

SECOND AMENDMENT FOR
AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR
between
SANTA BARBARA COUNTY
and
COREMEDICAL GROUP
EFFECTIVE JULY 1, 2010

THIS IS THE SECOND AMENDMENT (hereafter referred to as **Amendment Two**) to the Agreement for Services of Independent Contractor, number BC-07-082 (hereafter **Agreement**), by and between the County of Santa Barbara (hereafter **COUNTY**) and CoreMedical Group (hereafter **CONTRACTOR**), for the provision of temporary health care professionals.

WHEREAS, the Agreement is effective through July 31, 2010.

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

WHEREAS, this Amendment Two incorporates the terms and conditions set forth in the Agreement and Amendment One, approved by the County of Santa Barbara.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, COUNTY and CONTRACTOR agree as follows:

1. **Definitions.** Capitalized terms used in this Amendment Two, 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 August 1, 2006 and end performance upon completion, but no later than ~~July 31, 2010~~ **June 30, 2012** unless otherwise directed by COUNTY or unless earlier terminated.
 5. **COMPENSATION OF CONTRACTOR.** CONTRACTOR shall be paid for performance under this Amendment ~~One~~ **Two** in accordance with the terms of Exhibit B, Compensation, as revised herein.
 - b. EXHIBIT B - PAYMENT ARRANGEMENTS is amended as follows:
 - A. For CONTRACTOR services to be rendered under this contract, CONTRACTOR may be paid a total contract amount, including cost reimbursements, not to exceed ~~\$500,000~~ **\$300,000**.
 - B. Payment for services and/or reimbursement of costs shall be made upon CONTRACTOR's satisfactory performance, based upon the scope and methodology contained in **EXHIBIT A** as determined by COUNTY. Payment for services and/or reimbursement of costs shall be based upon the costs, expenses, overhead charges and hourly rates for personnel, as defined in Attachment B1 (Schedule of Fees) **dated:**

~~June 1, 2010. and Attachment B2 (Schedule of Fees Effective 8/1/08).~~ Invoices submitted for payment that are based upon Attachment B1 ~~or Attachment B2~~ must contain sufficient detail to enable an audit of the charges and provide supporting documentation if so specified in EXHIBIT A.

C. Weekly, CONTRACTOR shall submit to COUNTY's designated representative or designee, an invoice or certified claim on the County Treasury for the service performed over the period specified. These invoices or certified claims must cite the assigned Board Contract Number. COUNTY's designated representative or designee shall evaluate the quality of the service performed and, if found to be satisfactory and within the cost basis of Attachment B1, ~~or Attachment B2~~ shall initiate payment processing. COUNTY shall pay invoices or claims for satisfactory work within 30 days of presentation.

3. **Ratifications.** The terms and provisions set forth in this Amendment Two shall modify and supercede all inconsistent terms and provisions set forth in the Agreement. The terms and provisions of the Agreement, as expressly modified and superseded by this Amendment Two, are ratified and confirmed and shall continue in full force and effect, and shall continue to be legal, valid, binding and shall continue to be legal, valid, binding enforceable obligations of the parties.
4. **Counterparts.** This Amendment Two may be executed in several counterparts, all of which taken together shall constitute a single agreement between the parties.

Amendment Two to Agreement for Services of Independent Contractor BC-07-082 between the
County of Santa Barbara and CoreMedical Group

IN WITNESS WHEREOF, the parties have executed this Amendment Two to be effective July 1,
2010.

COUNTY OF SANTA BARBARA

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

Chair, Board of Supervisors

By: _____
Deputy

Date: _____

APPROVED AS TO FORM:
DENNIS MARSHALL
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
RISK PROGRAM ADMINISTRATOR

By: _____
Director

By: _____
Risk Program Administrator

Amendment Two to Agreement for Services of Independent Contractor BC-07-082 between the **County of Santa Barbara** and **CoreMedical Group**

IN WITNESS WHEREOF, the parties have executed this Amendment Two to be effective July 1, 2010.

CONTRACTOR

CoreMedical Group

By: _____
Signature

Printed Name, Title

Date: _____

**Exhibit B
Attachment B2**

**Schedule of Fees
Effective June 1, 2010**

HOURLY FEE SCHEDULE

HEALTHCARE PROFESSIONAL		
General RN's	Med/Surg, Ortho, Rehab, LTC, SNF	\$54.00 - \$57.00
Specialty RN's Level I	Tele/Stepdown, Oncology, Psych, ER, OR, Peds, Mother/Baby, Post Partum, ICU, CCU, PACU	\$57.00 - \$60.00
Specialty RN's Level II	CVICU, CVOR, NICU, PICU, Dialysis, Cath Lab, LDRP, Burn Units, Open Heart, BMT	\$60.00 - \$64.00
Surgical Technicians	All Levels	N/A
LPN's	All Levels	N/A
ALLIED		
OT/PT/SLP		\$60.00 - \$66.00
PTA/COTA		\$50.00 - \$56.00
IMAGING		
Radiology		N/A
		N/A
Ultrasound		N/A
		N/A
Radiation Therapist		N/A

Professionals In Charge will be invoiced at an additional: \$3.00 per hour
Hours Professionals are placed On Call will be invoiced at: \$6.00 per hour

Above Fee Includes all Costs of: Hourly Wages, Professional Liability Insurance, Workers' Compensation, Payroll Taxes, Furnished Housing, Transportation and Administrative Fee. The above rates are for weekday, weekend, day, evening or night shifts. Fees may be subject to change for any particular assignment due to extraordinary costs of housing, direct labor rates, bonuses or competitiveness within the market. Any changes or exceptions will be agreed upon by both parties prior to the completion of the placement.

Overtime/Holiday/Called In Rates: Will be invoiced at 1.5 times the regular hourly bill rate.

Overtime Policy: Overtime rates will be used for any hours worked in excess of Healthcare Professional's specified weekly scheduled hours, i.e., 36 hours or 40 hours per week.

Holidays: 8 Hour Shifts: 11pm the eve of the holiday to 11pm the night of the holiday, 9, 10 or 12 Hour Shifts: 7pm the eve of the holiday to 7pm the night of the holiday. New Year's Day, Christmas Day, Thanksgiving Day, Memorial Day, July 4th, Labor Day.

Minimum Guarantee of Hours: COUNTY agrees to guarantee each Professional the minimum total assignment hours of 468/520 hours as specified in the assignment confirmation letter. Called-off hours will be made up within seven (7) days or billed at the regular rate.

Contract Summary Form:

BC-07-082 Amendment #2

- D1. Year(s).....: FYs 2006-07 through 2011-12
- D2. Department Number (plus -Ship/-Bill codes in paren's): 041
- D3. Requisition Number
- D4. Department Name: Public Health Department
- D5. Contact Person: Rose Davis
- D6. Phone.....: (805) 681-5107

- K1. Contract Type (check one): Personal Service Capital Project/Construction
- K2. Brief Summary of Contract Description/Purpose: Provider of temporary health care personnel.
- K3. Original Contract Amount.....: \$500,000
- K4. Contract Begin Date.....: August 1, 2006
- K5. Original Contract End Date.....: July 31, 2008
- K6. Amendment History (leave blank if no prior amendments): None.

<u>Seq#</u>	<u>Effective Date</u>	<u>ThisAmndtAmt</u>	<u>CumAmndtToDate</u>	<u>NewTotalAmt</u>	<u>NewEndDate</u>	<u>Purpose (2-4 words)</u>
1	8/1/06 to 7/31/08	\$500,000				Original Agreement
2	8/1/08 to 7/31/10	\$1,000,000				Amend One; Extend term; adjust amount; change rates
3	8/1/10 to 6/30/12	\$300,000				Amend Two: Extend term; adjust total amount

- K7. Department Project Number
- B1. Is this a Board Contract? (Yes/No): Yes
- B2. Number of Workers Displaced (if any): 0
- B3. Number of Competitive Bids (if any): N/A
- B4. Lowest Bid Amount (if bid): \$n/a
- B5. If Board waived bids, show Agenda Date
- B6. Agenda Item Number
- B7. Boilerplate Contract Text Unaffected? N/A

- F1. Encumbrance Transaction Code.....:
- F2. Current Year Encumbrance Amount
- F3. Fund Number.....: 0042
- F4. Department Number: 041
- F5. Division Number (if applicable).....: 1101
- F6. Account Number: 7460
- F7. Cost Center number (if applicable)
- F8. Payment Terms.....: Net 30

- V1. Vendor Numbers (A=uditor; P=urchasing).....:
- V2. Payee/Contractor Name.....: CoreMedical Group
- V3. Mailing Address: 2 Keewaydin Drive
- V4. City State (Three-letter) Zip (include +4 if known): Salem, NH 03079
- V5. Telephone Number: 800.995.2673 x1316
- V6. Contractor's Federal Tax ID Number (EIN or SSN): On File
- V7. Contact Person.....: Aram Hampoian
- V8. Workers Comp Insurance Expiration Date.....: 11/1/08
- V9. Liability Insurance Expiration Date[s] (G=enl; P=rofl): 11/1/08
- V10. Professional License Number.....: N/A
- V11. Verified by (name of County staff).....: Rose Davis
- V12. Company Type (Check one): Individual Sole Proprietorship Partnership Corporation

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

Date : _____ Authorized Signature _____