

AGREEMENT
between
COUNTY OF SANTA BARBARA
and
CENTRAL COAST INPATIENT CONSULTANTS, INC
for
HOSPITALIST COVERAGE
FIFTH AMENDMENT
Effective April 1, 2014

THIS IS THE FIFTH AMENDMENT (hereafter referred to as **Fifth Amendment**) to the Agreement for Hospitalist Services (hereafter **Agreement**), by and between the County of Santa Barbara (COUNTY) and Central Coast Inpatient Consultants, Inc. (CONTRACTOR), for the provision of hospitalist services at the Dignity Health Marian Regional Medical Center, Santa Maria, California.

WHEREAS, the Agreement is effective through March 31, 2014; and

WHEREAS, the parties desire to amend the Agreement to extend the term and adjust compensation; and

WHEREAS, this Fifth Amendment incorporates the terms and conditions set forth in the Agreement, First, Second, Third and Fourth Amendment, approved by the County of Santa Barbara; and

WHEREAS each party has agreed that changes to reimbursement from third party payers for COUNTY patients will increase as a result of Health Care Reform and additional support for these hospitalist services from the COUNTY will not be necessary after the term of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, the parties agree as follows:

1. **Definitions.** Capitalized terms used in this Fifth Amendment, to the extent not otherwise defined herein shall have the same meanings as in the Agreement.
2. **Amendments.**
 - a. The Agreement is amended as follows:
 4. **TERM.** CONTRACTOR shall commence performance on ~~July 1, 2013~~ **April 1, 2014**, and shall continue to provide services pursuant to this Agreement until, ~~March 31, 2014~~ **December 31, 2014** unless terminated sooner as provided herein.
 - b. EXHIBIT B PAYMENT ARRANGEMENTS Section A is amended as follows:
 - A. For CONTRACTOR services to be rendered under this contract, CONTRACTOR shall be paid a total contract amount, including cost reimbursements, not to exceed \$117,000 **\$81,000** for the period ~~July 1, 2013~~ **April 1, 2014** through ~~March 31, 2014~~ **December 31, 2014**.

COUNTY shall pay CONTRACTOR at the rate of \$13,000 per month **for the period of April 1, 2014 through June 30, 2014 and at the rate of \$7,000 per month for the period of July 1, 2014 through December 31, 2014. There will be no**

payment for services after December 31, 2014. CONTRACTOR will continue to provide services and bill all third party payment sources as appropriate

4. **Counterparts.** This Fifth Amendment may be executed in several counterparts, all of which taken together shall constitute a single agreement between the parties.

Fifth Amendment to Agreement for Hospitalist Services between the **County of Santa Barbara** and **Central Coast Inpatient Consultants, Inc.**

IN WITNESS WHEREOF, the parties have executed and ratified this Fifth Amendment to be effective April 1, 2014.

COUNTY OF SANTA BARBARA

Chair, Board of Supervisors

Date: _____

ATTEST:
MONA MIYASATO
CLERK OF THE BOARD

By: _____
Deputy Clerk

APPROVED AS TO FORM:
MICHAEL C. GHIZZONI
COUNTY COUNSEL

APPROVED AS TO ACCOUNTING FORM:
ROBERT W GEIS, CPA
AUDITOR-CONTROLLER

By: _____
Deputy County Counsel

By: _____
Deputy

APPROVED:
TAKASHI WADA, MD, MPH
DIRECTOR/HEALTH OFFICER
PUBLIC HEALTH DEPARTMENT

APPROVED AS TO FORM:
RAY AROMATORIO, ARM, AIC
RISK MANAGER

By: _____
Director

By: _____
Risk Manager

Fifth Amendment to Agreement for Hospitalist Services between the **County of Santa Barbara** and **Central Coast Inpatient Consultants, Inc.**

IN WITNESS WHEREOF, the parties have executed and ratified this Fifth Amendment to be effective April 1, 2014.

CONTRACTOR

CENTRAL COAST INPATIENT CONSULTANTS, INC.

By: _____
J. Kelly Newlander, MD, President

Date: _____

Contract Summary

Complete data below, print, obtain signature of authorized departmental representative, and submit this form (and attachments) to the Clerk of the Board (>\$25,000) or Purchasing (<\$25,000). See also "Contracts for Services" policy. Form is not applicable to revenue contracts.

D1.	Fiscal Year.....	FY 2013-2014 and 2014-2015
D2.	Budget Unit Number (plus –Ship/Bill codes in parenthesis).....	041
D3.	Requisition Number	
D4.	Department Name	Public Health
D5.	Contact Person	Dan Reid
D6.	Telephone.....	681-5173

K1.	Contract Type (check one): X Personal Service <input type="checkbox"/> Capital	
K2.	Brief Summary of Contract Description/Purpose	Hospitalist Services
K3.	Original Contract Amount	\$325,000
K4.	Contract Begin Date	6-1-09
K5.	Original Contract End Date.....	6-30-11
K6.	Amendment History (leave blank if no prior amendments)	A01; Extend term; replace exhibit; A02; Extended term, added performance objectives; A03 extends term through 12/31/2013, adds Compliance clause. A04 extends the term through 3/31/2014, A05 extends the term through 12/31/204 and changes the compensation rates after 7/1/2014.
K7.	Department Project Number	

B1.	Is this a Board Contract? (Yes/No)	Yes
B2.	Number of Workers Displaced (if any)	
B3.	Number of Competitive Bids (if any)	
B4.	Lowest Bid Amount (if bid)	
B5.	If Board waived bids, show Agenda Date	
	and Agenda Item Number.....	
B7.	Boilerplate Contract Text Unaffected? (Yes / or cite Paragraph)	

F1.	Encumbrance Transaction Code	
F2.	Current Year Encumbrance Amount	\$156,000
F3.	Fund Number.....	0042
F4.	Department Number	041
F5.	Division Number (if applicable)	12
F6.	Account Number	7467
F7.	Cost Center number (if applicable)	1606
F8.	Payment Terms	Net 30

V1.	Vendor Numbers (A=Auditor; P=Purchasing)	
V2.	Payee/Contractor Name	Central Coast Inpatient
V3.	Mailing Address	1400 E. Church St.
V4.	City State (two-letter) Zip (include +4 if known)	Santa Maria, CA 93454
V5.	Telephone Number	739-3215
V7.	Contact Person	J. Kelly Newlander, MD, President
V8.	Workers Comp Insurance Expiration Date	n/a
V9.	Liability Insurance Expiration Date[s] (G=Genl; P=Prof)	n/a Med Mal provided by County
V10.	Professional License Number	n/a
V11.	Verified by (name of county staff)	Kelly Lazarus

V12 Company Type (Check one) ☐ Individual ☐ Sole Proprietorship ☐ Partnership X Corporation

I certify information complete and accurate; designated funds available; required concurrences evidenced on signature page.

Date: _____ Authorized Signature: _____