FIRST AMENDMENT TO THE PRIMARY HOSPITAL SERVICES AGREEMENT

This First Amendment to the Primary Hospital Services Agreement ("Amendment") is entered into and is effective this first day of October, 2008 ("Effective Date of Amendment"), by and between the Santa Cruz/Monterey Managed Medical Care Commission, doing business as the Central Coast Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. Plan and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007 (the "Agreement").

B. Both Plan and Contractor desire to change certain terms of the Agreement.

C. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

D. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Delete Exhibit 2 Section A. in its entirety and replace it with the following Exhibit 2 Section A.:

"A. Hospital Inpatient Services Reimbursement Effective 10/1/08.

(1)

*This payment (net of the amounts held in reserve by Contractor) is payment in full for all such Covered Services that are provided to Medi-Cal Members, as well as any necessary administrative services; provided, however, Plan shall pay the Laparoscopic Gastric Banding Implant kit at the invoice cost in addition to the Laparoscopic Gastric Banding Surgery Day One per diem. Payment may be subject to adjustment as described in Section 3.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 3.5 of this Agreement. Ten percent (10%) of the payment set forth above shall be held in reserve by Contractor to absorb possible cost overruns in Risk Group Medi-Cal risk sharing pools affiliated with Contractor as set forth below in Section C.

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical or surgical Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (i).

(b) 'Acute Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (a) or (c) through (i).

(c) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only.

(d) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(e) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(f) 'ICU/NICU III /Cardiac Surgery Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU/NICU III/Cardiac Surgery Services.

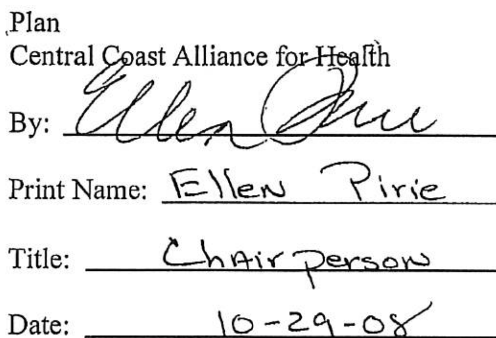
(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services.

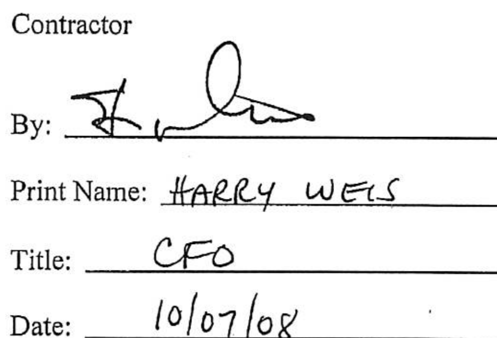
(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required.

(i) 'Laparoscopic Gastric Banding Surgery Day One' shall mean an Inpatient Day approved by Plan in a Hospital for the first day of laparoscopic gastric banding surgery (lap banding) Services. These Services shall be billed using inpatient revenue code 126. Inpatient Days approved by Plan for laparoscopic gastric banding surgery (lap banding) Services beyond the first Inpatient Day shall be defined as an Acute Medical/Surgical Day and reimbursed at the Acute Medical/Surgical per diem rate."

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.





Plan Central Coast Alliance for Health	Contractor
By: [signature]	By: [signature]
Print Name: Ellen Pirie	Print Name: HARRY WEIS
Title: ChAir Person	Title: CFO
Date: 10-29-08	Date: 10/07/08

SECOND AMENDMENT TO THE PRIMARY HOSPITAL SERVICES AGREEMENT

This Second Amendment to the Primary Hospital Services Agreement ("Amendment") is entered into and is effective this first day of February, 2009 ("Effective Date of Amendment"), by and between the Santa Cruz/Monterey Managed Medical Care Commission, doing business as the Central Coast Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. Plan and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007 and the First Amendment to the Primary Hospital Services Agreement effective October 1, 2008 (together the "Agreement").

B. Both Plan and Contractor desire to change certain terms of the Agreement.

C. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

D. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Add the following at the end of Exhibit 3:

   "D. Access for Infants and Mothers Program

   1. <u>State Access for Infants and Mothers ('AIM') Contract</u>. The State AIM Contract is the Membership Contract that Plan has entered into or may enter into with the State of California Managed Risk Medical Insurance Board under which Monterey individuals eligible for the AIM Program and enrolled with Plan will receive all specified health care services.

   2. <u>AIM Members</u>. AIM Members are Other Members. AIM Members include Monterey AIM Members.

      (a) Monterey AIM Member means any person who is eligible for and participates in the AIM Program, who resides in Monterey County and who is enrolled with Plan pursuant to Plan's State AIM Contract.

3. Covered Benefits. Covered Benefits for AIM Members are the Medically Necessary health care services and benefits which the AIM Member is entitled to receive, provided by and through Plan, under its State AIM Contract. The State AIM Contract currently covers Medically Necessary health care services and benefits set forth in Article 3, Chapter 5.6, Title 10 of the California Code of Regulations beginning with Section 2699.300. Covered Benefits for AIM Members are further described in the applicable Member Evidence of Coverage document. With respect to preventive pediatric health care services provided to AIM Members, Contractor will follow the most recent recommendations of the Recommended Childhood Immunization Schedule/United States adopted by the American Academy of Pediatrics, the Advisory committee on Immunization Practices (ACIP), and the American Academy of Family Physicians. Contractor shall provide immunizations for adult AIM Members as recommended by the ACIP. Health education related to tobacco use is a Covered Benefit under the AIM Program and the State AIM Contract requires Plan to encourage its Providers, including Contractor, to (i) provide a smoke free environment for Members, (ii) offer Members smoking cessation services and assistance in tobacco avoidance, (iii) include tobacco exposure questions in health history and review for family history of tobacco related conditions, and (iv) encourage Members using tobacco products or exposed to second hand smoke to attend an anti-tobacco use program.

4. Exclusions. Services excluded under the AIM Program by Article 3, Chapter 5.6, Title 10 of the California Code of Regulations and services excluded under the State AIM Contract are not Covered Benefits for AIM Members under this Agreement and Plan shall not pay Contractor for the provision of such excluded services to AIM Members. Exclusions for AIM Members are further described in the applicable Member Evidence of Coverage document.

5. Copayments. There are no copayments payable by AIM Members pursuant to the State AIM Contract. Contractor shall not charge any copayments to AIM Members.

6. Emergency Services. For AIM Members, Emergency Services shall mean twenty-four hour health care services required for a medical condition manifesting itself by acute symptoms of a sufficient severity (including active labor or severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) placing the Member's health in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part. According to California Health and Safety Code Section 1317.1, emergency services and care include (i) screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists and (ii) the treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

7. Self-Referral Services. For AIM Members, Self-Referral Services include family planning/sensitive services.

8. Compliance with the AIM Program. Contractor represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations necessary for participation in the AIM Program.

9. Rate Schedule, Effective February 1, 2009.

a. Hospital Inpatient Services Reimbursement.

(1)

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical or surgical Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h).

(b) 'Acute Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (a) or (c) through (h).

(c) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-

Section delivery. The related per diem rate includes payment for Covered Services for mother only.

(d) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care, during the period when the mother is also an inpatient at Contractor. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(e) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care, during the period when the mother is also an inpatient at Contractor. The related per diem rate includes payment for Covered Services for newborn child (children) only.

(f) 'ICU/NICU III /Cardiac Surgery Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU/NICU III/Cardiac Surgery Services. NICU III Services are covered for the newborn child (children) under the AIM Program during the period when the mother is also an inpatient at Contractor.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services.

(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required.

b. Hospital Outpatient and Emergency Room Services Reimbursement.

excluded from this Agreement and shall be referred to such clinical laboratory."

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.

Plan Central Coast Alliance for Health	Contractor
By: [signature]	By: [signature]
Print Name: Ellen Pirie	Print Name: HARRY WEIS
Title: Chairperson	Title: CFO
Date: 3-31-09	Date: 02/06/09

Natividad Medical Center

THIRD AMENDMENT TO THE PRIMARY HOSPITAL SERVICES AGREEMENT

This Third Amendment to the Primary Hospital Services Agreement ("Amendment") is entered into and is effective this first day of July, 2009 ("Effective Date of Amendment"), by and between the Santa Cruz/Monterey Managed Medical Care Commission, doing business as the Central Coast Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. Plan and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, the First Amendment to the Primary Hospital Services Agreement effective October 1, 2008, and the Second Amendment to the Primary Hospital Services Agreement effective February 1, 2009 (together the "Agreement").

B. Both Plan and Contractor desire to change certain terms of the Agreement.

C. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

D. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Delete Exhibit 2 Section A. in its entirety and replace it with the following Exhibit 2 Section A.:

"A. <u>Hospital Inpatient Services Reimbursement Effective July 1, 2009.</u>

(1)

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (i). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care.

The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Laparoscopic Gastric Banding Surgery Day One' shall mean an Inpatient Day approved by Plan in a Hospital for the first day of laparoscopic gastric banding surgery (lap banding) Services. Such Services shall be billed using inpatient revenue code 126. Inpatient Days approved by Plan for laparoscopic gastric banding surgery (lap banding) Services beyond the first Inpatient Day shall be defined as an Acute Medical/Surgical/Pediatric Day and reimbursed at the Acute Medical/Surgical/Pediatric per diem rate.

(i) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169."

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.

Plan Central Coast Alliance for Health	Contractor
By: [signature]	By: [signature]
Print Name: Ellen Pirie	Print Name: [illegible]
Title: Chairperson	Title: CEO
Date: 8/6/09	Date: 6/24/09

FOURTH AMENDMENT TO THE PRIMARY HOSPITAL SERVICES AGREEMENT

This Fourth Amendment to the Primary Hospital Services Agreement ("Amendment") is entered into and is effective this first day of July, 2009 ("Effective Date of Amendment"), by and between the Santa Cruz/Monterey Managed Medical Care Commission, doing business as the Central Coast Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. Plan and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, the First Amendment to the Primary Hospital Services Agreement effective October 1, 2008, the Second Amendment to the Primary Hospital Services Agreement effective February 1, 2009, and the Third Amendment to the Primary Hospital Services Agreement effective July 1, 2009 (together the "Agreement").

B. Both Plan and Contractor desire to change certain terms of the Agreement.

C. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

D. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Delete Exhibit 3 Section A. 10. a. (1) – (2) in its entirety and replace it with the following Exhibit 3 Section A. 10. a. (1) – (2):

   "10. Rate Schedule, Effective July 1, 2009.

   a. Hospital Inpatient Services Reimbursement.

This payment and the amount set forth in Section 3.4 (b) (i) (net of the amounts held in reserve by Contractor) is payment in full for all such Covered Services that are provided to Healthy Families Members, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 3.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 3.5 of this Agreement. Ten percent (10%) of the payment set forth above shall be held in reserve by Contractor to absorb possible cost overruns in Risk Group Healthy Families risk sharing pools affiliated with Contractor as set forth below in Section c. Compensation to Contractor for Covered Services provided to Healthy Families Members shall be reduced by any applicable copayment owed by or on behalf of such Healthy Families Members.

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the

newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174.

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169."

2. Delete Exhibit 3 Section B. 9. a. (1) – (2) in its entirety and replace it with the following Exhibit 3 Section B. 9. a. (1) – (2):

"9. Rate Schedule, Effective July 1, 2009.

a. Hospital Inpatient Services Reimbursement.

(1)

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for

mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174.

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169."

3. Delete Exhibit 3 Section C. 9. a. (1) – (2) in its entirety and replace it with the following Exhibit 3 Section C. 9. a. (1) – (2):

"9. Rate Schedule, Effective July 1, 2009.

a. Hospital Inpatient Services Reimbursement.

(1)

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for

mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174.

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169."

4. Delete Exhibit 3 Section D. 9. a. (1) – (2) in its entirety and replace it with the following Exhibit 3 Section D. 9. a. (1) – (2):

"9. Rate Schedule, Effective July 1, 2009.

a. Hospital Inpatient Services Reimbursement.

(1)

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care, during the period when the mother is also an inpatient at Contractor. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care, during the period when the mother is also an inpatient at Contractor. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care, during the period when the mother is also an inpatient at Contractor. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174.

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

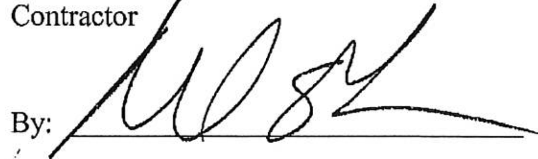
(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169."

5. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and

the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.

Plan Central Coast Alliance for Health	Contractor
By:	By: 
Print Name: Ellen Pirie	Print Name: MICHAEL MCGINNIS
Title: Chairperson	Title: CFO
Date: 9/25/09	Date: 7/16/09

FIFTH AMENDMENT TO THE PRIMARY HOSPITAL SERVICES AGREEMENT

This Fifth Amendment to the Primary Hospital Services Agreement ("Amendment") is entered into and is effective this first day of August, 2009 ("Effective Date of Amendment"), by and between the Santa Cruz/Monterey Managed Medical Care Commission, doing business as the Central Coast Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, the First Amendment to the Primary Hospital Services Agreement effective October 1, 2008, the Second Amendment to the Primary Hospital Services Agreement effective February 1, 2009, the Third Amendment to the Primary Hospital Services Agreement effective July 1, 2009 and the Fourth Amendment to the Primary Hospital Services Agreement effective July 1, 2009 (together the "Agreement").

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. On the first page and in the introductory paragraph, change the title of the Agreement to read: "PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT".

2. Add the following after the second to last sentence of Section 2.2 (a):

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"Contractor shall be available to provide on behalf of Members or arrange on behalf of Members prompt STAT outpatient laboratory Services that are ordered by a Physician."

3. Add the following after the fourth sentence of Section 2.6:

   "Laboratory Services shall be ordered by a Physician."

4. Add the following after the first sentence of Section 5.3:

   "Contractor will promptly forward copies of lab results to the Member's ordering Physician."

5. In the last sentence of Section 5.3, add the phrase "or ordering physician" before the phrase "at no charge".

6. In the first sentence of Section 5.5 (a), delete the phrase "and (ii) Contractor's financial resources" and replace it with the phrase ", (ii) Contractor's financial resources, and (iii) lab values and codes required for HEDIS reporting".

7. Add the following after the second sentence in Section 7.3 (a):

   "Contractor shall be certified under the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 and the California Clinical Laboratory requirements. Contractor agrees that if any performance under this Agreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto. Contractor shall also meet all applicable rules and regulations required of clinical laboratories in California. Equipment required to be licensed or registered by law shall be so licensed and registered."

8. In Section 9.9, delete the phrase "The Santa/Cruz Monterey Medical Care Commission" and replace it with the phrase "The Central California Alliance for Health".

9. Add the following at the end of Exhibit 1:

   "Hospital outpatient services shall include, but not be limited to, outpatient clinical laboratory services, which are described as follows:

   a. Outpatient clinical laboratory services are clinical laboratory testing for Members not provided or ordered as part of an Inpatient Hospital Service that provides information for the diagnosis, prevention or treatment of disease, or the assessment of a medical condition and includes, but is not

limited to, microbiological, serological, chemical, hematological, cytological, immunohematology, and pathological examinations performed on materials derived from the human body. Services shall also include consulting services for all tests performed or arranged by Contractor, all necessary and required supplies, requisition forms, specimen pickup, courier service as applicable, specimen collection, specimen preparation, specimen storage as appropriate, report delivery and inservice training. Services may include suitable phlebotomy services to draw sites and to Skilled Nursing Facilities and Long Term Care Facilities. If a Physician orders a repeat clinical laboratory test on the same specimen, Contractor shall provide such test at no additional charge if the repeat test is due to Contractor error. Contractor shall not bill for such errors.

b. STAT Testing and Other Testing.

(1) STAT laboratory tests are those tests for which the results may be necessary to treat a life-threatening condition or for immediate modification to therapy. Contractor shall be available to provide on behalf of Members or arrange on behalf of Members prompt STAT Services that are ordered by a Physician, within the standard time period for the industry.

(2) Routine Testing. Routine laboratory tests are those laboratory tests that are not STAT, culture or specialty tests. Contractor will complete routine tests and transmit results to the ordering Physicians within the standard time period for the industry.

(3) Cultures and Special Testing. Other tests such as cultures and specialty tests may take longer than routine testing depending on the organism. Contractor will complete culture and specialty tests and transmit results to the ordering Physicians within the standard time period for the industry.

c. Critical Values. Critical Values are laboratory test results which may indicate a life threatening condition. If a laboratory test result for a Member is in the Critical Value range, Contractor shall immediately contact the ordering Physician. If the ordering Physician is not available, Contractor shall immediately contact another appropriate physician."

10. Delete Exhibit 2 Section B. in its entirety and replace it with the following Exhibit 2 Section B., effective August 1, 2009:

"B. Hospital Outpatient and Emergency Room Services Reimbursement. Plan

11. Effective August 1, 2009, delete the fourth sentence of Exhibit 3 Section A. 10. b. in its entirety, that reads "All Services that are outpatient laboratory services provided by a clinical laboratory under contract with Plan shall be excluded from this Agreement and shall be referred to such clinical laboratory."

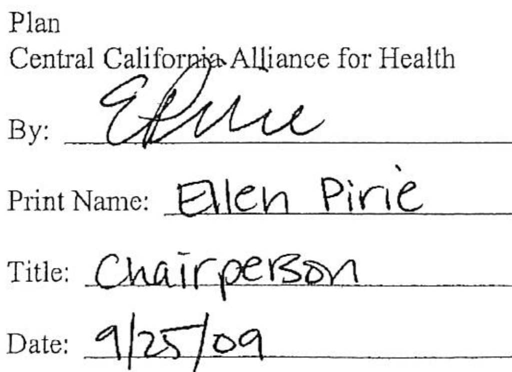
12. Effective August 1, 2009, delete the fourth sentence of Exhibit 3 Section B. 9. b. in its entirety, that reads "All Services that are outpatient laboratory services provided by a clinical laboratory under contract with Plan shall be excluded from this Agreement and shall be referred to such clinical laboratory."

13. Effective August 1, 2009, delete the fourth sentence of Exhibit 3 Section C. 9. b. in its entirety, that reads "All Services that are outpatient laboratory services provided by a clinical laboratory under contract with Plan shall be excluded from this Agreement and shall be referred to such clinical laboratory."

14. Effective August 1, 2009, delete the last sentence of Exhibit 3 Section D. 9. b. in its entirety, that reads "All Services that are outpatient laboratory services provided by a clinical laboratory under contract with Plan shall be excluded from this Agreement and shall be referred to such clinical laboratory."

15. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.



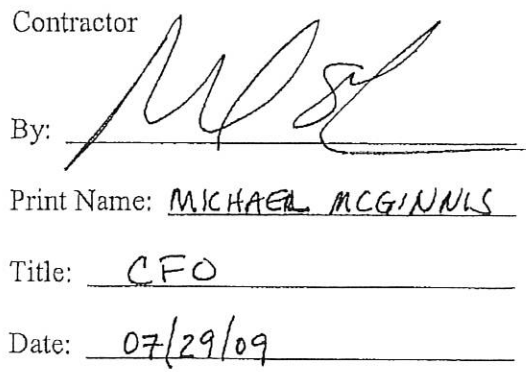
Plan
Central California Alliance for Health

By: ______

Print Name: Ellen Pirie

Title: Chairperson

Date: 9/25/09



Contractor

By: ______

Print Name: MICHAEL MCGINNIS

Title: CFO

Date: 07/29/09

PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

SIXTH AMENDMENT

This Agreement is made this 6 day of JUNE, 2011, by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, a public entity organized under the laws of California, doing business as the Central California Alliance for Health, hereinafter referred to as "PLAN", and Natividad Medical Center, a County Hospital, hereinafter referred to as "PROVIDER".

RECITALS:

WHEREAS, PLAN and PROVIDER have previously entered into the Primary Hospital and Outpatient Laboratory Services Agreement ("the Agreement") effective July 1, 2007;

WHEREAS, Section 9.5 of such Agreement provides for amending such Agreement;

WHEREAS, PLAN has been created by its County Boards of Supervisors to negotiate exclusive contracts with the California Department of Health Care Services and to arrange for the provision of Medi-Cal health care services to qualifying individuals in Monterey County and PLAN is a public entity, created pursuant to Welfare and Institutions Code 14087.54 and County Code Chapter 7.58, County Code Chapter 2.45 and County Code Chapter 9.43;

WHEREAS, Natividad Medical Center, an acute care medical center owned and operated by the County of Monterey ("County"), provides hospital services to PLAN enrollees pursuant to the Agreement, under which it is referred to as "Contractor"; and

WHEREAS, PLAN and PROVIDER desire to amend the Agreement to provide for supplemental payments to PLAN as a result of intergovernmental transfers from the County of Monterey to the California Department of Health Care Services ("State DHCS") to maintain the availability of Medi-Cal health care services to Medi-Cal beneficiaries.

NOW, THEREFORE, PLAN and PROVIDER hereby agree as follows:

Exhibit 2 of the Agreement is amended by adding Section D at the end to read as follows:

MANAGED CARE SUPPLEMENTAL PAYMENT

1. Supplemental Payments to PLAN

A. Payment

Should PLAN receive any Medi-Cal managed care capitation rate increases from State DHCS where the nonfederal share is funded by the County of Monterey specifically pursuant to the provisions of the Intergovernmental Agreement Regarding Transfer of Public

Funds ("Intergovernmental Agreement") for the period July 1, 2009 through June 30, 2010 (*i.e.*, Special Medi-Cal Managed Care Rate Increases) ("SMCRI"), PLAN shall pay to PROVIDER the amount of the SMCRIs received from State DHCS, in accordance with paragraph E below (*i.e.*, Local Medi-Cal Managed Care Supplemental Payments) ("LMSP"). LMSPs paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by PLAN.

B. Health Plan Retention

(1) Managed Care Organizations (MCO) Tax

The PLAN shall be responsible for any managed care organization ("MCO") tax due pursuant to the Revenue and Taxation Code Section 12201 relating to any SMCRI. If the PLAN receives any capitation rate increases based on the MCO tax attributable to the SMCRI, PLAN may retain an amount equal to the amount of such MCO tax that PLAN is required to pay to the State, and shall pay, as part of the LMSP, the remaining amount of the capitation rate increase to PROVIDER.

(2) PLAN will not retain any other portion of the SMCRIs received from the State DHCS other than those mentioned above.

C. Conditions for Receiving Supplemental Payments

As a condition for receiving LMSPs, PROVIDER shall, as of the date the particular supplemental payment is due:

(1) remain a participating provider in the PLAN and not issue a notice of termination of this Agreement;

(2) maintain its current emergency room licensure status and not close its emergency room;

(3) maintain its current inpatient surgery suites and not close these facilities.

D. Schedule and Notice of Transfer of County Funds

(1) PROVIDER shall provide PLAN with a copy of the schedule regarding the transfer of funds to State DHCS, referred to in the Intergovernmental Agreement, within fifteen (15) calendar days of establishing such schedule with the State DHCS. Additionally, PROVIDER shall notify PLAN, in writing, no less than seven (7) calendar days prior to any changes to an existing schedule including, but not limited to, changes in the amounts specified therein.

(2) PROVIDER shall provide PLAN with written notice of the amount and date of the transfer within seven (7) calendar days after funds have been transferred to State DHCS for use as the nonfederal share of any SMCRI.

E. Form and Timing of Payments

PLAN agrees to pay LMSPs to PROVIDER in the following form and according to the following schedule:

(1) PLAN agrees to pay to PROVIDER LMSPs using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

(2) PLAN will pay to PROVIDER the LMSPs no later than thirty (30) calendar days after receipt of the SMCRIs from State DHCS.

F. Consideration

(1) As consideration for the LMSPs, PROVIDER shall use the LMSPs for the following purposes and shall treat the LMSPs in the following manner:

(a) The LMSPs shall represent compensation for Medi-Cal services rendered to Medi-Cal PLAN members by PROVIDER and shall represent compensation for Medi-Cal services to Medi-Cal PLAN members during the State fiscal year to which the LMSP applies.

(b) To the extent that total payments received by PROVIDER in any State fiscal year under this Agreement exceed the cost of Medi-Cal services provided to Medi-Cal beneficiaries by PROVIDER during that fiscal year, any remaining LMSP amounts shall be retained by PROVIDER to be expended for health care services. Retained LMSP amounts may be used by the PROVIDER in either the State fiscal year received or subsequent State fiscal years.

(2) For purposes of subsection (1) (b) above, if the LMSPs are not used by PROVIDER in the State fiscal year received, retention of funds by PROVIDER will be established by demonstrating that the retained earnings account of PROVIDER at the end of any State fiscal year in which it received payments based on LMSPs funded pursuant to the Intergovernmental Agreement, has increased over the unspent portion of the prior State fiscal year's balance by the amount of LMSPs received, but not used. These retained PROVIDER funds may be commingled with other County funds for cash management purposes provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

(3) Both parties agree that none of these funds, either County or federal matching funds, will be recycled back to the County general fund, the State, or any other intermediary organization.

G. PLAN's Oversight Responsibilities

PLAN's oversight responsibilities regarding PROVIDER's use of the LMSPs shall be limited as described in this Paragraph. PLAN shall request, within thirty (30) calendar days after each State fiscal year in which LMSPs were transferred to PROVIDER, a written confirmation that states whether and how PROVIDER complied with the provisions set forth in Paragraph F above. In each instance, PROVIDER shall provide PLAN with written confirmation of compliance within thirty (30) calendar days of PLAN's request.

H. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the LMSPs, PROVIDER and PLAN agree to work together in all respects to support and preserve the LMSPs to the full extent possible on behalf of the safety net in Monterey County.

I. Reconciliation

Within one hundred twenty (120) calendar days after the end of each of PLAN's fiscal years in which LMSPs were made to PROVIDER, PLAN shall perform a reconciliation of the LMSPs transmitted to the PROVIDER during the preceding year to ensure that the supporting amount of SMCRIs were received by PLAN from State DHCS. PROVIDER agrees to return to PLAN any overpayment of LMSPs made to PROVIDER within thirty (30) calendar days after receipt from PLAN of a written notice of the overpayment, unless PROVIDER submits a written objection to PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8.1 of the Agreement. The reconciliation processes established under this paragraph are distinct from the indemnification provisions set forth below. PLAN agrees to transmit to the PROVIDER any underpayment of LMSPs within thirty (30) calendar days of PLAN's identification of such underpayment.

J. Indemnification

PROVIDER shall indemnify PLAN in the event that State DHCS, the Department of Health and Human Services or any other federal or state agency recoups, offsets, or otherwise withholds any monies from or fails to provide any monies to PLAN, or PLAN is denied any monies to which it otherwise would have been entitled, as a direct result of the SMCRIs arising from the Intergovernmental Agreement. Recovery by PLAN pursuant to this section shall include, but not be limited to, reduction in future LMSPs paid to PROVIDER in an amount equal to the amount of SMCRI payments withheld or recovered from PLAN, or by reduction of any other amounts owed by PLAN to PROVIDER. This provision shall survive the termination of this Amendment.

2. Term

The term of this Amendment shall commence on July 1, 2009 and shall terminate on October 28, 2012.

All other terms and provisions of said Agreement shall remain in full force and effect so that all rights, duties and obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Amendment and the Agreement, then the terms of this Amendment shall govern.

SIGNATURES

HEALTH PLAN: Central California Alliance for Health Date: 6-2-11

By: Title: Chair, [signature]

PROVIDER: [signature] Date: 6/6/11

By: Title: Chief Executive Officer [signature]

NATIVIDAD MEDICAL CENTER

Never executed
See Amendment 12

SEVENTH AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Seventh Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is made this ________ day of ______________, 2011, by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, the First Amendment to the Primary Hospital Services Agreement effective October 1, 2008, the Second Amendment to the Primary Hospital Services Agreement effective February 1, 2009, the Third Amendment to the Primary Hospital Services Agreement effective July 1, 2009, the Fourth Amendment to the Primary Hospital Services Agreement effective July 1, 2009, the Fifth Amendment to the Primary Hospital Services Agreement, whereby the Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement, effective August 1, 2009, and the Sixth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement effective July 1, 2009 (together the "Agreement").

B. Both Plan and Contractor desire to change certain terms of the Agreement.

C. Plan has entered into an agreement with the County of Monterey ("County") and has agreed to provide administrative support services on behalf of County for County's Low Income Health Program ("LIHP").

D. Contractor desires to participate as a Participating Provider for the County Low Income Health Program and agrees to look solely to County for payment for Covered Services provided to Low Income Health Program Members.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Section 4.7, Termination of LIHP Without Cause, shall be added to state in full as follows:

"4.7 Termination of LIHP Without Cause. Either party may terminate the Agreement at any time with respect to the Low Income Health Program (LIHP) only

PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

EIGHTH Amendment

This Amendment is made this 15 day of Dec, 2011 {month/year}, by and between the Central California Alliance for Health, a County Organized Health System hereinafter referred to as "PLAN", and Natividad Medical Center, a County Hospital, hereinafter referred to as "PROVIDER".

RECITALS:

WHEREAS, PLAN and PROVIDER have previously entered into an Agreement effective July 1, 2007;

WHEREAS, Section 9.5 of such Agreement provides for amending such Agreement;

WHEREAS, PLAN has been created by its County Boards of Supervisors to negotiate exclusive contracts with the California Department of Health Care Services and to arrange for the provision of Medi-Cal health care services to qualifying individuals in Monterey County and PLAN is a public entity, created pursuant to Welfare and Institutions Code 14087.54 and County Code Chapter 7.58, County Code Chapter 2.45 and County Code Chapter 9.43;

WHEREAS, PROVIDER is an acute care medical center owned and operated by the County of Monterey ("County"), provides hospital services to PLAN enrollees pursuant to the Agreement, under which it is referred to as "Contractor"; and

WHEREAS, PLAN and PROVIDER desire to amend the Agreement to provide for Medi-Cal managed care capitation rate increases to PLAN as a result of intergovernmental transfers (IGTs) from the County of Monterey ("County") to the California Department of Health Care Services ("State DHCS") to maintain the availability of Medi-Cal health care services to Medi-Cal beneficiaries.

NOW, THEREFORE, PLAN and PROVIDER hereby agree as follows:

Exhibit 2 of the Agreement is amended to add Section E at the end to read as follows:

IGT MEDI-CAL MANAGED CARE CAPITATION RATE INCREASES

1. IGT Capitation Rate Increases to PLAN

A. Payment

Should PLAN receive any Medi-Cal managed care capitation rate increases from State DHCS where the nonfederal share is funded by the County of Monterey specifically pursuant to the provisions of the Intergovernmental Agreement Regarding Transfer of Public Funds ("Intergovernmental Agreement") effective for the period January 1, 2011 through June 30, 2011 for, Intergovernmental Transfer Medi-Cal Managed Care Rate Increases ("IGT MMCRIs"), PLAN shall pay to PROVIDER the amount of the IGT MMCRIs received from State DHCS, in accordance with paragraph 1.E. below regarding the form and timing of Local Medi-Cal Managed Care Base Rate (LMMCBR) IGT PAYMENTS. LMMCBR IGT PAYMENTS paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by PLAN.

B. Health Plan Retention

1) Managed Care Organizations (MCO) Tax

The PLAN shall be responsible for any Managed Care Organization ("MCO") tax due pursuant to the Revenue and Taxation Code Section 12201 relating to any IGT MMCRIs . If the PLAN receives any capitation rate increases for MCO taxes based on the IGT MMCRIs , PLAN may retain an amount equal to the amount of such MCO tax that PLAN is required to pay to the State DHCS, and shall pay, as part of the LMMCBR IGT PAYMENTS, the remaining amount of the capitation rate increase to PROVIDER.

2) PLAN will not retain any other portion of the IGT MMCRIs received from the State DHCS other than those mentioned above.

C. Conditions for Receiving Local Medi-Cal Managed Care Base Rate IGT Payments

As a condition for receiving LMMCBR IGT PAYMENTS, PROVIDER shall, as of the date the particular LMMCBR IGT PAYMENT is due:

1) remain a participating provider in the PLAN and not issue a notice of termination of the Agreement;

2) maintain its current emergency room licensure status and not close its emergency room;

3) maintain its current inpatient surgery suites and not close these facilities.

D. Schedule and Notice of Transfer of Non-Federal Funds

1) PROVIDER shall provide PLAN with a copy of the schedule regarding the transfer of funds to State DHCS, referred to in the Intergovernmental Agreement, within fifteen (15) calendar days of establishing such schedule with the State DHCS. Additionally, PROVIDER shall notify PLAN, in writing, no less than seven (7) calendar days prior to any changes to an existing schedule including, but not limited to, changes in the amounts specified therein.

2) PROVIDER shall provide PLAN with written notice of the amount and date of the transfer within seven (7) calendar days after transferring funds to State DHCS for use as the nonfederal share of any IGT MMCRI .

E. Form and Timing of Payments

PLAN agrees to pay LMMCBR IGT PAYMENTS to PROVIDER in the following form and according to the following schedule:

1) PLAN agrees to pay the LMMCBR IGT PAYMENTS to PROVIDER using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

2) PLAN will pay the LMMCBR IGT PAYMENTS to PROVIDER no later than thirty (30) calendar days after receipt of the IGT MMCRIs from State DHCS.

F. Consideration

1) As consideration for the LMMCBR IGT PAYMENTS, PROVIDER shall use the LMMCBR IGT PAYMENTS for the following purposes and shall treat the LMMCBR IGT PAYMENTS in the following manner:

a) The LMMCBR IGT PAYMENTS shall represent compensation for Medi-Cal services rendered to Medi-Cal PLAN members by PROVIDER and shall represent compensation for Medi-Cal services to Medi-Cal PLAN members during the State fiscal year to which the LMMCBR IGT PAYMENTS apply.

b) To the extent that total payments received by PROVIDER in any State fiscal year under this Amendment exceed the cost of Medi-Cal services provided to Medi-Cal beneficiaries by PROVIDER during that fiscal year, any remaining LMMCBR PAYMENT amounts shall be retained by PROVIDER to be expended for health care services. Retained LMMCBR PAYMENT amounts may be used by the PROVIDER in either the State fiscal year received or subsequent State fiscal years.

2) For purposes of subsection (1) (b) above, if the LMMCBR IGT PAYMENTS are not used by PROVIDER in the State fiscal year received, retention of funds by PROVIDER will be established by demonstrating that the retained earnings account of PROVIDER at the end of any State fiscal year in which it received payments based on LMMCBR IGT PAYMENTS funded pursuant to the Intergovernmental Agreement, has increased over the unspent portion of the prior State fiscal year's balance by the amount of LMMCBR IGT PAYMENTS received, but not used. These retained PROVIDER funds may be commingled with other County funds for cash management purposes provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

3) Both parties agree that none of these funds, either County or federal matching funds, will be recycled back to the County general fund, the State, or any other intermediary organization. Payments made by the health plan to providers under the terms of this Agreement constitute patient care revenues.

G. PLAN's Oversight Responsibilities

PLAN's oversight responsibilities regarding PROVIDER's use of the LMMCBR IGT PAYMENTS shall be limited as described in this paragraph. PLAN shall request, within thirty (30) calendar days after the end of each State fiscal year in which LMMCBR IGT PAYMENTS were transferred to PROVIDER, a written confirmation that states whether and how PROVIDER complied with the provisions set forth in Paragraph I.F.above. In each insta nce, PROVIDER shall provide PLAN with written confirmation of compliance within thirty (30) calendar days of PLAN's request.

H. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the LMMCBR IGT PAYMENTS, PROVIDER and PLAN agree to work together in all respects to

support and preserve the LMMCBR IGT PAYMENTS to the full extent possible on behalf of the safety net in Monterey County.

I. Reconciliation

Within one hundred twenty (120) calendar days after the end of each of PLAN's fiscal years in which LMMCBR IGT PAYMENTS were made to PROVIDER, PLAN shall perform a reconciliation of the LMMCBR IGT PAYMENTS transmitted to the PROVIDER during the preceding fiscal year to ensure that the supporting amount of IGT MMCRIs were received by PLAN from State DHCS. PROVIDER agrees to return to PLAN any overpayment of LMMCBR IGT PAYMENTS made in error to PROVIDER within thirty (30) calendar days after receipt from PLAN of a written notice of the overpayment error, unless PROVIDER submits a written objection to PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8.1 of the Agreement. The reconciliation processes established under this paragraph are distinct from the indemnification provisions set forth below. PLAN agrees to transmit to the PROVIDER any underpayment of LMMCBR IGT PAYMENTS within thirty (30) calendar days of PLAN's identification of such underpayment.

J. Indemnification

PROVIDER shall indemnify PLAN in the event DHCS or any other federal or state agency recoups, offsets, or otherwise withholds any monies from or fails to provide any monies to PLAN, or PLAN is denied any monies to which it otherwise would have been entitled, as a direct result of the IGT MMCRIs arising from the Intergovernmental Agreement. Recovery by PLAN pursuant to this section shall include, but not be limited to, reduction in future LMMCBR IGT PAYMENTS paid to PROVIDER in an amount equal to the amount of IGT MMCRI payments withheld or recovered from PLAN, or by reduction of any other amounts owed by PLAN to PROVIDER. This provision shall survive the termination of this Amendment.

2. Term

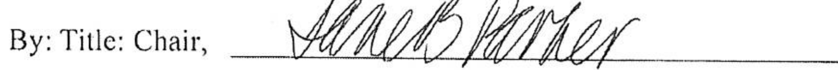
The term of this Amendment shall commence on January 1, 2011 and shall terminate on October 28, 2012, for IGT payments made during the 2011/12 FY.

All other terms and provisions of said Agreement shall remain in full force and effect so that all rights, duties and obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Amendment and the Agreement, then the terms of this Amendment shall govern.

Signatures

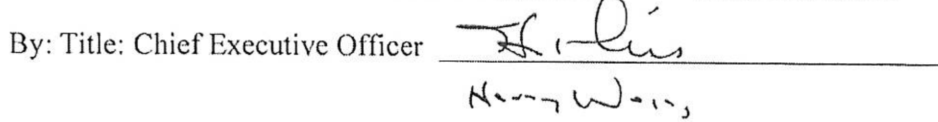
HEALTH PLAN: Central California Alliance for Health Date: 12-19-11

By: Title: Chair,



PROVIDER: Date:

By: Title: Chief Executive Officer



NINTH AMENDMENT TO
THE PRIMARY HOSPITAL AND
OUTPATIENT LABORATORY SERVICES AGREEMENT

This Ninth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is entered into and is effective this first day of May, 2012 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended. The Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement as a result of the Fifth Amendment, effective August 1, 2009.

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

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1. Exhibit 5 Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members, attached hereto, is added as a new exhibit and incorporated into the Agreement.

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.

Plan	Contractor
Central California Alliance for Health	Natividad Medical Center
By: [signature]	By: [signature]
Print Name: Jane Parker	Print Name: HARRY WEIS
Title: Chair, CCAH	Title: CEO
Date: 9/24/2012	Date: 9/7/12

EXHIBIT 5

HOSPITAL OUTPATIENT CLINICAL LABORATORY

INCENTIVE PROGRAM FOR MEDI-CAL MEMBERS

A. Introduction.

This Exhibit sets forth the terms of the hospital outpatient clinical laboratory incentive program offered to Hospitals by Plan. This program is designed to compensate Hospital outpatient clinical laboratories for reported valid HEDIS Laboratory Test Results for all Medi-Cal Members on such forms and within such times as requested by Plan, as described herein (the "Outpatient Laboratory Incentive" or the "OLI").

The OLI continues for a limited term as described in Section G of this Exhibit 5, unless it is specifically extended by mutual written agreement of the parties hereto.

B. Definitions.

For the purposes of this Exhibit, the following definitions are applicable. Additional terms are defined in other sections of this Exhibit and in the Agreement.

1. HEDIS Laboratory Test Results are a set of standardized performance measures maintained by the National Committee for Quality Assurance. These measures may change annually.

2. Technical Participation Requirements are those requirements that must be met by Contractor's outpatient clinical laboratory to ensure the confidentiality and validation of data that are received by the Plan. Therefore, Contractor's outpatient clinical laboratory must have the ability to meet the following Technical Participation Requirements:

   a. Establish communications through the internet with the Plan's system;

   b. Create and transmit documents in the proper format and with the required detail as determined by Plan;

   c. Receive reports from the Plan; and

   d. Return corrected and/or missing data, when necessary.

C. **Laboratory Test Results.**

Contractor shall submit the following HEDIS Laboratory Test Results for Medi-Cal Members for the outpatient laboratory procedure codes as specified in the chart below:

HEDIS Outpatient Laboratory Test	HEDIS Laboratory Procedure Code
HbA1c	CPT 83036, 83037 CPT Category II 3044F, 3045F, 3046F LOINC 4548-4, 4549-2, 17856-6, 59261-8, 62388-4
LDL-C	CPT 80061, 83700, 83701, 83704, 83721 CPT Category II 3048F, 3049F, 3050F LOINC 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2
Urine Macroalbuminuria	CPT 81000-81003, 81005 CPT Category II 3062F LOINC 5804-0, 20454-5, 50561-0, 53525-2, 57735-3

D. **Submission of Data.**

Contractor's outpatient clinical laboratory shall submit valid HEDIS Laboratory Test Results to Plan, according to specific data interchange requirements of Plan, on a regular basis in a Microsoft Excel spreadsheet, CSV (comma-separated values) file format, or text file.

E. **Payment.**

F. **OLI Payment Determination Final.**

Plan's calculation of payments under the OLI shall be based upon valid HEDIS Laboratory Test Results and shall be final. Contractor acknowledges that Plan would not be willing to offer the OLI if Plan's calculation of payments under the OLI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation.

Accordingly, in consideration of Plan's agreement to offer the OLI to Contractor, Contractor agrees that Contractor will have no right to dispute Plan's determination of payments due under the OLI, including determination of valid HEDIS Laboratory Test Results.

G. Term of Hospital Outpatient Clinical Laboratory Incentive Program.

The OLI shall cover HEDIS Laboratory Test Results for those HEDIS laboratory tests performed beginning January 1, 2012 and continuing through December 31, 2012 ("OLI Term"). All HEDIS Laboratory Test Results must be submitted by January 31, 2013 in order to be compensated under the OLI.

H. Incentive Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement incentive programs for the reporting of HEDIS Laboratory Test Results for periods after completion of the OLI Term. Any such programs shall be on terms determined by Plan. Until Plan and Contractor enter into a written agreement with respect to any such new incentive program extending beyond the OLI Term, no such incentive program shall be binding upon Plan.

I. Effect of Termination of Agreement.

In the event of the termination of the Agreement for any reason prior to the expiration of the OLI Term, OLI incentive payments shall be made only for those calendar quarters in which the Agreement was in effect for the full three (3) months. No OLI incentive payments shall be earned for any quarter during which the Agreement is terminated or for any future quarter.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	NATIVIDAD MEDICAL CENTER
By: [signature]	By: [signature]
Print Name: Jane Parker	Print Name: HARRY WEIS
Title: Chair, CCAH	Title: CEO
Date: 9/24/2012	Date: 9/5/12

TENTH AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Tenth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is entered into and is effective this first day of January, 2012 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended. The Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement as a result of the Fifth Amendment, effective August 1, 2009.

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Exhibit 2 Section A. (1). In the first paragraph of Exhibit 2 Section A. (1), delete the * symbol located in the last sentence, effective January 1, 2012.

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2. Exhibit 2 Section A. (1). In the second paragraph of Exhibit 2 Section A. (1), delete the entire first sentence and replace with the following sentence, effective January 1, 2012:

   "This payment is payment in full for all such Covered Services that are provided to Medi-Cal Members, as well as any necessary administrative services; provided, however, Plan shall pay the Laparoscopic Gastric Banding Implant kit at the invoice cost in addition to the Laparoscopic Gastric Banding Surgery Day One per diem."

3. Exhibit 2 Section A. (1). In the second paragraph of Exhibit 2 Section A. (1), delete the entire last sentence "Ten percent (10%) of the payment set forth above shall be held in reserve by Contractor to absorb possible cost overruns in Risk Group Medi-Cal risk sharing pools affiliated with Contractor as set forth below in Section C." in its entirety, effective January 1, 2012.

4. Exhibit 2 Section B., Hospital Outpatient and Emergency Room Services. Delete Exhibit 2 Section B., Hospital Outpatient and Emergency Room Services, in its entirety, and replace with the following Exhibit 2 Section B., Hospital Outpatient and Emergency Room Services, effective March 1, 2012:

   "B.

3.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 3.5 of this Agreement."

5. Exhibit 2 Section C., Risk Sharing. Delete Exhibit 2 Section C., Risk Sharing, in its entirety, effective January 1, 2012.

6. Exhibit 3 Section A. 10. a. (1). In the second paragraph of Exhibit 3 Section A. 10. a. (1), delete the entire first sentence and replace with the following sentence, effective January 1, 2012:

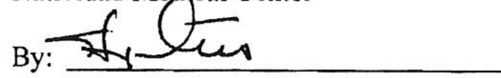
   "This payment and the amount set forth in Section 3.4 (b) (i) is payment in full for all such Covered Services that are provided to Healthy Families Members, as well as any necessary administrative services."

7. Exhibit 3 Section A. 10. a. (1). In the second paragraph of Exhibit 3 Section A. 10. a. (1), delete the second to the last sentence, "Ten percent (10%) of the payment set forth above shall be held in reserve by Contractor to absorb possible cost overruns in Risk Group Healthy Families risk sharing pools affiliated with Contractor as set forth below in Section c." in its entirety, effective January 1, 2012.

8. Exhibit 3 Section A. 10. c., Risk Sharing. Delete Exhibit 3 Section A. 10. c, Risk Sharing, in its entirety, effective January 1, 2012.

9. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.

Plan	Contractor
Central California Alliance for Health	Natividad Medical Center
By:	By: 
Print Name: Jane Parker	Print Name: Harry Weis
Title: Chair, CCAH	Title: CEO
Date: May 15, 2012	Date: 5/1/12

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