristics and that some governments should maintain unrestricted fund balances that exceed the minimum 17% (e.g., 2 months of operations) of general fund revenues or expenditures that GFOA recommends. Because LHDs in Ohio – including MPH -- rely heavily on external funding sources for core public health services that are subject to fluctuations, as well as termination in some cases, it would seem prudent to establish a policy specifying a minimum fund balance of an amount greater than the 17% forwarded by GFOA. In addition, because Ohio LHDs rely on external funds to pay salaries and benefits for their staffs and – more generally -- for a high proportion of their public health expenditures, it seems appropriate to apply this minimum balance to total expenditures (perhaps less any larger and temporary capital investments) rather than only to expenditures made from the general fund.

While the actual determination of an appropriate minimum fund balance is a policy judgment that is most appropriately made by Marion County's Board of Health, we believe Hamilton County's ongoing effort to establish balances of "at least 25%" of annual expenditures would be an appropriate starting point for discussions in this area. This figure is also consistent with the average reported carryover balances provided by LHDs in Ohio, which is just over 25%.

6. The MPH may also want consider a staged process of policy responses to differing fund balances as is done in the City of Tallmadge, Ohio (see appendix). Decisions on policy responses may also affect judgments on threshold fund balances incorporated into the written policy referenced in 1 and 2 above.

VII. Conclusion

In summary, MPH benefits from local government support within a range that roughly approximates other LHDs in Ohio and around the nation. Its unrestricted carryover balance of 22.7% of total annual expenditures seems to us be in the range of what might be expected from a financially solvent LHD in Ohio. However, the MPH's current reliance on a fixed 68-32% funding share split is problematic because it enshrines expenditures levels from more than five years ago as an ongoing foundation for shares of city-county funding to support MPH services, and this foundation has no clear and ongoing relationship to health needs, service utilization, or ability to pay. As a result, over time this practice is likely to undermine support for MPH's work, and impede its growth and effectiveness in fostering the health of Marion County citizens.

While policies regarding city and county shares of local government revenues for public health and appropriate carryover fund balances should be set by local communities, we offer in this report two sets of recommendations designed to support the ongoing improvement of public health in Marion County. We suggest that Marion County move toward a more dynamic, population-based, foundation for allocating local shares of public health service costs. We also suggest that MPH establish – in cooperation with its Board of Health – a written policy concerning carryover of general fund account balances. By taking these steps, and building relationships that are characterized by transparency and trust, we believe the MPH, its governing institutions, and the stakeholders with whom it works can build a brighter public health future for the citizens of Marion County.

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IX. Appendices

Appendix 1: Government Finance Officers Association Guidance



BEST PRACTICE

Appropriate Level of Unrestricted Fund Balance in the General Fund (2002 and 2009) (BUDGET and CAAFR)

Background. Accountants employ the term *fund balance* to describe the net assets of governmental funds calculated in accordance with generally accepted accounting principles (GAAP). Budget professionals commonly use this same term to describe the net assets of governmental funds calculated on a government's budgetary basis.¹ In both cases, fund balance is intended to serve as a measure of the financial resources available in a governmental fund.

Accountants distinguish up to five separate categories of fund balance, based on the extent to which the government is bound to honor constraints on the specific purposes for which amounts can be spent: *nonspendable fund balance*, *restricted fund balance*, *committed fund balance*, *assigned fund balance*, and *unassigned fund balance*.² The total of the last three categories, which include only resources without a constraint on spending or for which the constraint on spending is imposed by the government itself, is termed *unrestricted fund balance*.

It is essential that governments maintain adequate levels of fund balance to mitigate current and future risks (e.g., revenue shortfalls and unanticipated expenditures) and to ensure stable tax rates. Fund balance levels are a crucial consideration, too, in long-term financial planning.

In most cases, discussions of fund balance will properly focus on a government's general fund. Nonetheless, financial resources available in other funds should also be considered in assessing the adequacy of unrestricted fund balance (i.e., the total of the amounts reported as committed, assigned, and unassigned fund balance) in the general fund.

Credit rating agencies monitor levels of fund balance and unrestricted fund balance in a government's general fund to evaluate a government's continued creditworthiness. Likewise, laws and regulations often govern appropriate levels of fund balance and unrestricted fund balance for state and local governments.

Those interested primarily in a government's creditworthiness or economic condition (e.g., rating agencies) are likely to favor increased levels of fund balance. Opposing pressures often come from unions, taxpayers and citizens' groups, which may view high levels of fund balance as "excessive."

Recommendation. The Government Finance Officers Association (GFOA) recommends that governments establish a formal policy on the level of unrestricted fund balance that should be maintained in the general fund.³ Such a guideline should be set by the appropriate policy body and should provide both a temporal framework and

¹ For the sake of clarity, this recommended practice uses the terms GAAP fund balance and budgetary fund balance to distinguish these two different uses of the same term.

² These categories are set forth in Governmental Accounting Standards Board (GASB) Statement No. 54, *Fund Balance Reporting and Governmental Fund Type Definitions*, which must be implemented for financial statements for periods ended June 30, 2011 and later.

³ Sometimes restricted fund balance includes resources available to finance items that typically would require the use of unrestricted fund balance (e.g., a contingency reserve). In that case, such amounts should be included as part of unrestricted fund balance for purposes of analysis.

specific plans for increasing or decreasing the level of unrestricted fund balance, if it is inconsistent with that policy.⁴

The adequacy of unrestricted fund balance in the general fund should be assessed based upon a government's own specific circumstances. Nevertheless, GFOA recommends, at a minimum, that general-purpose governments, regardless of size, maintain unrestricted fund balance in their general fund of no less than two months of regular general fund operating revenues or regular general fund operating expenditures.⁵ The choice of revenues or expenditures as a basis of comparison may be dictated by what is more predictable in a government's particular circumstances.⁶ Furthermore, a government's particular situation often may require a level of unrestricted fund balance in the general fund significantly in excess of this recommended minimum level. In any case, such measures should be applied within the context of long-term forecasting, thereby avoiding the risk of placing too much emphasis upon the level of unrestricted fund balance in the general fund at any one time.

In establishing a policy governing the level of unrestricted fund balance in the general fund, a government should consider a variety of factors, including:

- The predictability of its revenues and the volatility of its expenditures (i.e., higher levels of unrestricted fund balance may be needed if significant revenue sources are subject to unpredictable fluctuations or if operating expenditures are highly volatile);
- Its perceived exposure to significant one-time outlays (e.g., disasters, immediate capital needs, state budget cuts);
- The potential drain upon general fund resources from other funds as well as the availability of resources in other funds (i.e., deficits in other funds may require that a higher level of unrestricted fund balance be maintained in the general fund, just as, the availability of resources in other funds may reduce the amount of unrestricted fund balance needed in the general fund);⁷
- Liquidity (i.e., a disparity between when financial resources actually become available to make payments and the average maturity of related liabilities may require that a higher level of resources be maintained); and
- Commitments and assignments (i.e., governments may wish to maintain higher levels of unrestricted fund balance to compensate for any portion of unrestricted fund balance already committed or assigned by the government for a specific purpose).

Furthermore, governments may deem it appropriate to exclude from consideration resources that have been committed or assigned to some other purpose and focus on unassigned fund balance rather than on unrestricted fund balance.

Naturally, any policy addressing desirable levels of unrestricted fund balance in the general fund should be in conformity with all applicable legal and regulatory constraints. In this case in particular, it is essential that differences between GAAP fund balance and budgetary fund balance be fully appreciated by all interested parties.

Approved by the GFOA's Executive Board, October, 2009.

⁴ See Recommended Practice 4.1 of the National Advisory Council on State and Local Budgeting governments on the need to "maintain a prudent level of financial resources to protect against reducing service levels or raising taxes and fees because of temporary revenue shortfalls or unpredicted one-time expenditures" (Recommended Practice 4.1).

⁵ In practice, a level of unrestricted fund balance significantly lower than the recommended minimum may be appropriate for states and America's largest governments (e.g., cities, counties, and school districts) because they often are in a better position to predict contingencies (for the same reason that an insurance company can more readily predict the number of accidents for a pool of 500,000 drivers than for a pool of fifty), and because their revenues and expenditures often are more diversified and thus potentially less subject to volatility.

⁶ In either case, unusual items that would distort trends (e.g., one-time revenues and expenditures) should be excluded, whereas recurring transfers should be included. Once the decision has been made to compare unrestricted fund balance to either revenues or expenditures, that decision should be followed consistently from period to period.

⁷ However, except as discussed in footnote 4, not to a level below the recommended minimum.

Appendix 2: City of Tallmadge, Ohio Fund Balance Related Ordinances

Ordinance 33-2005

Presented by:
Director of Finance Jill Stritch

AMENDING AND SUPPLEMENTING TALLMADGE CODIFIED ORDINANCES SECTION 125.02 TO EXPAND AND FURTHER DEFINE THE MINIMUM FUND BALANCE POLICY AND PROVIDING FOR IMMEDIATE ENACTMENT

WHEREAS, Ordinance 64-1998 established a minimum fund balance policy for the City; and

WHEREAS, the Financial Review Committee met and has recommended changes to the policy to provide a more extensive financial management plan with guidelines.

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF TALLMADGE, COUNTIES OF SUMMIT AND PORTAGE, STATE OF OHIO:

SECTION 1. That Tallmadge Codified Ordinances Section 125.02 is hereby amended and supplemented to provide as follows:

“125.02 MINIMUM FUND BALANCE POLICY.

(a) Purpose. This policy is designed to take a proactive approach to financial management in the City of Tallmadge. A minimum fund balance policy assists the City in maintaining the security of major operating funds and contributes to the financial stability of the City by maintaining adequate financial reserves. Also, a minimum fund balance policy will allow the Administration and Council to recognize and react to warning indicators of financial stress and set guidelines for proactive measures.

(b) Policy. At the time of budget preparation, annual appropriations shall be adjusted to ensure that the Anticipated Fund Balances are greater than or equal to the Minimum Fund Balance as described in the scope of this policy.

(c) Definitions.

(1) “Projected Beginning Fund Balance” means the projected unencumbered fund balance for the beginning of the fiscal year. The projected beginning fund balance is calculated at the time the budget is prepared.

(2) “Operating Appropriation” means total appropriations including transfers for Bond Retirement and Pension as these represent ongoing commitments of the City. Excluded are all other transfers and capital appropriations.

- (3) “Anticipated Revenue” means the amount of revenue the City expects to receive in the upcoming fiscal year to fund annual appropriations.
- (4) “Anticipated Fund Balance” means an amount equal to the Projected Beginning Fund Balance less Total Appropriations plus Anticipated Revenue. The anticipated fund balance is calculated at the time the budget is prepared.
- (5) “Financial Review Committee” means a committee to review financial matters of the City, consisting of the Director of Finance, Mayor, Director of Administration, Chairman of Finance Committee of Council, and member of the Finance Committee of Council.

(d) Scope.

- (1) This Policy applies to all Major Funds used by the City and are listed below in three different categories:
 - A. Category 1: These funds have more than one million dollars (\$1,000,000) in operating appropriations and receive no more than 10% of revenue from transfers. They have their own significant source of revenues and therefore should be required to carry a minimum fund balance of 25% of operating appropriations. These funds are Category 1 Major Funds and include: General Fund, Sanitary Sewer Operating Fund, and Water Operating Fund.
 - B. Category 2: These funds have more than one million dollars (\$1,000,000) in operating appropriations. They rely heavily on operating transfers and therefore should be required to carry a smaller minimum fund balance of 8.5% of operating appropriations. These funds are Category 2 Major Funds and include: Fire/EMS Fund and Street Maintenance and Repair Fund.

Note: The Self Insurance Fund would fall under a Category 2 fund, although it has separate legislation that requires a minimum balance of one hundred thousand dollars (\$100,000) due to the nature of that fund.
 - C. Category 3: These funds are created for the sole purpose of a capital project, whether governmental, enterprise, internal service, trust, or agency funds. These are Category 3 Major Fund status even if they satisfy the criteria for the above two categories. There is no requirement to maintain a minimum fund balance on these funds.
- (2) All other funds are considered minor funds and are not required to maintain a minimum fund balance. Funds may be recategorized as needed if they meet the requirements of Category 1, 2, or 3 at a future date.

(e) Application.

- (1) The anticipated fund balance will be calculated at the time of budget preparation. Anticipated fund balance will be calculated taking the budget year's projected beginning fund balance less appropriations (which may include debt service) plus anticipated revenue. The resulting fund balance must comply to the minimum fund balances established in the scope of this policy.
- (2) This policy will be applied to the annual operating budget of the City prior to presenting it to Council. Any changes in the budget made by Council must also comply with the restrictions established in this policy prior to the adoption of the annual appropriation ordinance.

(f) Monitoring. Fund balances will be monitored on a month-to-month basis. Monitoring projections will be based upon trend data. The fund balances may drop temporarily below the minimum level due to current operations or emergencies. Additional monitoring and reports will be done per the Financial Action Plan when required.

(g) Compliance. Once it is determined that the City cannot meet the requirements of this policy, the Mayor will include a concise statement in the annual appropriations ordinance explaining the decision to waive the policy. The statement should include the present financial status of the City, a specified timetable for returning to the policy, and reason(s) given for overriding the policy. Should it be determined that the City will not be able to fall within conformance within one year, the Financial Action Plan will be implemented.

(h) Financial Action Plan. Once it is determined that the General Fund will not be able to meet the required 25% reserve, the financial action plan shall be implemented in various stages for each category of funds.

(1) Category 1 Funds - General Fund:

A. Step 1 Projected reserves drop between 20% to 25%

1. If the reserves drop below 25% because of a one-time capital purchase, no action will be needed on the assumption that the reserves will be met within one year.
2. If the reserves drop below 25% due to operational expenses, the Director of Administration shall, during the budget process, reduce all possible appropriations. If this process brings the budget within the required 25% reserve, no further action is required.
3. If the above process does not provide for the required reserves, the reserve may be reduced to 20%, provided that a report is compiled from the Mayor, as stated in the Compliance section

of this policy.

B. Step 2 Projected reserves drop between 15% to 20%

1. If the reserves drop between 15%–20%, the City must take additional measures to limit expenditures and increase revenues.
2. The City will enact a hiring freeze for any additional personnel who are funded through this fund, unless there is a revenue generating program to pay for the individual(s).
3. All non-union wages may be frozen; a request for wage concessions from its union employees will be made.
4. All non-essential expenditures shall cease.
5. The use of contractual employees and/or consultants will be closely scrutinized and discouraged.
6. Purchase of capital items shall only be made if absolutely necessary, provided that those purchases do not increase future operating costs.
7. The Mayor and his/her designees shall review all charges for fees and seek additional revenue sources.
8. The Director of Administration shall prepare a two-year budget projection to determine the long-term financial impact of the recommended changes.
9. The Financial Review Committee shall meet and consider the necessary suggestions for revenue enhancements.

C. Step 3 Projected reserves drop between 10% to 15%

1. The City should consider itself in a fiscal alert.
2. Review existing tax levies and consider replacements or other alternatives.
3. Reduction in staffing shall be reviewed and considered.
4. The Financial Review Committee shall meet to discuss revenue enhancements, tax levies, and reductions in personnel. The Committee must present a report back to Council with a financial plan for recovery.
5. This reduction in reserves should not be considered as acceptable.

D. Step 4 Projected reserves drop below 10%

1. The City should be considered in a fiscal crisis and shall take all measures necessary to improve the financial condition of the City.
2. In addition to the steps above, tax levies must be considered.
3. Capital purchases must be held to an absolute minimum or stopped.

4. Mandatory reduction of staffing at all levels.
5. Reciprocity of income tax should be reduced.
6. All City Administrators shall work to make every effort to raise revenues to bolster their reserves and limit expenditures. This may continue for multiple years, but it is suggested to make changes in a short time frame.

(2) Category 1 - Enterprise Funds (Water and Sewer Operating)

A. Step 1 Projected reserves drop between 20% to 25%

1. If the reserves drop below 25% because of a one-time capital purchase, no further action will be needed on the assumption that the reserves will be met within one year.
2. If the reserves drop below 25% due to operational expenses, the Director of Administration shall, during the budget process, reduce all possible appropriations. If this step brings the budget within the required 25% reserve, no further action is required.
3. If the above process does not provide for the required reserves, the reserve may be reduced to 20%, provided that a report is compiled from the Mayor, as stated in the Compliance section of this policy.
4. During the fiscal year that the fund is below 25% reserve, the Director of Public Service may raise fees to bring the fund back into alignment.

B. Step 2 Projected reserves drop between 15% to 20%

1. If the reserves drop between 15%–20%, the City must take additional measures to limit expenditures and increase revenues.
2. The City will enact a hiring freeze for any additional personnel who are funded through this fund, unless there is a revenue generating program to pay for the individual(s).
3. All non-union wages may be frozen; a request for wage concessions from its union employees will be made.
4. All non-essential expenditures shall cease.
5. The use of contractual employees and or consultants will be closely scrutinized and discouraged.
6. Purchase of capital items shall only be made if absolutely necessary, provided that those purchases do not increase future operating costs.
7. The Director of Public Service shall notify Council and may institute a rate increase for the enterprise fund(s).
8. The Director of Administration shall prepare a two-year budget projection to determine the long-term financial impact of the recommended changes.
9. The Director of Public Service must do a rate study which reflects the anticipated revenues and expenditures along with capital outlays for the particular enterprise fund.

C. Step 3 Projected reserves drop below 15%

1. If the reserves drop below 15%, it is considered unacceptable and the above actions must continue.
 2. Reduction in staffing shall be reviewed.
- (3) Category 2 Funds - Fire/EMS and Street Maintenance and Repair (SMR)
- A. Step 1 Projected reserves drop below 8.5%
1. If the reserves drop below 8.5% due to operational expenses, the Director of Administration shall, during the budget process, reduce all possible appropriations. If this step brings the budget within the required 8.5% reserve, no further action is required.
 2. When these funds are unable to meet the 8.5% reserve, revenues may be transferred in from the General Fund when possible.
 3. Should the General Fund be unable to meet its required reserve, the Category 2 funds balances may drop to 5%, provided that a report is compiled from the Mayor, as stated in the Compliance section of this policy.
- B. Step 2 Projected reserves drop below 5%
1. All City Administrators shall work to make every effort to raise revenues to bolster their reserves and limit expenditures.
 2. The City will enact a hiring freeze for any additional personnel charged to the specific fund, unless there is a revenue generating program to pay for the individual(s).
 3. Reduction in staffing shall be reviewed.
 4. Review of services and staffing shall be done.
 5. All non-union wages may be frozen; a request for wage concessions from its union employees will be made.
 6. All non-essential expenditures shall cease.
 7. The use of contractual employees and/or consultants will be closely scrutinized and discouraged.
 8. Purchases of capital items shall only be made if absolutely necessary, provided that those purchases do not increase future operating costs.
 9. The Mayor, Director of Administration, and Finance Director shall review all charges for fees and evaluate new revenue sources, including but not limited to, tax levy replacements, additional levies, etc.
 10. The Director of Administration shall prepare a two-year budget projection to determine the long term financial impact of the recommended changes.
 11. The Financial Review Committee shall meet and consider the necessary suggestions for revenue enhancements and present them to Council.
- (4) Category 3 Funds are excluded from major fund status, thereby requiring no minimum balance.”

SECTION 2. That it is found and determined that all formal actions of this Council concerning and relating to the adoption of this ordinance were adopted in an open meeting of this Council, and that all deliberations of this Council and of any of its committees on or after November 28, 1975 that resulted in such formal action, were in meetings open to the public, in compliance with all legal requirements including Section 121.22 of the Ohio Revised Code.

SECTION 3. That this ordinance is necessary to provide for and to accomplish the purposes herein set forth, which are conducive to the health, safety, and welfare of the citizens of Tallmadge. For that reason, provided this ordinance shall receive the affirmative vote of three-fourths of the members of Council and approval by the Mayor, it shall be enacted immediately and shall be of immediate effect.

Passed:

Susan E. Wilson, Clerk of Council

PKT/kl

03/08/05

Filed with the Mayor _____

Jerry E. Feeman, President of Council

Approved:

Christopher B. Grimm, Mayor

This _____ day of _____, 2005

Committee Assignment: _____

Readings 1st _____

2nd _____

3rd

AMENDED 10/12/00

Ordinance 137-2000

Presented by:

Director of Finance Jill Stritch

**AMENDING ORDINANCES 79-1985 AND 29-1994 TO REFLECT CURRENT POLICY FOR
THE GENERAL INFRASTRUCTURE FUND AND PROVIDING FOR IMMEDIATE
ENACTMENT**

WHEREAS, Ordinance 79-1985 established the General Infrastructure Reserve Fund; and

WHEREAS, this Council and Administration recognize the importance of financial reserves in order to maintain the City's general infrastructure which is crucial for the health and safety of the citizens of Tallmadge and to promote economic development; and

WHEREAS, a Financial Review Committee has been established to periodically review financial policies of the City; and

WHEREAS, the Financial Review Committee has recommended updating the general infrastructure ordinance to reflect current procedures and to better define the use of expenditures of the General Infrastructure Fund and to incorporate Ordinance 29-1994.

**NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF TALLMADGE,
COUNTIES OF SUMMIT AND PORTAGE, STATE OF OHIO:**

SECTION 1. That the annual sum equal to five percent (5%) of the General Fund capital improvement allocation be transferred to the General Infrastructure Fund.

SECTION 2. That the monies in this fund shall be used exclusively for the emergency repairs, renovation and refurbishing of existing general capital facilities, provided the expenditure is intended to lengthen the life of the asset. This fund can also be used for the payment of costs of third party damages and corrective actions necessary to clean up any petroleum release from city-owned or maintained underground storage tanks.

SECTION 3. That expenditures of this fund shall not be used for routine maintenance of the general infrastructure system. Items of a routine nature shall be included in the operating budget(s) of the respective department(s).

SECTION 4. That the Director of Finance shall prepare an annual fixed asset report, listing all capital assets for which records exist and with an assigned value, which are owned by the City. That such listing shall be maintained on file in the Finance Office and will be available for inspection. That such assets shall continue to be included and audited as part of the Comprehensive Annual Financial Report prepared by the office of the Director of Finance.

SECTION 5. That the appropriation of monies for this fund shall be in the annual appropriation of the City or otherwise as needed.

SECTION 6. That all portions of Ordinances 79-1985 and 29-1994 inconsistent with this legislation are hereby repealed.

SECTION 7. That it is found and determined that all formal actions of this Council concerning and relating to the adoption of this ordinance were adopted in an open meeting of this Council, and that all deliberations of this Council and of any of its committees on or after November 28, 1975 that resulted in such formal action, were in meetings open to the public, in compliance with all legal requirements including Section 121.22 of the Ohio Revised Code.

SECTION 8. That this ordinance is necessary to provide for and to accomplish the purposes herein set forth, which are conducive to the health, safety, and welfare of the citizens of Tallmadge. For that reason, provided this ordinance shall receive the affirmative vote of three-fourths of the members of Council and approval by the Mayor, it shall be enacted immediately and shall be of immediate effect.

Passed:

Susan E. Wilson, Clerk of Council

Jerry E. Feeman, President of Council

RAS/kl

09/11/00

AMENDED 10/12/00

Filed with the Mayor _____

Approved:

Christopher B. Grimm, Mayor

This _____ day of _____,

2000

Committee Assignment: _____

Readings 1st _____ 2nd _____ 3rd

AMENDING ORDINANCE 80-1985 TO REFLECT CURRENT SEWER INFRASTRUCTURE
POLICY AND PROVIDING FOR IMMEDIATE ENACTMENT

WHEREAS, Ordinance 80-1985 established the Sanitary Sewer Infrastructure Reserve Fund; and

WHEREAS, this Council and Administration recognize the importance of financial reserves in order to maintain the City's Sanitary Sewer Infrastructure which is crucial for the health and safety of the citizens of Tallmadge and to promote economic development; and

WHEREAS, a Financial Review Committee has been established to periodically review financial policies of the City; and

WHEREAS, the Financial Review Committee has recommended updating the sewer infrastructure policy to reflect current procedures and to better define the use of expenditures of the Sewer Infrastructure Fund.

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF TALLMADGE,
COUNTIES OF SUMMIT AND PORTAGE, STATE OF OHIO:

SECTION 1. That an annual sum equal to six percent (6%) of the actual Sanitary Sewer Operating Fund Revenue shall be transferred to the Sanitary Sewer Infrastructure Fund.

SECTION 2. That the monies in this fund shall be used exclusively for the emergency repairs, renovation and refurbishing of existing sanitary sewer capital facilities, provided the expenditure is intended to lengthen the life of the asset.

SECTION 3. That expenditures of this fund shall not be used for routine maintenance of the sanitary sewer infrastructure system. Items of a routine nature shall be included in the operating budget(s) of the respective department(s).

SECTION 4. That the Director of Finance shall prepare an annual fixed asset report, listing all capital assets for which records exist and with an assigned value, which are owned by the City. That such listing shall be maintained on file in the Finance Office and will be available for inspection. That such assets shall continue to be included and audited as part of the Comprehensive Annual Financial Report prepared by the office of the Director of Finance.

SECTION 5. That the appropriation of monies for this fund shall be in the annual appropriation of the City or otherwise as needed.

SECTION 6. That all portions of Ordinance 80-1985 inconsistent with this legislation are hereby repealed.

SECTION 7. That it is found and determined that all formal actions of this Council concerning and relating to the adoption of this ordinance were adopted in an open meeting of this Council, and that all deliberations of this Council and of any of its committees on or after November 28, 1975 that resulted in such formal action, were in meetings open to the public, in compliance with all legal requirements including Section 121.22 of the Ohio Revised Code.

SECTION 8. That this ordinance is necessary to provide for and to accomplish the purposes herein set forth, which are conducive to the health, safety, and welfare of the citizens of Tallmadge. For that reason, provided this ordinance shall receive the affirmative vote of three-fourths of the members of Council and approval by the Mayor, it shall be enacted immediately and shall be of immediate effect.

Passed:

Susan E. Wilson, Clerk of Council

Jerry E. Feeman, President of Council

RAS/kl

09/11/00

Filed with the Mayor _____

Approved:

Christopher B. Grimm, Mayor

This _____ day of _____,

2000

Committee Assignment: _____

Readings 1st _____ 2nd _____ 3rd _____
