

AMENDMENT

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "Thirteenth Amended Contract") to the Agreement for Services of Independent Contractor, number **BC 05-103**, by and between the **County of Santa Barbara** (County) and **Aurora Vista del Mar Hospital** (Contractor), for the continued provision of Psychiatric Inpatient Hospital Services.

Whereas, this Thirteenth Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in September 2004, the First Amendment approved by the County Board of Supervisors in January 2005, the Second Amendment approved by the ADMHS Director in June 2005, the Third Amendment approved by the County Board of Supervisors in December 2005, the Fourth Amendment approved by the County Board of Supervisors in October 2006, the Fifth Amendment approved by the County Board of Supervisors in August 2006, the Sixth Amendment approved by the County Board of Supervisors in April 2007, the Seventh Amendment approved by the County Board of Supervisors in July 2007, the Eighth Amendment approved by the County Board of Supervisors in June 2008, the Ninth Amendment approved by the County Board of Supervisors in May 2009, the Tenth Amendment approved by the County Board of Supervisors in June 2009, the Eleventh Amendment approved by the ADMHS Director in August 2009, the Twelfth Amendment approved by the ADMHS Director in February 2010, except as modified by this Thirteenth Amended Contract.

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

I. Delete Section II, MAXIMUM CONTRACT AMOUNT, from Exhibit B, Payment Arrangements, and replace with the following:

II. MAXIMUM CONTRACT AMOUNT

The Maximum Contract Amount has been calculated based on the total UOS to be provided pursuant to this Agreement as set forth in Exhibit B-1 and shall not exceed **\$1500000**. The Maximum Contract Amount shall consist of County, State, and/or Federal funds as shown in Exhibit B-1. Notwithstanding any other provision of this Agreement, in no event shall County pay Contractor more than this Maximum Contract Amount for Contractor's performance hereunder without a properly executed amendment.

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II. Delete Exhibit B-1, Schedule of Rates, and replace with the following:

FY 2009-10 SCHEDULE OF RATES

Accommodation Code/Service	Rate
Adolescent Mental Health Inpatient	Services will be paid at the county-negotiated rates in effect at the time that services were rendered under this Agreement
Adult Mental Health Inpatient 114 Room and Board, Private, Psychiatric 124 Room and Board, Semi-Private 2 Bed, Psychiatric 134 Room and Board, Semi-Private 3 or 4 Bed, Psychiatric 154 Room and Board - Ward (Medical or General), Psychiatric 204 Intensive Care, Psychiatric	\$650/day

Total Contract Maximum Value

\$1500000

**ALL OTHER TERMS AND CONDITIONS OF ORIGINAL AGREEMENT AND
SUBSEQUENT AMENDMENTS REMAIN IN FULL FORCE AND EFFECT.**

CONTRACTOR SIGNATURE: _____

STAFF ANALYST SIGNATURE: _____

FISCAL SERVICES
SIGNATURE: _____

AMENDMENT

SIGNATURE PAGE

Amendment to Agreement for Services of Independent Contractor between the County of Santa Barbara and Aurora Vista del Mar Hospital.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the date executed by County.

COUNTY OF SANTA BARBARA

By: _____
Chair, Board of Supervisors
Date: _____

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

CONTRACTOR

By: _____
Deputy
Date: _____

APPROVED AS TO FORM:
DENNIS MARSHALL
COUNTY COUNSEL

By: _____
Tax Id No 33-0986642.
Date: _____

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

By _____
Deputy County Counsel
Date: _____

By _____
Deputy
Date: _____

APPROVED AS TO FORM :
ALCOHOL, DRUG, AND MENTAL HEALTH
SERVICES
ANN DETRICK, PH.D.
DIRECTOR

APPROVED AS TO INSURANCE FORM:
RAY AROMATORIO
RISK PROGRAM ADMINISTRATOR

By _____
Director
Date: _____

By: _____
Date: _____

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CONTRACT SUMMARY PAGE

BC 05-103

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 09-10
D2. Budget Unit Number 043
D3. Requisition Number N/A
D4. Department Name Alcohol, Drug, & Mental Health Services
D5. Contact Person..... Danielle Spahn
D6. Telephone (805) 681-5229

K1. Contract Type (check one): ☐ Personal Service ☐ Capital
K2. Brief Summary of Contract Description/Purpose Psychiatric services
K3. Contract Amount \$1500000
K4. Contract Begin Date 7/1/2009
K5. Original Contract End Date..... 6/30/2005
K6. Amendment History

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
10	7/1/09	900000		900000	6/30/2010	Renew for 09-10
11	7/1/08	127,500			6/30/2009	Add funds for 08-09
12	7/1/09	90000	990000	990000	6/30/2010	Add funds
13	7/1/09	510000	1500000	1500000	6/30/2010	Add funds

B1. Is this a Board Contract? (Yes/No)..... Yes
B2. Number of Workers Displaced (if any)..... N/A
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 N/A
and Agenda Item Number
B6. Boilerplate Contract Text Unaffected? (Yes / or cite Paragraph)..... Yes

F1. Encumbrance Transaction Code 1701
F2. Current Year Encumbrance Amount \$1500000
F3. Fund Number 0044
F4. Department Number 043
F5. Division Number (if applicable)..... N/A
F6. Account Number..... 7460
F7. Cost Center number (if applicable)..... 3550
F8. Payment Terms Net 30

V1. Vendor Numbers (A=Auditor; P=Purchasing) EID A = 119525
V2. Payee/Contractor Name Aurora Vista del Mar Hospital
V3. Mailing Address..... 801 Seneca Street.
V4. City, State (two-letter) Zip (include +4 if known) Ventura, CA 93001
V5. Telephone Number..... 8056536434
V6. Contractor's Federal Tax ID Number (EIN or SSN)..... 33-0986642
V7. Contact Person..... Mayla Krebsbach CEO
V8. Workers Comp Insurance Expiration Date 9/1/2010
V9. Liability Insurance Expiration Date[s] G-9/8/2010 P-9/8/2010
V10. Professional License Number..... N/A
V11. Verified by (name of county staff) Danielle Spahn
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: _____