AMENDMENT #1 TO THE CONTRACT WITH
CF Merced Behavioral, LLC d/b/a
Merced Behavioral Center (PESP4380)

THIS AMENDMENT is executed this 10th day of May 2022 by and between CF Merced Behavioral, LLC D/B/A Merced Behavioral Center, hereinafter referred to as "Contractor" and COUNTY OF NEVADA, hereinafter referred to as "County". Said Amendment will amend the prior Agreement between the parties entitled Professional Services Contract, executed on October 12, 2021 per Purchase Order No. PESP4380; and

WHEREAS, the Contractor provides skilled nursing services, plus long-term 24-hour treatment program services for chronic mentally ill clients; and

WHEREAS, the parties desire to amend their Agreement increase the maximum contract price from $50,000 to $156,000 (an increase of $106,000) by increasing FY 21/22 from $50,000 to $78,000 (an increase of $28,000) and adding $78,000 for FY 22/23, extend the contract termination date from June 30, 2022 to June 30, 2023 and amend Exhibit "B" Schedule of Charges and Payments to reflect the increase in the maximum contract price.

NOW, THEREFORE, the parties hereto agree as follows:

1. That Amendment #1 shall be effective as of February 1, 2022.
2. That Maximum Contract Price, shall be amended to the following: $156,000
3. That the Contract Termination Date, shall be changed to the following: June 30, 2023.
4. That the Schedule of Charges and Payments, Exhibit "B" is amended to the revised Exhibit "B" attached hereto and incorporated herein.
5. That in all other respects the prior agreement of the parties shall remain in full force and effect except as amended herein.

COUNTY OF NEVADA:

By:_____
Susan Hoek
Chair of the Board of Supervisors

ATTEST:

By:_____
Julie Patterson-Hunter
Clerk of the Board

CONTRACTOR:

By: _____
CF Merced Behavioral, LLC. d/b/a
Merced Behavioral Center
1255 B Street
Merced, CA 95341

EXHIBIT "B"
SCHEDULE OF CHARGES AND PAYMENTS
CF Merced Behavioral, LLC d/b/a
Merced Behavioral Center

I. IMD BASIC CARE SERVICES

A. Rate

As long as Contractor is required to maintain nursing facility licensure and certification, reimbursement for basic services shall be at the rate established by the State Department of Health Services for nursing facilities, plus the rate established for special treatment.

For FY 20/21, County shall pay Contractor as payment in full a rate of Two Hundred Four Dollars and Ninety Four Cents ($204.94) per bed day, subject to any fees and patient share of costs, for services provided to authorized County clients.

For FY 21/22, County shall pay Contractor as payment in full a rate of Two Hundred Twelve Dollars and Eleven Cents ($212.11) per bed day and a bed hold rate of Two Hundred Three Dollars and Forty Seven Cents ($203.47), subject to any fees and patient share of costs, for services provided to authorized County clients.

Should County be notified of an increase in negotiated rates with Host County or if Medi-Cal raises rates, then the rates for this contract will increase commensurately.

II. PAYMENTS

A. Monthly Payment

County shall provide Contractor with an approved form for use in billing services under this Agreement. Contractor shall bill for services under this Agreement on a monthly basis in arrears. Contractor shall provide County with a bill on the approved form within ten (10) days of the end of the month of service. County shall reimburse Contractor for services within thirty (30) days of receipt of the approved form.

B. Amount

The total amount of reimbursement available for IMD Services under this Agreement shall not exceed One Hundred Fifty Six Thousand Dollars ($156,000).

C. Final Payment

County shall provide Contractor with final payment for services under this Agreement within thirty (30) days of receipt of Contractor billing for the last month of service.

MONTHLY IMD BILLING STATEMENT INFORMATION

The monthly billing statements from Contractor to Behavioral Health must contain, at minimum, the following information:

FACILITY INFORMATION:

Facility Name: _____

Facility Address: _____ _____

Phone Number: _____ _____

CLIENT INFORMATION:

1. Client Name/ Identification: _____

2. Number of days of service rendered: _____

Dates of service: _____ to _____

3. $_____Daily rate
(Title 22, Section 51511 and Section 51511.1)

4. Subtotal: $ _____
(Line 1 x Line 2)

5. Client's share of costs billed: $ _____

6. Net owed by BEHAVIORAL HEALTH: $ _____ _____
(Line 3 - Line 4)

AUTHORIZATION FOR ADMISSION TO IMD PROGRAM

Authorization for Admission to:_____
(Facility Name)

Client Name:_____ Planned Admit Date:_____

Soc. Sec. No.: _____Conserved: _____ Yes Public _____

Date of Birth: _____ No Private _____

Private Conservator Information: Name:__
_____

Address:_____
_____

City/State/Zip: _____

Relationship:_____ Phone: (_____)_____

County of Residence:_____
_____

Medi-Cal No.: _____Client
SSI: _____Yes _____No_____

Client SSA: _____Yes _____No

Brief explanation as to why client needs IMD level of care:
_____
_____

Authorization:

Written: _____Approved _____Not Approved _____
Effective Date:
Verbal: _____ Approved _____Not Approved _____

_____
Date:_____
Signature

_____
Title

Distribution:
Facility:
Client Chart:
Placement Coordinator: