



Independent Auditor's Report and Combined
Financial Statements

**Santa Clara County Health Authority
(dba Santa Clara Family Health
Plan) and Santa Clara Community
Health Authority**

Years Ended June 30, 2010 and 2009

MOSS ADAMS LLP

Certified Public Accountants | Business Consultants

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MANAGEMENT'S DISCUSSION AND ANALYSIS

**SANTA CLARA COUNTY HEALTH AUTHORITY
(dba SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
MANAGEMENT'S DISCUSSION AND ANALYSIS
Fiscal Years Ended June 30, 2010, 2009, and 2008**

The management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively the "Health Authority"), has prepared this discussion and analysis to provide readers and interested parties with an overview of the organization's financial activities for the fiscal years ended June 30, 2010, 2009, and 2008. This discussion and analysis should be reviewed in conjunction with the Health Authority's financial statements and accompanying notes to enhance the readers understanding of the Health Authority's financial performance.

Key Operating Indicators

Key operating indicators for the Health Authority for the fiscal years ending June 30, 2010, 2009 and 2008 are highlighted below:

Key Operating/Performance Indicators	Fiscal Year Ended June 30,		
	2010	2009	2008
Members (at end of fiscal period):			
Medi-Cal Program	97,562	88,912	81,715
Healthy Families Program	16,277	16,846	15,437
Healthy Kids Program	7,914	9,459	10,122
Healthy Generations Program	-	4,059	2,504
Agnews	136	139	55
Healthy Workers Program	41	-	-
Average monthly enrollment:			
Medi-Cal Program	93,857	84,977	77,197
Healthy Families Program	16,207	16,074	14,808
Healthy Kids Program	8,671	9,532	11,353
Healthy Generations Program (6 months in 2010)	4,113	3,363	1,520
Agnews (6 months in 2008)	140	101	17
Healthy Workers Program (3 months in 2010)	29	-	-
	<u>123,017</u>	<u>114,047</u>	<u>104,895</u>
Total premium revenues - net of premium tax	\$ 224,522,896	\$ 229,276,976	\$ 180,319,598
Interest income	168,933	748,284	1,122,878
Operating expenses:			
Medical expenses	191,814,176	207,381,619	163,824,726
Administrative expenses	<u>18,582,555</u>	<u>25,460,837</u>	<u>25,145,990</u>
Change in net assets	<u>\$ 14,295,098</u>	<u>\$ (2,817,196)</u>	<u>\$ (7,528,240)</u>
Total premium revenue - per member per month	\$ 152.09	\$ 167.53	\$ 143.25
Interest income - per member per month	\$ 0.11	\$ 0.55	\$ 0.89
Operating expenses - per member per month			
Medical expenses - per member per month	\$ 129.94	\$ 151.53	\$ 130.15
Administrative expenses - per member per month	\$ 12.59	\$ 18.60	\$ 19.98
Medical loss ratio	85.43%	90.45%	90.85%
Administrative expense ratio	8.28%	11.10%	13.95%

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Fiscal Years Ended June 30, 2010, 2009, and 2008**

Overview of Health Authority's Financial Statements

The Health Authority's annual financial report includes the annual combined financial statements and related notes, which reflect the Health Authority's financial position and changes in financial position for the fiscal years ended June 30, 2010, 2009, and 2008. The annual basic combined financial statements include the Health Authority's balance sheets, statements of revenues, expenses, and changes in net assets, and statements of cash flows as well as the notes to the financial statements. These statements report on the following financial information:

- The balance sheets summarize the Health Authority's assets, liabilities, and net assets as of June 30, 2010, 2009 and 2008.
- The statements of revenues, expenses, and changes in net assets present the results of operations during the fiscal years, and the resulting changes in net assets.
- The statements of cash flows identify sources and uses of cash from operating activities, as well as other sources and uses of cash from investing activities and other financial activities.

Financial Position Highlights

The financial position of the Health Authority, as reported in the combined balance sheets, increased during the fiscal year ended June 30, 2010. Significant changes included:

- Total Health Authority's assets increased to \$54,255,623 as of June 30, 2010 from \$39,080,577 as of June 30, 2009, and exceeded liabilities by \$25,103,012 as of June 30, 2010 and \$10,807,914 as of June 30, 2009.
- The current ratio (current assets over current liabilities) of 1.79 as of June 30, 2010, improved from 1.29 as of June 30, 2009.
- Net assets increased by \$14,295,098 (or approximately 132.3%) for the fiscal year ended June 30, 2010 due to operating income.

Condensed Balance Sheet Information

	As of June 30			2010 to 2009 Change		2009 to 2008 Change	
	2010	2009	2008	Amount	% Change	Amount	% Change
Assets:							
Current assets	\$ 52,321,838	\$ 36,431,390	\$ 30,338,951	\$ 15,890,448	43.6%	\$ 6,092,439	20.1%
Capital assets	1,628,435	2,343,837	2,709,602	(715,402)	-30.5%	(365,765)	-13.5%
Other assets	305,350	305,350	305,350	-	0.0%	-	0.0%
Total assets	<u>\$ 54,255,623</u>	<u>\$ 39,080,577</u>	<u>\$ 33,353,903</u>	<u>\$ 15,175,046</u>	<u>38.8%</u>	<u>\$ 5,726,674</u>	<u>17.2%</u>
Liabilities:							
Current liabilities	\$ 29,152,611	\$ 28,272,663	\$ 19,728,793	\$ 879,948	3.1%	\$ 8,543,870	43.3%
Total liabilities	<u>29,152,611</u>	<u>28,272,663</u>	<u>19,728,793</u>	<u>879,948</u>	<u>3.1%</u>	<u>8,543,870</u>	<u>43.3%</u>
Net assets:							
Invested in capital assets	1,628,435	2,343,837	2,709,602	(715,402)	-30.5%	(365,765)	-13.5%
Restricted under Knox-Keene agreement	305,350	305,350	305,350	-	0.0%	-	0.0%
Unrestricted	23,169,227	8,158,727	10,610,158	15,010,500	184.0%	(2,451,431)	-23.1%
Total net assets	<u>25,103,012</u>	<u>10,807,914</u>	<u>13,625,110</u>	<u>14,295,098</u>	<u>132.3%</u>	<u>(2,817,196)</u>	<u>-20.7%</u>
Total liabilities and net assets	<u>\$ 54,255,623</u>	<u>\$ 39,080,577</u>	<u>\$ 33,353,903</u>	<u>\$ 15,175,046</u>	<u>38.8%</u>	<u>\$ 5,726,674</u>	<u>17.2%</u>

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Assets and Liabilities

Assets increased \$15,175,046 or 38.8% during fiscal year 2010 due primarily to an increase in cash which was offset by a decrease in capitation premium receivable primarily due from the Department of Health Care Services (“DHCS”) under the Medi-Cal program. Liabilities increased \$879,948 or 3.1% during fiscal year 2010 due to increases in accounts payable and accrued liabilities, payables to other government agencies, and amounts due to Santa Clara County Valley Health Plan, offset by a decrease in incurred but not reported medical claims payable. The decrease in incurred but not reported medical claims payable is primarily due to reduced claims payable for the Healthy Generations program since the program ended operations effective December 31, 2009.

Results of Operations

The Health Authority’s fiscal year 2010 activities resulted in an increase in net assets of \$14,295,098, compared to decreases of \$2,817,196 and \$7,528,240 reported in fiscal years 2009 and 2008, respectively. The following table highlights the revenues, expenses, and changes in net assets for fiscal year 2010 compared to 2009 and 2008 results.

	Fiscal Year			2010 to 2009		2009 to 2008	
	2010	2009	2008	Amount	% Change	Amount	% Change
Enrollment/Member months:							
Medi-Cal Program	1,126,280	1,019,720	926,365	106,560	10.4%	93,355	10.1%
Healthy Families Program	194,483	192,882	177,695	1,601	0.8%	15,187	8.5%
Healthy Kids Program	104,055	114,387	136,240	(10,332)	-9.0%	(21,853)	-16.0%
Healthy Generations Program	24,679	40,350	18,234	(15,671)	-38.8%	22,116	121.3%
Agnews	1,683	1,206	206	477	39.6%	1,000	485.4%
Healthy Workers Program	86	-	-	86	100.0%	-	0.0%
Total member months	1,451,266	1,368,545	1,258,740	82,721	6.0%	109,805	8.7%
Operating revenue:							
Premium revenue - net of premium tax	\$ 224,522,896	\$ 229,276,976	\$ 180,319,598	\$ (4,754,080)	-2.1%	\$ 48,957,378	27.2%
Total operating revenue	224,522,896	229,276,976	180,319,598	(4,754,080)	-2.1%	48,957,378	27.2%
Operating expenses:							
Medical expenses:							
Provider capitation	97,134,778	93,529,678	87,151,236	3,605,100	3.9%	6,378,442	7.3%
Hospital inpatient	22,152,261	38,104,681	21,969,095	(15,952,420)	-41.9%	16,135,586	73.4%
Physician referral and emergency	46,217,967	45,350,264	31,826,228	867,703	1.9%	13,524,036	42.5%
Prescription drugs	26,309,170	30,396,996	22,878,167	(4,087,826)	-13.4%	7,518,829	32.9%
Total medical expenses	191,814,176	207,381,619	163,824,726	(15,567,443)	-7.5%	43,556,893	26.6%
Administrative expenses:							
Salaries, taxes, and benefits	\$ 12,214,942	\$ 15,595,994	\$ 15,459,289	\$ (3,381,052)	-21.7%	\$ 136,705	0.9%
Services and supplies	3,054,231	5,716,518	4,235,023	(2,662,287)	-46.6%	1,481,495	35.0%
Leases and rentals	1,198,863	1,257,011	1,444,360	(58,148)	-4.6%	(187,349)	-13.0%
Utilities and insurance	690,608	990,889	1,038,966	(300,281)	-30.3%	(48,077)	-4.6%
Depreciation	798,227	836,156	410,807	(37,929)	-4.5%	425,349	103.5%
Bad Debt Expense	-	-	2,191,498	-	0.0%	(2,191,498)	-100.0%
Other expenses	625,684	1,064,269	366,047	(438,585)	-41.2%	698,222	190.7%
Total administrative expenses	18,582,555	25,460,837	25,145,990	(6,878,282)	-27.0%	314,847	1.3%
Total operating expenses	210,396,731	232,842,456	188,970,716	(22,445,725)	-9.6%	43,871,740	23.2%
Operating income (loss)	14,126,165	(3,565,480)	(8,651,118)	17,691,645	-496.2%	5,085,638	-58.8%
Nonoperating revenues (expenses):							
Interest income	168,933	748,284	1,122,878	(579,351)	-77.4%	(374,594)	-33.4%
Changes in net assets	14,295,098	(2,817,196)	(7,528,240)	17,112,294	-607.4%	4,711,044	-62.6%
Net assets, beginning of year	10,807,914	13,625,110	21,153,350	(2,817,196)	-20.7%	(7,528,240)	-35.6%
Net assets, end of year	\$ 25,103,012	\$ 10,807,914	\$ 13,625,110	\$ 14,295,098	132.3%	\$ (2,817,196)	-20.7%

(a) Enrollment

During the fiscal year ended June 30, 2010, the Health Authority experienced enrollment increases in the Medi-Cal line of business, as well as small increases in the Healthy Families, and Agnews Program lines of business. Enrollment in the Healthy Kids program continued to decline. The Healthy Generations line of business ceased operations after the first six months of fiscal year 2010, and therefore, also showed a decline in annual member months compared to the previous fiscal year.

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(b) Operating Revenues

Although Medi-Cal premium revenues increased for the fiscal year ended June 30, 2010, the plan's overall premium revenues decreased from the previous year by \$4,754,080 million, or 2.1%. This decrease in overall total premium revenue is attributable to the fact that the Healthy Generations Program ended operations effective December 31, 2009, and thus was only in operation for six months. Enrollment in the Healthy Generations Program decreased by 15,671 members as of fiscal year-end 2010, and contributed \$16,087,623 less in premium revenues than in the previous fiscal year. These declines were offset by increases in the Medi-Cal Program in which enrollment increased by 106,560 members, and contribution to premium revenues increased by \$11,861,054, net of premium taxes of \$6,365,998, during fiscal year 2010. The contribution made by the Agnews Program also declined.

(c) Medical Expenses

Overall medical expenses for fiscal year ended 2010 were \$15,567,443 less than in the prior year. This decline is also primarily due to the Healthy Generations Program ending operations effective December 31, 2009, thus being in operation for only six months of the year. Medical expenses for all programs totaled \$191,814,176 or \$129.94 per member per month in 2010, compared to total medical expenses of \$207,381,619 and \$163,824,726, or \$151.53 and \$130.15 per member per month, for fiscal 2009 and 2008, respectively. The Health Authority's medical loss ratio, or medical expenses as a percent of premium revenues, was 85.43% for fiscal year 2010 compared to 90.45% and 90.85%, for fiscal years 2009 and 2008, respectively.

(d) Administrative Expenses

Total administrative expenses, for fiscal year ended June 30, 2010, totaled \$18,582,555 or approximately 8.28% of premium revenues compared to 11.10% and 13.95% of revenues for fiscal years 2009 and 2008, respectively. On a per member basis, administration costs were \$12.59 per member per month in fiscal year 2010 compared to \$18.60 and \$19.98 in fiscal years 2009 and 2008, respectively. The administration cost per member per month decrease was primarily due to cost containment efforts and net growth in membership during fiscal year 2010.

Future Economic Factors and 2010/2011 Budget Assumptions

The Health Authority's Board of Directors formally approved a fiscal year budget for fiscal year 2011 which included continued participation in the current lines of business. The budget anticipates continued enrollment growth in the Medi-Cal line of business, and membership declines in the Healthy Families and Healthy Kids programs.

The 2010-11 State Budget was passed on October 8th, 100 days past the July 1 deadline. Although the Health Authority has received increased preliminary Medi-Cal capitation rates for the 2010/2011 fiscal year the final rates have not yet been issued.

Due to the continued significant budget shortfalls at the State of California, the Health Authority expects continued pressure to reduce payments to Medi-Cal managed care health plans.

INDEPENDENT AUDITOR'S REPORT

The Board of Directors of
Santa Clara County Health Authority
dba Santa Clara Family Health Plan and
Santa Clara Community Health Authority

We have audited the accompanying combined balance sheets of Santa Clara County Health Authority dba Santa Clara Family Health Plan and Santa Clara Community Health Authority (collectively the "Health Authority"), as of June 30, 2010 and 2009, and the related combined statements of revenues, expenses, changes in net assets, and cash flows for the years then ended. These combined financial statements are the responsibility of the Health Authority's management. Our responsibility is to express an opinion on these combined financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform our audits to obtain reasonable assurance about whether the combined financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Authority's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the combined financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall combined financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the above referenced combined financial statements present fairly, in all material respects, the combined financial position of Santa Clara County Health Authority dba Santa Clara Family Health Plan and Santa Clara Community Health Authority as of June 30, 2010 and 2009, and the changes in their net assets and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The accompanying Management's Discussion and Analysis on pages 1 through 4 is not a required part of the basic combined financial statements, but is supplementary information required by the Governmental Accounting Standards Board. This supplementary information is the responsibility of the Health Authority's management. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit such information, and we do not express an opinion on it.

Moss Adams LLP

San Francisco, California
October 28, 2010

COMBINED FINANCIAL STATEMENTS

**SANTA CLARA COUNTY HEALTH AUTHORITY
(dbA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
COMBINED BALANCE SHEETS
June 30, 2010 and 2009**

	2010	2009
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 38,565,389	\$ 13,721,072
Premiums receivable	12,537,133	21,762,476
Due from Santa Clara Family Health Foundation	470,798	26,762
Other current assets and prepaids	748,518	921,080
Total current assets	52,321,838	36,431,390
Capital assets, net	1,628,435	2,343,837
Assets restricted as to use	305,350	305,350
Total assets	<u>\$ 54,255,623</u>	<u>\$ 39,080,577</u>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued liabilities	\$ 4,457,227	\$ 2,973,905
Payable to other governmental agencies	2,137,706	-
Due to Santa Clara County Valley Health Plan	8,858,780	1,811,154
Advance premiums - Healthy Kids	85,547	96,581
Incurred but not reported medical claims payable	11,406,146	21,131,691
Provider incentives and other medical liabilities	2,207,205	2,259,332
Total current liabilities	29,152,611	28,272,663
NET ASSETS		
Invested in capital assets	1,628,435	2,343,837
Restricted under Knox-Keene agreement	305,350	305,350
Unrestricted	23,169,227	8,158,727
Total net assets	25,103,012	10,807,914
Total liabilities and net assets	<u>\$ 54,255,623</u>	<u>\$ 39,080,577</u>

See accompanying notes.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(dba SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF REVENUES, EXPENSES,
AND CHANGES IN NET ASSETS
Years Ended June 30, 2010 and 2009**

	2010	2009
OPERATING REVENUES		
Premium revenues	\$ 230,888,894	\$ 229,276,976
Premium tax	(6,365,998)	-
Total operating revenues	224,522,896	229,276,976
OPERATING EXPENSES		
Medical expenses	191,814,176	207,381,619
Salaries and benefits	12,214,942	15,595,994
Services and supplies	3,054,231	5,716,518
Leases and rentals	1,198,863	1,257,011
Utilities	510,410	638,841
Insurance	180,198	352,048
Depreciation	798,227	836,156
Other	625,684	1,064,269
Total operating expenses	210,396,731	232,842,456
Operating income (loss)	14,126,165	(3,565,480)
NON-OPERATING REVENUES		
Interest income	168,933	748,284
Change in net assets	14,295,098	(2,817,196)
Net assets, beginning of year	10,807,914	13,625,110
Net assets, end of year	\$ 25,103,012	\$ 10,807,914

See accompanying notes.

**SANTA CLARA COUNTY HEALTH AUTHORITY
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COMBINED STATEMENTS OF CASH FLOWS
Years Ended June 30, 2010 and 2009**

	2010	2009
Cash flows from operating activities		
Premiums received	\$ 233,304,203	\$ 212,887,113
Medical expenses paid	(194,555,256)	(197,478,526)
Administrative expenses paid	(13,990,738)	(25,765,688)
Net cash provided by (used in) operating activities	<u>24,758,209</u>	<u>(10,357,101)</u>
Cash flows used in capital and related financing activities		
Purchases of capital assets	(82,825)	(470,391)
Net cash used in financing activities	<u>(82,825)</u>	<u>(470,391)</u>
Cash flows from investing activities		
Interest collection on investments	168,933	748,284
Net cash provided by investing activities	<u>168,933</u>	<u>748,284</u>
Net increase (decrease) in cash and cash equivalents	24,844,317	(10,079,208)
Cash and cash equivalents, beginning of year	13,721,072	23,800,280
Cash and cash equivalents, end of year	<u>\$ 38,565,389</u>	<u>\$ 13,721,072</u>
Reconciliation of operating loss to net cash (used in) provided by operating activities		
Operating income (loss)	\$ 14,126,165	\$ (3,565,480)
Adjustments to reconcile operating loss to net cash (used in) provided by operating activities		
Depreciation	798,227	836,156
Changes in operating assets and liabilities		
Premiums receivable	9,225,343	(16,939,317)
Due from Santa Clara Family Health Foundation	(444,036)	549,454
Other current assets and prepaids	172,562	218,216
Accounts payable and accrued liabilities	1,483,322	(1,359,223)
Payable to other governmental agencies	2,137,706	-
Due to Santa Clara County Valley Health Plan	7,047,626	1,811,154
Advance premiums - Healthy Kids	(11,034)	12,206
Incurred but not reported medical claims payable	(9,725,545)	6,783,628
Provider incentives and other medical liabilities	(52,127)	1,296,105
Net cash provided by (used in) operating activities	<u>\$ 24,758,209</u>	<u>\$ (10,357,101)</u>
Supplemental cash flow disclosure		
Cash paid during the year for		
Premium tax	<u>\$ 6,254,799</u>	<u>\$ -</u>

See accompanying notes.

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NOTES TO COMBINED FINANCIAL STATEMENTS**

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

History and organization – The Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively the “Health Authority”), was established August 1, 1995 by the Santa Clara County Board of Supervisors pursuant to Section 14087.38 of the Welfare and Institutions Code. The Health Authority was created for the purpose of developing the Local Initiative Plan (the “Plan”) for the expansion of Medi-Cal Managed Care, as presently regulated by the California State Department of Managed Health Care. The Medi-Cal Managed Care Program offers no-cost health coverage to children, birth through age 18, pregnant women, and other low-income adults. During 1997, the Health Authority obtained licensure under the Knox-Keene Health Care Service Plan Act of 1975.

The Santa Clara Community Health Authority Joint Powers Authority (the “JPA”) is a licensed health maintenance organization that operates in the County. The County’s Board of Supervisors established the JPA in October 2005 in accordance with State of California Welfare and Institutions Code (the “Code”) Section 14087.54. This legislation provides that the JPA is a public entity, separate and apart from the County, and is not considered to be an agency, division, or department of the County. Further, the JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County’s policies or operational rules. The JPA received its Knox-Keene license on May 11, 2006, and commenced operations on June 1, 2006.

Santa Clara County Health Authority has contracted with the California Department of Health Care Services (“DHCS”) to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Health Authority (“DHCS contract”). The current DHCS contract effective through December 31, 2010 is still under negotiation. Management does not anticipate any significant issues in the renewal of the contract. The DHCS contract specifies capitation rates which may be adjusted annually. DHCS revenue is paid monthly and is based upon contracted rates and actual Medi-Cal enrollment. Santa Clara County Health Authority, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

During fiscal year 2000, the Health Authority contracted with the California Managed Risk Medical Insurance Board’s (“MRMIB”) Healthy Families Program (“Healthy Families”) to provide health care benefits to certain children whose families do not qualify for Medi-Cal and cannot afford to purchase insurance out-of-pocket. The current contract continues through June 30, 2011 and was assigned to the JPA effective June 1, 2006.

During fiscal year 2001, the Health Authority launched its Healthy Kids program to provide medical coverage to children of parents not otherwise eligible for either the Medi-Cal or Healthy Families programs. This program was assigned to the JPA effective June 1, 2006.

In January 2007, the Health Authority began operating a Medicare Special Needs Plan called Healthy Generations. The program ended operations as of December 31, 2009. During its three years of operations, the program was oriented towards a population in Santa Clara County who qualified for both the Medicare and Medi-Cal programs. The program provided coverage to eligible individuals under Part C and Part D of the Medicare program, plus coverage for eligible individuals under the Health Authority’s existing contract with DHCS for Medi-Cal. The Health Authority originally received approval to offer the program effective January 1, 2007 under a contract with the Center for Medicare and Medicaid Services (“CMS”). In order to receive CMS approval, the Health Authority provided a certified actuarial report on the underlying revenue and cost assumptions.

In July 2005, DHCS implemented the Quality Improvement Fee (“QIF”) program. This program imposed a 5.5% assessment on the Health Authority’s revenue. DHCS used such assessments to obtain matching federal funds, of which 50% was returned to plans in the form of a Medi-Cal rate increase. In order to minimize the impact on the Health Authority, the JPA was created. Effective June 1, 2006, all non Medi-Cal programs were assigned to the JPA, thus reducing the resulting assessment levied on the Health Authority. Effective on September 30, 2009, DHCS terminated the QIF program.

In November 2009, DHCS implemented the Assembly Bill No. 1422 (“AB 1422”) or Managed Care Organization (“MCO”) premium tax. This program imposes an assessment on the Health Authority’s revenue. DHCS uses this assessment to obtain matching federal funds, which is used to sustain enrollment in the Healthy Families program. This program was implemented retroactive to January 1, 2009 and continues through December 31, 2010.

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In June 2010, DHCS implemented a supplemental revenue or intra-governmental transfer (“IGT”). This program assessed a fee on the revenue of one of the Health Authority’s hospitals, Santa Clara Valley Medical Center (“SCVMC”). DHCS uses this assessment to obtain matching federal funds, which are returned to SCVMC. In late June 2010 and early July 2010, the Health Authority received supplemental medical revenue of \$11,267,776, representing the assessment and matching funds to be paid to SCVMC, net of QIF and MCO premium tax, of \$10,445,630. As of June 30, 2010, \$2,137,706 was payable to SCVMC, and was subsequently paid in early July 2010. This liability is recorded under payable to other governmental agencies in the combined balance sheet as of June 30, 2010.

Basis of accounting – The Health Authority is a governmental health insuring organization and is governed by the Governmental Accounting Standards Board (“GASB”). The Health Authority utilizes the proprietary fund method of accounting under which the combined financial statements are prepared on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred.

Pursuant to GASB Statement No. 20, “*Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*”, the Health Authority has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (“FASB”), including those issued after November 30, 1989, that do not conflict with or contradict with GASB pronouncements.

Basis of combination – The accompanying combined financial statements as of June 30, 2010 and 2009 and for the years then ended include the Santa Clara County Health Authority and JPA. The operations of the JPA are included from the date of its inception on June 1, 2006.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Incurred but not reported medical claims payable, useful lives of capital assets, provider incentive liabilities, Medicare Part D receivables, and premiums receivable represent significant estimates. Actual results could differ from those estimates.

Risks and uncertainties – The Health Authority’s business could be impacted by continuing price pressure on new and renewal business, the Health Authority’s ability to effectively control health care costs, additional competitors entering the Health Authority’s markets, federal and state legislation in the area of health care reform, and governmental licensing regulations of HMOs and insurance companies. Changes in these areas could adversely impact the Health Authority’s operations in the future.

Cash and cash equivalents – The Health Authority considers all highly liquid instruments with a maturity of three months or less at the time of purchase to be cash equivalents. Cash and cash equivalents are carried at cost which approximates fair value. At June 30, 2010 and 2009, the Health Authority’s cash deposits had carrying amounts of \$38,565,389 and \$13,721,072, respectively, and bank balances of \$39,950,044 and \$17,171,186, respectively. Of the bank balances at June 30, 2010 and 2009, \$250,000 were covered by federal depository insurance for both June 30, 2010 and 2009, per account.

Amounts invested in the County Treasurer’s investment pool (the “Investment Pool”) are considered as cash and cash equivalents, as funds can be withdrawn by the Health Authority on demand. The County’s Investment Oversight Committee Board has oversight responsibility for the Investment Pool. The Investment Pool is not SEC-registered, and based on the California statutes and the County’s investment policy, primarily invests in obligation of U.S. Treasury, certain federal agencies, bankers’ acceptances, commercial papers, certificates of deposit, repurchase agreements, and California State Treasurer’s Local Agency Investment Fund (“LAIF”). The amounts invested in the Investment Pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the Investment Pool is generally based on published market prices and quotations from major investment firms. As the Health Authority does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these cash and cash equivalents are not individually identifiable and were not required to be categorized under GASB Statement No. 3, “*Deposits with Financial Institutions, Investments (including Repurchase Agreements), and Reverse Repurchase Agreements.*” The fair value of the Health Authority’s share in the pool approximated the fair value of the position in the pool at June 30, 2010 and 2009.

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Capital assets – Purchased capital assets are stated at cost. Depreciation is provided using the straight-line method over the estimated useful lives of the respective assets, generally three to five years. Leasehold improvements are amortized over the shorter of the remaining term of the lease or the useful life. The Health Authority capitalizes capital expenditures over \$500 which will have a useful life of three or more years.

The Health Authority evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Assets restricted as to use – Assets restricted as to use consist of bank certificates of deposit and are stated at fair value at June 30, 2010 and 2009. Under the Knox-Keene licensure agreement, the Health Authority is required to maintain three \$100,000 certificates of deposit with separate financial institutions. In the event the Health Authority discontinues operations, these certificates of deposit are to be used for closing costs.

Incurred but not reported medical claims payable – The Health Authority contracts with various providers, including physicians and hospitals, to provide certain health care products and services to enrolled Medi-Cal, Healthy Families, Healthy Kids, and formerly Healthy Generations beneficiaries. The cost of the health care products and services provided or contracted for is accrued in the period in which it is provided to a member, based in part on actuarial estimates, including an accrual for medical services incurred but not as yet reported to the Health Authority. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Provider incentives and other medical liabilities – The Health Authority has various incentive agreements with certain providers whereby the providers are reimbursed for efficient and quality services provided to enrolled Medi-Cal and Healthy Families beneficiaries. Under the agreement, health care costs (which include all fee-for-service claims and estimated incurred but not reported medical claims payable) are allocated on a per member per month basis. Based on the terms of certain incentive agreements, a final reconciliation of surpluses are completed annually and paid within six months of the Health Authority's fiscal year.

Incentive payments and related liabilities are recorded in medical expenses in the accompanying combined financial statements.

Net assets – Net assets are classified as invested in capital assets, restricted assets or unrestricted assets. Invested in capital assets represents investments in furniture and equipment and leasehold improvements, net of depreciation. Restricted net assets are noncapital net assets that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to the Health Authority. Unrestricted net assets consist of net assets that do not meet the definition of restricted or invested in capital assets.

Premium revenue – The Health Authority has agreements with the Medi-Cal Program and Healthy Families Program in the state to provide certain health care products and services to enrolled Medi-Cal and Healthy Families beneficiaries. The Health Authority receives monthly premium payments from the state based on the number of enrolled Medi-Cal and Healthy Families beneficiaries, regardless of services actually performed. Premiums are due from the state monthly and are recognized as revenue during the period in which the Health Authority is obligated to provide services to members. A portion of revenues received from DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments.

The Health Authority has agreements with the County of Santa Clara, the City of San Jose, and the Children & Families First Commission to provide health care services to enrolled Healthy Kids beneficiaries. The Health Authority issues monthly invoices to the individual funding organizations for their respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Health Authority is obligated to provide medical services. A nominal monthly premium is invoiced directly to the family of the Healthy Kids enrolled child and recognized as revenue in the service month.

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For the year ended June 30, 2010, premium revenues received from the state under the Medi-Cal Program and Healthy Families Program totaled \$174,909,900, less premium taxes of \$6,365,998, and \$13,607,916, respectively. Annual premium grants for the Healthy Kids Program totaled \$11,114,382 and were funded by the following organizations: County of Santa Clara \$3,336,370, the Children & Families First Commission \$2,885,231, the City of San Jose \$1,813,998, Santa Clara Family Health Foundation \$2,555,662 and monthly family premiums of \$523,121.

For the year ended June 30, 2009, premium revenues received from the state under the Medi-Cal Program and Healthy Families Program totaled \$156,682,848 and \$13,532,366, respectively. Annual premium grants for the Healthy Kids Program totaled \$11,031,230 and were funded by the following organizations: County of Santa Clara \$3,309,362, the Children & Families First Commission \$3,183,934, the City of San Jose \$1,799,735, Santa Clara Family Health Foundation \$2,254,588 and monthly family premiums of \$483,611.

Payment to the Health Authority from Medicare for Part C is partially based on a risk adjustment score that is unique to each individual enrolled in the program. The risk adjustment score includes factors such as age, sex, reasons for initial enrollment in Medicare, institutional status, and diagnosis information from previous Medicare encounters. The payment is subject to subsequent adjustment based on a reconciliation process that occurs after each calendar year. Payment to the Health Authority for Part D is based on the risk score factors described above, and includes approximately \$97.57 per member per month for Low Income Subsidies and Reinsurance. The Low Income Subsidy and Reinsurance is subject to a reconciliation process that is expected to be completed on an ongoing basis. For the years ended June 30, 2010 and 2009, the Health Authority has recorded \$28,684,124 and \$44,771,747, respectively, as revenues based on the preliminary risk score assigned to the members enrolled in the program.

An amendment to the existing agreement between DHCS and Santa Clara County Health Authority was added that includes provisions implementing special arrangements to provide health care services for patients being transferred from Agnews Developmental Center to community facilities. This amendment was effective July 1, 2007, and the first former Agnews members were enrolled in the plan in January 2008. The current amendment continues to renew along with the regular DHCS contract. For the years ended June 30, 2010 and 2009, the Health Authority has recorded revenues related to the Agnews Program in the amount of \$2,551,872 and \$3,258,785, respectively.

In 2010 the Health Authority launched “Healthy Workers”, a program for low income adults who live and are employed in Santa Clara County, earn incomes up to 350 percent of the federal poverty level, and are without health insurance. Premiums are due monthly and are recognized as revenue in the period members are covered. For the year ended June 30, 2010, premium revenues totaled \$20,700.

Concentration of credit risk – A majority of the Health Authority’s revenues are derived from contracts with the Medi-Cal Program, Healthy Families Program, and Healthy Kids Program in the state and with the Federal Medicare Program. Loss of the contracts due to non-renewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Health Authority.

As of June 30, 2010, the Health Authority had premiums receivable of \$5,159,783, \$1,122,282, and \$1,735,974 due from the Medi-Cal Program, Healthy Families Program, and Healthy Kids Program in the state, respectively, and \$4,517,519, \$0, and \$1,575 due from the Medicare Program, Agnews Program, Healthy Workers Program, respectively. As of June 30, 2009, the Health Authority had premiums receivable of \$14,303,598, \$1,152,540, and \$1,220,102 from the Medi-Cal Program, Healthy Families Program, and Healthy Kids Program in the state, respectively. As of June 30, 2009, the Health Authority also had premiums receivables of \$5,086,236, \$0, and \$0, from the Medicare Program, Agnews Program, and Healthy Workers Program, respectively.

Medical expenses – Hospital, physician, and other service costs are based on actual paid claims plus an estimate for accrued incurred, but not reported, claims. Claims are paid primarily on a fee-for-service basis. Many physicians belonging to medical groups and certain hospitals are compensated primarily on a capitation basis with provisions for additional incentive payments in certain circumstances.

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Operating revenues and expenses – The Health Authority’s primary operating revenue is derived from capitation. As defined by GASB Statement No. 34, *“Basic Financial Statements – and Management’s Discussion and Analysis – for State and Local Governments,”* all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating expense is medical care cost. Non-operating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from non-exchange transactions or net investment income and changes in the fair value of investments.

Income taxes – The Health Authority falls under the purview of Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

New accounting pronouncements – In June 2007, the GASB issued GASB Statement No. 51, *“Accounting and Financial Reporting for Intangible Assets.”* This statement provides guidance on recognizing internally generated computer software as an intangible asset. This guidance serves as an application of the specified conditions approach described above to the development cycle of computer software. This statement also establishes guidance specific to amortization of intangible assets, determining useful lives and determining if the asset has an indefinite useful life. The Health Authority implemented GASB Statement No. 51 for the fiscal year ending June 30, 2010. The implementation of GASB Statement No. 51 had no material effect on the combined financial statements.

In June 2009, the FASB issued Accounting Standards Codification (“ASC”) No. 105 *“The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles”* (the “Codification”). The Codification establishes one level of authoritative generally accepted accounting principles (“GAAP”) and is effective for annual financial statements with fiscal years ending after September 15, 2009. Adoption of the Codification did not have a significant impact on the Health Authority’s combined financial statements.

Reclassifications – Certain amounts in the 2009 combined financial statements have been reclassified to conform to the 2010 presentation. This reclassification has no effect on the 2009 operations or net assets.

NOTE 2 – DESIGNATED NET ASSETS

Of the \$23,169,227 of unrestricted net assets reported in 2010, \$1,425,000 has been designated by the Health Authority’s board of directors to be used for future Healthy Kids premiums. Designated funds remain under the control of the board of directors, which may at its discretion later use the funds for other purposes. There were no board designated funds in 2009.

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NOTE 3 – CAPITAL ASSETS

Capital asset activity for the fiscal year ended June 30, 2010 was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	\$ 5,517,573	\$ 66,749	\$ -	\$ 5,584,322
Leasehold improvements	241,501	16,076	-	257,577
Total capital assets	<u>5,759,074</u>	<u>82,825</u>	<u>-</u>	<u>5,841,899</u>
Less accumulated depreciation and amortization for				
Furniture and equipment	3,196,913	776,520	-	3,973,433
Leasehold improvements	218,324	21,707	-	240,031
Total accumulated depreciation	<u>3,415,237</u>	<u>798,227</u>	<u>-</u>	<u>4,213,464</u>
Capital assets, net	<u>\$ 2,343,837</u>	<u>\$ (715,402)</u>	<u>\$ -</u>	<u>\$ 1,628,435</u>

Capital asset activity for the fiscal year ended June 30, 2009 was as follows:

	Beginning Balance	Increases	Decreases	Ending Balance
Furniture and equipment	\$ 5,047,182	\$ 470,391	\$ -	\$ 5,517,573
Leasehold improvements	241,501	-	-	241,501
Total capital assets	<u>5,288,683</u>	<u>470,391</u>	<u>-</u>	<u>5,759,074</u>
Less accumulated depreciation and amortization for				
Furniture and equipment	2,380,171	816,742	-	3,196,913
Leasehold improvements	198,910	19,414	-	218,324
Total accumulated depreciation	<u>2,579,081</u>	<u>836,156</u>	<u>-</u>	<u>3,415,237</u>
Capital assets, net	<u>\$ 2,709,602</u>	<u>\$ (365,765)</u>	<u>\$ -</u>	<u>\$ 2,343,837</u>

NOTE 4 – RELATED PARTY TRANSACTIONS

The Health Authority has a capitated contractual relationship with Valley Health Plan, a wholly owned health plan of the County of Santa Clara, to provide medical services to certain Health Authority enrollees. Because of continuing retroactive enrollment adjustments and capitation payment adjustments, periodic adjustments are recorded to reflect the outstanding amounts receivable from or payable to Valley Health Plan. The Health Authority accrued capitation payments in the amounts of \$909,199 and \$1,811,154 for the Valley Health Plan for the years ended June 30, 2010 and 2009, respectively, not including incentive payments.

The Health Authority also has provider incentive and medical case management arrangements with Valley Health Plan. The Health Authority accrued provider incentive and medical case management payments in the amount of \$7,949,581 for the Valley Health Plan for the year ended June 30, 2010. No provider incentive and medical case management payments were accrued for the Valley Health Plan as of June 30, 2009.

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NOTE 5 – SANTA CLARA FAMILY HEALTH FOUNDATION

During June 2000, the Health Authority formed the Santa Clara Family Health Foundation (the “Foundation”) which is dedicated to the support of medically related community service programs. The bylaws of the Foundation require that no more than 49% of the Foundation’s board of directors, as appointed by Santa Clara County, may be management or directors of the Health Authority, as defined. Because the Health Authority does not have financial accountability for the Foundation, it has not been included in the Health Authority’s accompanying combined financial statements. The Health Authority accrued a receivable due from the Foundation of \$470,798 and \$26,762 at June 30, 2010 and 2009, respectively for Healthy Kids premiums and certain administrative costs incurred.

NOTE 6 – INCURRED BUT NOT REPORTED CLAIMS (“IBNR”) MEDICAL CLAIMS PAYABLE

Activity for IBNR medical claims payable as of June 30 is summarized as follows:

	2010	2009
Beginning balance	\$ 21,131,691	\$ 14,674,037
Incurred - current year	50,262,033	70,206,907
Paid related to		
Current year	45,933,511	48,302,164
Prior year	14,054,067	15,447,089
Total paid	59,987,578	63,749,253
Ending balance	\$ 11,406,146	\$ 21,131,691

As a result of changes between actual payments for medical services and estimated amounts accrued in previous years, claims expenses decreased in 2010, reflecting lower-than-anticipated claims expenses for 2009. Management believes the decrease is largely a result of lower-than-anticipated healthcare expenditures related to the announcement of the termination of the Healthy Generations line of business effective December 31, 2009.

NOTE 7 – OPERATING LEASE OBLIGATIONS

The Health Authority leases its facilities under an operating lease that expires in June 2013. The Health Authority also has various equipment leases expiring in various years through April 2014. Monthly rent expenses of \$110,770 under these leases are included in the future minimum lease commitments schedule.

Future minimum lease payments as of June 30, 2010 consist of the following:

Years ending June 30,		
2011	\$	1,118,398
2012		978,323
2013		1,003,499
2014		70,578
Total minimum lease payments	\$	3,170,798

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NOTE 8 – EMPLOYEE BENEFIT PLANS

The Health Authority has a defined contribution plan and a deferred compensation plan under Sections 401(a) and 457, respectively, of the Internal Revenue Code (the “Code”). Under the 401(a) Plan, participants must contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participants’ gross compensation. The Health Authority contributes greater than 3% of gross compensation for senior staff level employees. In return, senior staff level employees contribute less than 6% of their gross compensation. Contributions by the Health Authority totaled \$226,420 and \$496,520 for the years ended June 30, 2010 and 2009, respectively. Under the 457 Plan, participants may contribute up to the maximum contribution allowed under the Code and the Health Authority makes no matching contributions.

On April 4, 1999, the Health Authority elected not to continue participation in Social Security and began participation in the California Public Employees’ Retirement System (“CalPERS”). CalPERS is an agent multiple-employer defined benefit retirement plan that acts as a common investment and administrative agent for various local and state governmental agencies within the state. CalPERS provides retirement, disability, and death benefits based on the employees’ years of service, age, and final compensation. Employees vest after 5 years of CalPERS-credited service and they are eligible for service retirement if they are 55 years old or over and have at least 5 years of CalPERS-credited service.

These provisions and all other requirements are established by state statute. CalPERS issues a stand-alone report that is available upon request at the following address: CalPERS Actuarial & Employer Service Division; P.O. Box 942709; Sacramento, California 94229-2709.

Participating employees are required to contribute 7.00% of their monthly salaries to CalPERS. The Health Authority deducts the contributions from employees’ wages and remits to CalPERS on their behalf and for their account. The Health Authority is required to contribute an actuarially determined rate. The employer contribution rates were 8.58% and 8.91% of annual covered payroll for the years ended June 30, 2010 and 2009, respectively. The contribution requirements of the plan members and the Health Authority are established and may be amended by CalPERS. With the election to participate in CalPERS, participation in Social Security is discontinued, and contributions to CalPERS are in lieu of contributions to Social Security.

The Health Authority’s annual pension cost for CalPERS was equal to the Health Authority’s required and actual contributions which were determined as part of the actuarial valuation using the entry age normal actuarial cost method. The actuarial assumptions included: (a) 7.75% investment rate of return (net of administrative expenses); (b) projected salary increases of 3.25% - 14.45% varying by duration of services, age and type of employment, and (c) 3.25% payroll growth. Both (a) and (b) included an inflation component of 3%. These assumptions are expected to change in the subsequent valuation. The Health Authority’s annual pension cost was \$1,013,423 for the year ended June 30, 2010. This was equal to the annual required contribution.

Historical trend information:

Fiscal Year Ended	Annual Pension Cost (APC)	Percentage of APC Contributed	Net Pension Obligation
June 30, 2008	\$ 736,061	100%	\$ -
June 30, 2009	\$ 795,427	100%	\$ -
June 30, 2010	\$ 1,013,423	100%	\$ -

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NOTE 9 – POST RETIREMENT HEALTH BENEFITS

The Health Authority has a single employer agent plan as administered by CalPERS for its post retirement health benefits, the California Employers' Retiree Benefit Trust ("CERBT"). The Health Authority must contribute the minimum required amount of \$5,000 or the annual required contribution ("ARC"), whichever is lower. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities over a period not to exceed thirty years. Retired employees who retire directly from the health plan are eligible to receive contributions from Santa Clara Family Health Plan toward their monthly PEMHCA (health plans offered by CalPERS) if they meet certain age and service eligibility requirements as outlined in the plan document, as approved by the Board of Directors of the Health Authority. All employees who attain age 50 with a minimum of 5 years of CalPERS service and employed by the Health Authority at the time of retirement are eligible. Effective January 1, 2010, retirees are required to fund 10% of the cost of their monthly premiums.

Benefits are funded by the health plan on a pay-as-you go basis. As of June 30, 2010 and 2009, approximately 145 and 166 employees and former employees, respectively, were eligible to participate in the plan.

The following table sets forth the actuarial calculation of the annual required contribution and net other post-employment benefit ("OPEB") obligation for the fiscal years ended June 30:

	2010	2009
Determination of annual required contribution		
Normal cost at fiscal year end	\$ 342,247	\$ 479,780
Amortization of unfunded actuarial accrued liability	333,223	346,228
Annual required contribution	675,470	826,008
Determination of net OPEB obligation		
Annual required contribution	675,470	826,008
Interest on prior year net OPEB obligation (asset)	-	-
Adjustment to ARC	-	-
Annual OPEB cost	675,470	826,008
Benefit payments made directly by the Health Authority	206,152	118,000
Contributions made to CERBT	469,318	708,008
Total contributions made	675,470	826,008
Net OPEB obligation (asset)	\$ -	\$ -

The Health Authority's annual OPEB cost, the percentage of annual OPEB cost contributed to the plan, and the net OPEB obligation for the year ending June 30, 2010 and June 30, 2009 are as follows:

Fiscal Year Ended	Annual OPEB Cost	Percentage of OPEB Cost Contributed	Net OPEB Obligation
June 30, 2009	\$826,008	100%	\$ -
June 30, 2010	\$675,470	100%	\$ -

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As of January 1, 2010, the most recent actuarial valuation date, the plan was 17.65% funded. The actuarial accrued liability for benefits was \$4,842,425, and the actuarial value of assets was \$854,733, resulting in an unfunded accrued liability of \$3,987,692. Unfunded actuarial accrued liability is amortized over 30 years and is included in the annual required contribution.

As of January 1, 2009, the plan was 0% funded. The actuarial accrued liability for benefits was \$4,143,316, and the actuarial value of assets was \$0, resulting in an unfunded accrued liability of \$4,143,316. Unfunded actuarial accrued liability is amortized over 30 years and is included in the annual required contribution.

The following table shows a schedule of funded status and progress at June 30:

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL)	Unfunded Actuarial Accrued Liability (UAAL)	Funded Ratio	Covered Payroll	UAAL as a Percentage of Covered Payroll
January 1, 2009	\$ -	\$ 4,143,316	\$ 4,143,316	0.0%	\$ 12,000,000	34.53%
January 1, 2010	\$ 854,733	\$ 4,842,425	\$ 3,987,692	17.65%	\$ 8,500,077	46.91%

The measurement date for the actuarial analysis is January 1, 2010 for 2010. For measurement purposes, an annual rate of increase in the per capita cost of covered healthcare benefits of 8.00% was assumed for the fiscal year ended June 30, 2010. The rate was assumed to decrease gradually to 7.00% in 2011, to 6.50% in 2012 through 2019, and to remain at 6.00% on 2020 and beyond. The discount rate used is 7.75% for 2010.

The measurement date for the actuarial analysis is January 1, 2009 for 2009. For measurement purposes, an annual rate of increase in the per capita cost of covered healthcare benefits of 7.5% was assumed for the fiscal year ended June 30, 2009. The rate was assumed to decrease gradually to 6.5% over the years of 2010 through 2014 and to 6% over the years of 2015 through 2018 and to remain at 5.78% for 2019 and beyond. The discount rate used is 7.75% for 2009.

The actuarial cost method used for determining the benefit obligations is the “projected unit credit cost method,” under this method, the actuarial present value of projected benefits is the value of benefits expected to be paid for current active members and retirees and is calculated based on assumptions discussed above and underlying census data.

Projections of benefits for financial reporting purposes are based on the substantive plan (the plan as understood by the employer and plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Actuarially determined amounts are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future.

NOTE 10 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

The Health Authority has entered into certain reinsurance (“stop-loss”) agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Health Authority certain proportions of the cost of each member’s annual hospital services excluding those that are capitated, in excess of specified deductibles, up to a maximum of \$2,000,000 per member per contract year. Reinsurance premiums are recorded as health care operating expenses and recoveries are recorded as a reduction of these expenses. Stop-loss premiums exceed recoveries by \$351,429 and \$149,433 in 2010 and 2009, respectively.

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NOTE 11 – TANGIBLE NET EQUITY

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975 (the “Act”), the Health Authority is required to maintain a minimum level of tangible net equity. The required tangible net equity level was \$6,388,000 at June 30, 2010. The Health Authority’s management believes that the Health Authority is in compliance with the required tangible net equity level at June 30, 2010.

NOTE 12 – RISK MANAGEMENT

The Health Authority is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Health Authority carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Health Authority’s commercial coverage.

NOTE 13 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the Health Authority is a party to claims and legal actions by enrollees, providers, and others. The Health Authority’s policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, Health Authority management is of the opinion that any liability that may ultimately result from claims or legal actions will not have a material effect on the financial position or results of operations of the Health Authority.

NOTE 14 – SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the combined balance sheet date but before combined financial statements are available to be issued. The Health Authority recognizes in the combined financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the combined balance sheet, including the estimates inherent in the process of preparing the combined financial statements. The Health Authority’s combined financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the combined balance sheet but arose after the balance sheet date and before the combined financial statements are available to be issued.

The Health Authority has evaluated subsequent events through October 28, 2010 which is the date the combined financial statements are available to be issued.

NOTE 15 – HEALTH CARE REFORM

As a result of recently enacted and pending federal health care reform legislation, substantial changes are anticipated in the United States health care system. Such legislation includes numerous provisions affecting the delivery of health care services, the financing of health care costs, reimbursement of health care providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over approximately the next decade. This federal health care reform legislation does not affect the Health Authority’s combined financial statements.