### SUMMARY OF CONTRACT TERMS

**Contract # (if assigned):** 100  
**Effective Date:** 7/1/20

<table>
<thead>
<tr>
<th>Purpose of Contract:</th>
<th>Example exhibits. Purpose is to provide nursing services to particular clinic.</th>
</tr>
</thead>
</table>

**Parties:**  
UNCH or UNCHCS Department  
SOM Department and Division (if applicable)  

**Term:**  
Begin: 7/1/20  
End: 6/30/22

**Renewal Terms:**  
- Written Renewal Required: ✔  
- Auto Renew (Pre-Transplant Only absent special approval):  
- Will Not Renew:  

**Type:**  
- New: ✔  
- Amendment:  
- Termination (eff. date): (complete Exhibit H)  
- Renewal-Revised Scope:  
- Renewal-Same Scope:  

**Category:**  
- Physician or APP Clinical Services (complete Exhibit A): ✔  
- Admin Services Physicians (complete Exhibit B):  
- Services by staff (non MDs/APPs) (complete Exhibit C):  
- Program Support (complete Exhibit D):  
- Medical Director/Service Lead/ACMO/Physician Champion (complete Exhibit E):  
- Pre-Transplant (complete Exhibit F):  

**Financial:**  
- UNCH Receivable/University Payable: ✔  
- UNCH Payable/University Receivable:  

#### Contract Amounts:

<table>
<thead>
<tr>
<th>Year</th>
<th>FY21</th>
<th>FY22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Amount</td>
<td>$12,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>Fixed or Variable</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Months</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Mo. Accrual = Annual/12 *</td>
<td>1,000</td>
<td>1,500</td>
</tr>
</tbody>
</table>

*Will use straight line accrual method for all contracts.*

Variable contracts are intended to be invoiced or reconciled to actual costs, e.g. reimbursement for FTEs. Fixed contracts are for a flat amount. Most non-medical director contracts are variable.

Total in future years should reflect anticipated market and/or merit rate increases.

### INFORMATION REQUIRED FOR ACCOUNTING

**Company Cost Center & Account:** 1000-123456-123456  
**UNCH Invoice Approver:** Jane Doe  
**SOM Chartfield:**  
**SOM Invoice Contact:** Jane Doe email@email.com

**Reconciliation Schedule:**  
- Quarterly: ✔  
- Semi-Annual:  
- Annual:  
- Other:  

**Invoicing:**  
- Quarterly: ✔  
- Semi-Annual:  
- Annual:  

*If invoicing actual expenses for a variable contract, supporting payroll information is required.*

### REQUIRED APPROVALS

**UNCH Director:**  
Name: Name of UNCH director  
E-mail: Must include person's email

**UNCH Finance (Confirm Cost Center & Acknowledge):**  
Name: Name of finance representative  
E-mail: Must include person's email

**SOM Department ACA or Designee:**  
Name: Name of ACA or OPSCA Designee  
E-mail: Must include person's email

**SOM Division or Center (optional):**  
Name: Name of division person to approve  
E-mail: Must include person's email

**UNCH VP:**  
Name: Name of UNCH VP  
E-mail: Must include person's email

**UNCFP (optional):**  
Name: Per UNCFP policy--legal will add  
E-mail: Legal may add per UNCFP policy

**OPSCA CRF Submitter:** Jane Doe  
**OPSCA Dept. Contact and e-mail:** Jane Doe email@email.com
Agreement for Clinical Services that Generate Professional Receipts (MDs and/or APPs)

Please provide description of the services to be provided, including scope of services, extent of coverage, etc.

Provide dermatology coverage to UNCH Hillsborough campus. Coverage every day M-F from 8-5 for inpatient and emergency room consults. This is not a real contract and is an example only. Department will provide 1.0 FTE coverage. Also add any details re: vacation or holiday coverage so they can be included in the contract.

Identify all expenses to be included in the contract. Must include details including salary amounts, benefit amounts, and any overhead expenses. It is acceptable to include a chart or excel spreadsheet as an attachment.

Dr. Pierce at 0.50 FTE. Salary: $200,000 x 0.50 = $100,000 on contract. Benefits = $30,000. 1/2 of $1000 annual LITF premium = $1,500

Dr. Lawless at 0.50 FTE: Salary: $200,000 x 0.50 = $100,000 on contract. Benefits = $30,000. 1/2 of $1000 annual LITF premium = $1,500

Total salary/benefits expenses: $263,000/fiscal year. Salaries will increase annually, and SOM will invoice 50% of MD salary. This estimate is for first year only, but same formula will apply.

Provide estimate of professional receipts. Identify any fees that will be deducted from receipts. It is acceptable to include a chart or excel spreadsheet as an attachment.

Professional receipts estimate per fiscal year (note these are actual receipts, and not any sort of wRVU credit): $100,000 in receipts.

UNCFP fees of 21% of receipts: ($21,000)

Net estimated receipts: $79,000 in net receipts each fiscal year estimated

Provide estimate of total subsidy/backstop. This should equal total expenses minus net receipts.

Subsidy for first fiscal year is $263,000 - $79,000 = $184,000

Is there a maximum amount for each fiscal year?  

___ Yes ✓ No

If yes, what is the maximum amount per year?

If yes, does the maximum amount increase over time?  

___ Yes ___ No  

If so, by how much?

Identify method of payment—choose one of two options:

✓ Option 1:  
UNCH pays estimated monthly subsidy. At end of fiscal year, parties reconcile to actuals.  
If this option is chosen, provide monthly subsidy amount: $15,333  
Name of SOM contact:  
Name of UNCH contact:  

Option 2:  
UNCH pays actual loss each month (monthly expenses- monthly receipts).
Exhibit B

Administrative Services by Physicians (except medical director services)

Please provide description of the services to be provided, including estimated time/FTE commitment.

Dr. Jane Doe will provide administrative services to the Hospital to plan and oversee the Hospital's Heart and Vascular program. Duties will include: please provide a description of the program. While the SOM will not have this, the Hospital folks should have this information, and completing this CTC is a joint effort. Dr. Jane Doe will spend 20% of her time on this program.

Identify all expenses to be included in the contract. Must include details including salary amounts, benefit amounts, and any overhead expenses. It is acceptable to include a chart or excel spreadsheet as an attachment.

Department will be reimbursed for 20% of Dr. Doe's salary and benefits. Her salary is $150,000, with estimated $50,000 in benefits. So an estimate of 20% is $40,000 per fiscal year.

Expenses to be Covered in the Contract

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Salary</th>
<th>Benefits</th>
<th>Other</th>
<th>%FTE for Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Jane Doe</td>
<td>$30,000</td>
<td>$10,000</td>
<td>N/A</td>
<td>20%</td>
</tr>
</tbody>
</table>
Services by staff (non MDs/APPs)

Please provide description of the services to be provided, including estimated time/FTE commitment.

Hospital to reimburse Department for 50% of RN for time that RN works in HBC. RN will provide following duties to clinic: RN will function as nurse in clinic. We need something to describe the services.

Is this arrangement funded by a SOM grant?  ____ Yes  ____ No

If yes, identify grant: ______________________________________________________

If yes, identify where to send invoice:

Identify all expenses to be included in the contract. Must include details including salary amounts, benefit amounts, and any overhead expenses. It is acceptable to include a chart or excel spreadsheet as an attachment.

Hospital to reimburse SOM 50% of RN's salary and benefits.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Salary</th>
<th>Benefits</th>
<th>Other</th>
<th>%FTE for Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander Hamilton, RN</td>
<td>$40,000 (50% of $80,000)</td>
<td>$12,000 (30% estimate on $40,000)</td>
<td>N/A</td>
<td>50%</td>
</tr>
</tbody>
</table>
### Exhibit D

### Program Support

<table>
<thead>
<tr>
<th>Amount of Program Support:</th>
<th>Taking Care of Our Own Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100,000</td>
</tr>
</tbody>
</table>

**Reason for Program Support:**

This is for example only—there is not a contract for program support of the Taking Care of our Own Program. But this section should include the goals/services of the program, and why the hospital is providing support to the program.

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**Provide any relevant details of how program support funding is used:**

If there are hospital requirements as to how the funding is to be used, please provide that here.

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### Exhibit E

**Medical Director/Service Lead/ACMO/Physician Champion**

<table>
<thead>
<tr>
<th>Role</th>
<th>Division</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director - Inpatient Unit</td>
<td>Surgery</td>
<td>Dr. Iam Beautiful</td>
</tr>
<tr>
<td>Service Leader Plastic Surgery Service</td>
<td>Plastic Surgery</td>
<td></td>
</tr>
<tr>
<td>Medical Director – Hospital Based Clinic Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACMO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Champion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FTE Commitment/Funding</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant AAMC Specialty</td>
<td>Plastic Surgery (if that is an AAMC Specialty)</td>
</tr>
<tr>
<td>Relevant AAMC Rank</td>
<td>Associate Professor</td>
</tr>
<tr>
<td>Relevant AAMC Salary</td>
<td>$300,000 (this is not real amount)</td>
</tr>
</tbody>
</table>
Exhibit F

Pre Transplant

Department: Medicine
Division: Nephrology
Physician: Dr. New Nephrologist

Department:
Division:
Physician:

Department:
Division:
Physician:

Department:
Division:
Physician:

Department:
Division:
Physician:

Department:
Division:
Physician:

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Division:
Physician:
Exhibit G

Other

Explain contractual arrangement, including details of any funding.

If the contractual arrangement does not fit into any of the other categories, please complete the coversheet and put the details here. Please reach out to the UNCHCS Legal Department if you would like assistance completing this.
**TERMINATION**

**Reason for Termination:**
Hospital no longer wants to support this program. The Hospital should have already informed the SOM Department of termination. This is not necessary if a contract expires by its terms and is not going to be renewed. But if a contract is going to be terminated before it expires by its terms, this exhibit and the coversheet should be completed.

**Party Terminating**: Hospital

**Effective Date of Termination**: 1/1/21

*Attach documentation that termination notice has been provided to the other party. (Email is sufficient)*