

**REPORT  
ON THE  
RATE SETTING AUDIT**

**DELTA REHAB AND CARE CENTER  
LODI, CALIFORNIA  
NATIONAL PROVIDER IDENTIFIER: 1851392500**

**FISCAL PERIOD ENDED  
OCTOBER 31, 2011**

**Audits Section—Sacramento  
Financial Audits Branch  
Audits and Investigations  
Department of Health Care Services**

**Section Chief: Robert G. Kvick  
Audit Supervisor: Gary Diffenderffer  
Auditor: Firas Yaghmour and Lucille Ramos**



TOBY DOUGLAS  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

June 24, 2013

Jim Kline, Controller  
Riverside Health Care  
1469 Humboldt Road, Suite 175  
Chico, CA 95828

DELTA REHAB AND CARE CENTER  
NATIONAL PROVIDER IDENTIFIER (NPI) 1851392500  
FISCAL PERIOD ENDED OCTOBER 31, 2011

We have examined the facility's Integrated Disclosure and Medi-Cal Cost Report for the above-referenced fiscal period. We also examined the facility's use of and Records of Noncovered Services deducted from patient share of cost. Our examination was made under the authority of Section 14170 of the Welfare and Institutions Code and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the data presented in the accompanying Summary of Audited Facility Cost per Patient Day represents a proper determination of the allowable costs, patient days, and use of share of cost for the above fiscal period in accordance with Medi-Cal reimbursement principles.

This audit report includes the:

1. Summary of Audited Facility Cost per Patient Day and supporting schedules
2. Audit adjustments that include a summary of the total due the State in the amount of \$14,147, which resulted from Medi-Cal overpayments

The audit settlement will be incorporated into a Statement of Account Status, which may reflect tentative retroactive adjustment determinations, payments from the provider, and other financial transactions initiated by the Department. The Statement of Account Status will be forwarded to the provider by the State's fiscal intermediary. Instructions regarding payment will be included with the Statement of Account Status.

Future Medi-Cal long-term care prospective rates may be affected by this examination. The extent to which the rates change will be determined by the Department's Fee-For-Service Rates Development Division.

Jim Kline  
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Notwithstanding this audit report, overpayments to the provider are subject to recovery pursuant to Section 51458.1, Article 6 of Division 3, Title 22, California Code of Regulations.

If you disagree with the decision of the Department, you may appeal by writing to:

Chief  
Department of Health Care Services  
Office of Administrative Hearings and Appeals  
1029 J Street, Suite 200  
Sacramento, CA 95814  
(916) 322-5603

The written notice of disagreement must be received by the Department within 60 calendar days from the day you receive this letter. A copy of this notice should be sent to:

**United States Postal Service (USPS)**

Assistant Chief Counsel  
Department of Health Care Services  
Office of Legal Services  
MS 0010  
PO Box 997413  
Sacramento, CA 95899

**Courier (UPS, FedEx, etc.)**

Assistant Chief Counsel  
Department of Health Care Services  
Office of Legal Services  
MS 0010  
1501 Capitol Avenue, Suite 71.5001  
Sacramento, CA 95814  
(916) 440-7700

The procedures that govern an appeal are contained in Welfare and Institutions Code, Section 14171, and California Code of Regulations, Title 22, Section 51016, et seq.

If you have questions regarding this report, you may call the Audits Section—Sacramento at (916) 650-6994.

**Original Signed By**

Robert G. Kvick, Chief  
Audits Section—Sacramento  
Financial Audits Branch

Certified

## SUMMARY OF AUDITED FACILITY COSTS / COST PER PATIENT DAY

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility No.:  
206391887

Line No.	PROGRAM DESCRIPTION	AS REPORTED	AS AUDITED	AUDITED COST PER PATIENT DAY
<b>SKILLED NURSING CARE</b>				
1	Cost of Direct Care - Labor (Sch. 2, Ln. 105)	\$ N/A	\$ 2,132,640	\$ 87.14
2	Cost of Indirect Care - Labor (Sch. 3, Ln. 105)	\$ N/A	\$ 480,393	\$ 19.63
3	Cost of Direct and Indirect Nonlabor - Other (Sch. 4, Ln. 105)	\$ N/A	\$ 511,635	\$ 20.91
4	Cost of Capital Related (Sch. 5, Ln. 105)	\$ N/A	\$ 41,495	\$ 1.70
5	Property Taxes (Sch. 5, Ln. 105)	\$ N/A	\$ 28,310	\$ 1.16
6	CDPH Licensing Fees (Sch. 6, Ln. 105)	\$ N/A	\$ 13,512	\$ 0.55
7	Professional Liability Insurance (Sch. 6, Ln. 105)	\$ N/A	\$ 38,871	\$ 1.59
8	Caregiver Training (Sch. 6, Ln. 105)	\$ N/A	\$ 0	\$ 0.00
9	Quality Assurance Fees (Sch. 6, Ln. 105)	\$ N/A	\$ 241,100	\$ 9.85
10	Cost of Administration (Sch. 6, Ln. 105)	\$ N/A	\$ 363,819	\$ 14.87
11	Cost of Routine Service/Audited Total Costs	\$ 3,897,133.00	\$ 3,851,776	\$ 157.39
12	Total Patient Days (Adj )	24,473	24,473	
13	Cost Per Patient Day (Cost Divided by Days)	\$ 159.24	\$ 157.39	
14	Overpayments (Adj 24,25)		\$ 14,147	
15	Medi-Cal Days (Adj 23)	13,471	12,894	
16	Medi-Cal Managed Care Days (Adj 22)		577	
<b>INTERMEDIATE CARE</b>				
17	Cost of Routine Service (Sch. 2, 3, 4, 5, 6)	\$	\$ 0	
18	Total Patient Days (Adj )		0	
19	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
20	Overpayments (Adj )	\$	\$ 0	
<b>MENTALLY DISORDERED CARE</b>				
21	Cost of Routine Service (Sch. 2, 3, 4, 5, 6)	\$	\$ 0	
22	Total Patient Days (Adj )		0	
23	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
24	Overpayments (Adj )	\$	\$ 0	
<b>DEVELOPMENTALLY DISABLED CARE</b>				
25	Cost of Routine Service (Sch. 2, 3, 4, 5, 6)	\$	\$ 0	
26	Total Patient Days (Adj )		0	
27	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
28	Overpayments (Adj )	\$	\$ 0	
<b>SUBACUTE CARE</b>				
29	Cost of Direct Care - Labor (Subacute Care Sch. 1, Ln. 25)	\$ N/A	\$ 0	\$ 0.00
30	Cost of Indirect Care - Labor (Subacute Care Sch. 1, Ln. 26)	\$ N/A	\$ 0	\$ 0.00
31	Cost of Direct and Indirect Nonlabor - Other (Subacute Care Sch. 1, Ln. 27)	\$ N/A	\$ 0	\$ 0.00
32	Cost of Capital Related (Subacute Care Sch. 1, Ln. 28)	\$ N/A	\$ 0	\$ 0.00
33	Property Taxes (Subacute Care Sch. 1, Ln. 29)	\$ N/A	\$ 0	\$ 0.00
34	CDPH Licensing Fees (Subacute Care Sch. 1, Ln. 30)	\$ N/A	\$ 0	\$ 0.00
35	Professional Liability Insurance (Subacute Care Sch. 1, Ln. 31)	\$ N/A	\$ 0	\$ 0.00
36	Quality Assurance Fees (Subacute Care Sch. 1, Ln. 32)	\$ N/A	\$ 0	\$ 0.00
37	Caregiver Training (Subacute Care Sch. 1, Ln. 33)	\$ N/A	\$ 0	\$ 0.00
38	Cost of Administration (Subacute Care Sch.1, Ln. 34)	\$ N/A	\$ 0	\$ 0.00
39	Total Cost of Subacute Service (Subacute Care Sch. 1, Ln. 35)	\$ 0	\$ 0	\$ 0.00
40	Total Patient Days (Subacute Care Sch. 1, Ln. 36)	0	0	
41	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
42	Amount Due Provider (State) (Subacute Care Sch. 1, Ln. 40)	\$ 0	\$ 0	

## SUMMARY OF AUDITED FACILITY COSTS / COST PER PATIENT DAY

**Provider Name:**  
DELTA REHAB AND CARE CENTER

**Fiscal Period:**  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

**Provider NPI:**  
1851392500

**OSHPD Facility No.:**  
206391887

Line No.	PROGRAM DESCRIPTION	AS REPORTED	AS AUDITED	AUDITED COST PER PATIENT DAY
<b>SUBACUTE CARE - PEDIATRIC</b>				
43	Cost of Routine Service (Subacute Care - Pediatric, Sch. 1, Ln 3)	\$ 0	\$ 0	
44	Cost of Ancillary Service (Subacute Care - Pediatric, Sch. 1, Ln. 1 + Ln. 2)	\$ 0	\$ 0	
45	Total Cost of Subacute Care - Pediatric Service (Ln. 43 + Ln. 44)	\$ 0	\$ 0	
46	Total Patient Days (Subacute Care - Pediatric, Sch. 1, Ln. 5)	0	0	
47	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
48	Amount Due Provider (State) (Subacute Care - Pediatric, Sch. 1, Ln. 9)	\$ 0	\$ 0	
<b>TRANSITIONAL INPATIENT CARE</b>				
49	Cost of Routine Service (Sch. 2, 3, 4, 5, 6)	\$	\$ 0	
50	Total Patient Days (Adj )		0	
51	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
52	Overpayments (Adj )	\$	\$ 0	
<b>HOSPICE INPATIENT CARE</b>				
53	Cost of Routine Service (Sch. 2, 3, 4, 5, 6)	\$	\$ 0	
54	Total Patient Days (Adj )		0	
55	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
56	Overpayments (Adj )	\$	\$ 0	
<b>OTHER ROUTINE SERVICES</b>				
57	Cost of Routine Service (Sch. 2, 3, 4, 5, 6)	\$	\$ 0	
58	Total Patient Days (Adj )		0	
59	Cost Per Patient Day (Cost Divided by Days)	\$ 0.00	\$ 0.00	
60	Overpayments (Adj )	\$	\$ 0	

ALLOCATION OF GENERAL SERVICES  
DIRECT CARE LABOR

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility No.:  
206391887

Line No.	DESCRIPTION	Net Exp For Cost Alloc (From Sch 8)	Soc Srvs	Activities	Total
			155	160	
<b>GENERAL SERVICES</b>					
005	Plant Operations and Maintenance				
010	Housekeeping				
060	Laundry and Linen				
065	Dietary				
155	Social Services	\$ 45,725	\$ 45,725		
160	Activities	60,619		\$ 60,619	
165	Administration				
166	Medical Records				
170	Inservice Education - Nursing				
<b>ANCILLARY SERVICES</b>					
075	Patient Supplies	0	0	0	0
077	Specialized Support Surfaces	N/A	0	0	0
080	Physical Therapy	413,897	0	0	413,897
081	Respiratory Therapy	0	0	0	0
082	Occupational Therapy	309,926	0	0	309,926
083	Speech Pathology	102,680	0	0	102,680
085	Pharmacy	0	0	0	0
090	Laboratory	0	0	0	0
095	Home Health Services	0	0	0	0
100	Other Ancillary Services	0	0	0	0
101	Subacute Care Ancillary Services	0	0	0	0
102	Subacute Care - Pediatric Ancillary Services	0	0	0	0
<b>ROUTINE SERVICES</b>					
105	Skilled Nursing Care	2,026,296	45,725	60,619	2,132,640 *
110	Intermediate Care	0	0	0	0 *
115	Mentally Disordered Care	0	0	0	0 *
120	Developmentally Disabled Care	0	0	0	0 *
125	Subacute Care	0	0	0	0 *
126	Subacute Care - Pediatric	0	0	0	0 *
128	Transitional Inpatient Care	0	0	0	0 *
130	Hospice Inpatient Care	0	0	0	0 *
135	Other Routine Services	0	0	0	0 *
<b>NONREIMBURSABLE</b>					
139	Residential Care	0	0	0	0
140	Beauty and Barber	0	0	0	0
145	Other Nonreimbursable	0	0	0	0
	<b>TOTAL</b>	<b>\$ 2,959,143</b>	<b>\$ 45,725</b>	<b>\$ 60,619</b>	<b>\$ 2,959,143</b>

\* (To Schedule 1)

ALLOCATION OF GENERAL SERVICES  
INDIRECT CARE LABOR

Provider Name:  
DELTA REHAB AND CARE CENTER

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Line No.	DESCRIPTION	Net Exp For Cost Alloc (From Sch 8)	Plant Ops 005	Hskpng 010	Laundry 060	Dietary 065	Soc Srvs 155	Activities 160	Inserv. Ed 170	Accumulated Costs	Admin 165	Medical Records 166	Total
<b>GENERAL SERVICES</b>													
005	Plant Operations and Maintenance	\$ 40,617	\$ 40,617										
010	Housekeeping	117,798	831	\$ 118,629									
060	Laundry and Linen	73,916	682	2,034	\$ 76,633								
065	Dietary	178,832	5,340	15,922	0	\$ 200,094							
155	Social Services	N/A	2,136	6,369	0	0	\$ 8,505						
160	Activities	N/A	0	0	0	0	0	\$ -					
165	Administration	N/A	5,162	15,391	0	0	0	0		\$ 20,553	\$ 20,553		
166	Medical Records	40,636	0	0	0	0	0	0		40,636		\$ 40,636	
170	Inservice Education - Nursing	49,229	0	0	0	0	0	0	\$ 49,229				
<b>ANCILLARY SERVICES</b>													
075	Patient Supplies		0	0	0	0	0	0	0	0	368	729	\$ 1,097
077	Specialized Support Surfaces		0	0	0	0	0	0	0	0	7	14	21
080	Physical Therapy		831	2,477	0	0	0	0	0	3,307	2,043	4,038	9,388
081	Respiratory Therapy		0	0	0	0	0	0	0	0	0	0	0
082	Occupational Therapy		0	0	0	0	0	0	0	0	1,500	2,966	4,466
083	Speech Pathology		0	0	0	0	0	0	0	0	497	983	1,480
085	Pharmacy		0	0	0	0	0	0	0	0	747	1,476	2,223
090	Laboratory		0	0	0	0	0	0	0	0	118	233	350
095	Home Health Services		0	0	0	0	0	0	0	0	0	0	0
100	Other Ancillary Services		0	0	0	0	0	0	0	0	95	189	284
101	Subacute Care Ancillary Services		0	0	0	0	0	0	0	0	0	0	0
102	Subacute Care - Pediatric Ancillary Services		0	0	0	0	0	0	0	0	0	0	0
<b>ROUTINE SERVICES</b>													
105	Skilled Nursing Care		25,339	75,550	76,633	200,094	8,505	0	49,229	435,350	15,130	29,913	480,393 *
110	Intermediate Care		0	0	0	0	0	0	0	0	0	0	0 *
115	Mentally Disordered Care		0	0	0	0	0	0	0	0	0	0	0 *
120	Developmentally Disabled Care		0	0	0	0	0	0	0	0	0	0	0 *
125	Subacute Care		0	0	0	0	0	0	0	0	0	0	0 *
126	Subacute Care - Pediatric		0	0	0	0	0	0	0	0	0	0	0 *
128	Transitional Inpatient Care		0	0	0	0	0	0	0	0	0	0	0 *
130	Hospice Inpatient Care		0	0	0	0	0	0	0	0	0	0	0 *
135	Other Routine Services		0	0	0	0	0	0	0	0	0	0	0 *
<b>NONREIMBURSABLE</b>													
139	Residential Care		0	0	0	0	0	0	0	0	0	0	0
140	Beauty and Barber		297	885	0	0	0	0	0	1,181	49	96	1,326
145	Other Nonreimbursable		0	0	0	0	0	0	0	0	0	0	0
	<b>TOTAL</b>	<b>\$ 501,028</b>	<b>\$ 40,617</b>	<b>\$ 118,629</b>	<b>\$ 76,633</b>	<b>\$ 200,094</b>	<b>\$ 8,505</b>	<b>\$ -</b>	<b>\$ 49,229</b>	<b>\$ 439,839</b>	<b>\$ 20,553</b>	<b>\$ 40,636</b>	<b>\$ 501,028</b>

\* (To Schedule 1)

**ALLOCATION OF GENERAL SERVICES  
OTHER - NONLABOR**

Provider Name:  
DELTA REHAB AND CARE CENTER

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Line No.	DESCRIPTION	Net Exp For Cost Alloc (From Sch 8)	Plant Ops 5	Hskpng 10	Laundry 60	Dietary 65	Soc Svcs 155	Activities 160	Inserv. Ed 170	Accumulated Costs	Admin 165	Medical Records 166	Total
<b>GENERAL SERVICES</b>													
005	Plant Operations and Maintenance	\$ 140,177	\$ 140,177										
010	Housekeeping	15,427	2,867	\$ 18,294									
060	Laundry and Linen	12,633	2,355	314	\$ 15,302								
065	Dietary	180,434	18,430	2,455	0	\$ 201,319							
155	Social Services	7,198	7,372	982	0	0	\$ 15,552						
160	Activities	7,539	0	0	0	0	0	\$ 7,539					
165	Administration	N/A	17,815	2,374	0	0	0	0		\$ 20,189	\$ 20,189		
166	Medical Records	2,040	0	0	0	0	0	0		2,040		\$ 2,040	
170	Inservice Education - Nursing	2,064	0	0	0	0	0	0	\$ 2,064				
<b>ANCILLARY SERVICES</b>													
075	Patient Supplies	76,130	0	0	0	0	0	0	0	76,130	362	37	\$ 76,529
077	Specialized Support Surfaces	1,456	0	0	0	0	0	0	0	1,456	7	1	1,464
080	Physical Therapy	0	2,867	382	0	0	0	0	0	3,249	2,006	203	5,458
081	Respiratory Therapy	0	0	0	0	0	0	0	0	0	0	0	0
082	Occupational Therapy	0	0	0	0	0	0	0	0	0	1,473	149	1,622
083	Speech Pathology	0	0	0	0	0	0	0	0	0	488	49	537
085	Pharmacy	154,256	0	0	0	0	0	0	0	154,256	733	74	155,063
090	Laboratory	24,320	0	0	0	0	0	0	0	24,320	116	12	24,447
095	Home Health Services	0	0	0	0	0	0	0	0	0	0	0	0
100	Other Ancillary Services	19,730	0	0	0	0	0	0	0	19,730	94	9	19,833
101	Subacute Care Ancillary Services	0	0	0	0	0	0	0	0	0	0	0	0
102	Subacute Care - Pediatric Ancillary Services	0	0	0	0	0	0	0	0	0	0	0	0
<b>ROUTINE SERVICES</b>													
105	Skilled Nursing Care	154,398	87,448	11,651	15,302	201,319	15,552	7,539	2,064	495,272	14,861	1,502	511,635 *
110	Intermediate Care		0	0	0	0	0	0	0	0	0	0	0 *
115	Mentally Disordered Care		0	0	0	0	0	0	0	0	0	0	0 *
120	Developmentally Disabled Care		0	0	0	0	0	0	0	0	0	0	0 *
125	Subacute Care	0	0	0	0	0	0	0	0	0	0	0	0 *
126	Subacute Care - Pediatric	0	0	0	0	0	0	0	0	0	0	0	0 *
128	Transitional Inpatient Care		0	0	0	0	0	0	0	0	0	0	0 *
130	Hospice Inpatient Care		0	0	0	0	0	0	0	0	0	0	0 *
135	Other Routine Services		0	0	0	0	0	0	0	0	0	0	0 *
<b>NONREIMBURSABLE</b>													
139	Residential Care	0	0	0	0	0	0	0	0	0	0	0	0
140	Beauty and Barber	7,154	1,024	136	0	0	0	0	0	8,314	48	5	8,367
145	Other Nonreimbursable	0	0	0	0	0	0	0	0	0	0	0	0
	<b>TOTAL</b>	<b>\$ 804,956</b>	<b>\$ 140,177</b>	<b>\$ 18,294</b>	<b>\$ 15,302</b>	<b>\$ 201,319</b>	<b>\$ 15,552</b>	<b>\$ 7,539</b>	<b>\$ 2,064</b>	<b>\$ 782,727</b>	<b>\$ 20,189</b>	<b>\$ 2,040</b>	<b>\$ 804,956</b>

\* (To Schedule 1)

ALLOCATION OF CAPITAL COSTS

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	DESCRIPTION	Net Exp For Cost Alloc (From Sch 8)	Ratio	Capital	Plant Ops	Hskpng	Laundry	Dietary	Soc Srvs	Activities
				Various	5	10	60	65	155	160
<b>GENERAL SERVICES</b>										
	Capital Related (excluding lines 40 & 45)	\$ 44,265	59%							
	Property Tax (line 40)	30,200	41%	\$ 74,465						
005	Plant Operations and Maintenance			2,926	\$ 2,926					
010	Housekeeping			1,463	60	\$ 1,523				
060	Laundry and Linen			1,202	49	26	\$ 1,277			
065	Dietary			9,405	385	204	0	\$ 9,995		
155	Social Services			3,762	154	82	0	0	\$ 3,998	
160	Activities			0	0	0	0	0	0	\$ -
165	Administration			9,092	372	198	0	0	0	0
166	Medical Records			0	0	0	0	0	0	0
170	Inservice Education - Nursing			0	0	0	0	0	0	0
<b>ANCILLARY SERVICES</b>										
075	Patient Supplies			0	0	0	0	0	0	0
077	Specialized Support Surfaces			0	0	0	0	0	0	0
080	Physical Therapy			1,463	60	32	0	0	0	0
081	Respiratory Therapy			0	0	0	0	0	0	0
082	Occupational Therapy			0	0	0	0	0	0	0
083	Speech Pathology			0	0	0	0	0	0	0
085	Pharmacy			0	0	0	0	0	0	0
090	Laboratory			0	0	0	0	0	0	0
095	Home Health Services			0	0	0	0	0	0	0
100	Other Ancillary Services			0	0	0	0	0	0	0
101	Subacute Care Ancillary Services			0	0	0	0	0	0	0
102	Subacute Care - Pediatric Ancillary Services			0	0	0	0	0	0	0
<b>ROUTINE SERVICES</b>										
105	Skilled Nursing Care			44,629	1,825	970	1,277	9,995	3,998	0
110	Intermediate Care			0	0	0	0	0	0	0
115	Mentally Disordered Care			0	0	0	0	0	0	0
120	Developmentally Disabled Care			0	0	0	0	0	0	0
125	Subacute Care			0	0	0	0	0	0	0
126	Subacute Care - Pediatric			0	0	0	0	0	0	0
128	Transitional Inpatient Care			0	0	0	0	0	0	0
130	Hospice Inpatient Care			0	0	0	0	0	0	0
135	Other Routine Services			0	0	0	0	0	0	0
<b>NONREIMBURSABLE</b>										
139	Residential Care			0	0	0	0	0	0	0
140	Beauty and Barber			523	21	11	0	0	0	0
145	Other Nonreimbursable			0	0	0	0	0	0	0
	<b>TOTAL</b>	<b>\$ 74,465</b>	<b>100%</b>	<b>\$ 74,465</b>	<b>\$ 2,926</b>	<b>\$ 1,523</b>	<b>\$ 1,277</b>	<b>\$ 9,995</b>	<b>\$ 3,998</b>	<b>\$ -</b>

\* (To Schedule 1)

## ALLOCATION OF CAPITAL COSTS

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	DESCRIPTION	Net Exp For Cost Alloc (From Sch 8)	Ratio	Inserv. Ed 170	Accumulated Costs	Admin 165	Medical Records 166	Total	Capital Related 59% Of Total	Property Tax 41% Of Total
	<b>GENERAL SERVICES</b>									
	Capital Related (excluding lines 40 & 45)	\$ 44,265	59%							
	Property Tax (line 40)	30,200	41%							
005	Plant Operations and Maintenance									
010	Housekeeping									
060	Laundry and Linen									
065	Dietary									
155	Social Services									
160	Activities									
165	Administration				\$ 9,661	\$ 9,661				
166	Medical Records				0		\$ -			
170	Inservice Education - Nursing			\$ -						
	<b>ANCILLARY SERVICES</b>									
075	Patient Supplies			0	0	173	0	\$ 173	\$ 103	\$ 70
077	Specialized Support Surfaces			0	0	3	0	3	2	1
080	Physical Therapy			0	1,555	960	0	2,515	1,495	1,020
081	Respiratory Therapy			0	0	0	0	0	0	0
082	Occupational Therapy			0	0	705	0	705	419	286
083	Speech Pathology			0	0	234	0	234	139	95
085	Pharmacy			0	0	351	0	351	209	142
090	Laboratory			0	0	55	0	55	33	22
095	Home Health Services			0	0	0	0	0	0	0
100	Other Ancillary Services			0	0	45	0	45	27	18
101	Subacute Care Ancillary Services			0	0	0	0	0	0	0
102	Subacute Care - Pediatric Ancillary Services			0	0	0	0	0	0	0
	<b>ROUTINE SERVICES</b>									
105	Skilled Nursing Care			0	62,694	7,112	0	69,806	41,495	28,310
110	Intermediate Care			0	0	0	0	0	0	0
115	Mentally Disordered Care			0	0	0	0	0	0	0
120	Developmentally Disabled Care			0	0	0	0	0	0	0
125	Subacute Care			0	0	0	0	0	0	0
126	Subacute Care - Pediatric			0	0	0	0	0	0	0
128	Transitional Inpatient Care			0	0	0	0	0	0	0
130	Hospice Inpatient Care			0	0	0	0	0	0	0
135	Other Routine Services			0	0	0	0	0	0	0
	<b>NONREIMBURSABLE</b>									
139	Residential Care			0	0	0	0	0	0	0
140	Beauty and Barber			0	555	23	0	578	344	234
145	Other Nonreimbursable			0	0	0	0	0	0	0
	<b>TOTAL</b>	\$ 74,465	100%	\$ -	\$ 64,804	\$ 9,661	\$ -	\$ 74,465	\$ 44,265	\$ 30,200

\* (To Schedule 1)

ALLOCATION OF ADMINISTRATION AND OTHER DIRECT PASS-THROUGH COSTS

Provider Name:  
DELTA REHAB AND CARE CENTER

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Line No.	DESCRIPTION	Net Exp For Cost Alloc (From Sch 8)	Ratio	Accum Costs (From Sch 2)	Accum Costs (From Sch 3)	Accum Costs (From Sch 4)	Accum Costs (From Sch 5)	Total Accum Costs	Allocated Admin. Costs	Admin. 55% of Total	DPH Licensing Fees 2% of Total	Professional Liability Ins. 6% of Total	Quality Assur. Fees 37% of Total	Caregiver Training 0% of Total
<b>GENERAL SERVICES</b>														
045	Property Insurance	\$ 5,596												
055	Interest - Other	1,322												
165	Administration (Salaries & Wages, Fringe Benefits, Agency Staff and Other - Nonlabor)	487,319												
	Total Costs Allocable as Administration	494,237	55%											
167	CDPH Licensing Fees	18,355	2%											
168	Professional Liability Insurance	52,805	6%											
169	Quality Assurance Fees	327,527	37%											
174	Caregiver Training	0	0%											
	Total	892,924	100%						\$ 892,924					
<b>ANCILLARY SERVICES</b>														
075	Patient Supplies			\$ -	\$ -	\$ 76,130	\$ -	\$ 76,130	16,008	\$ 8,861	\$ 329	\$ 947	\$ 5,872	\$ -
077	Specialized Support Surfaces			0	0	1,456	0	1,456	306	169	6	18	112	0
080	Physical Therapy			413,897	3,307	3,249	1,555	422,008	88,737	49,116	1,824	5,248	32,549	0
081	Respiratory Therapy			0	0	0	0	0	0	0	0	0	0	0
082	Occupational Therapy			309,926	0	0	0	309,926	65,169	36,071	1,340	3,854	23,904	0
083	Speech Pathology			102,680	0	0	0	102,680	21,591	11,951	444	1,277	7,920	0
085	Pharmacy			0	0	154,256	0	154,256	32,436	17,953	667	1,918	11,898	0
090	Laboratory			0	0	24,320	0	24,320	5,114	2,831	105	302	1,876	0
095	Home Health Services			0	0	0	0	0	0	0	0	0	0	0
100	Other Ancillary Services			0	0	19,730	0	19,730	4,149	2,296	85	245	1,522	0
101	Subacute Care Ancillary Services			0	0	0	0	0	0	0	0	0	0	0
102	Subacute Care - Pediatric Ancillary Services			0	0	0	0	0	0	0	0	0	0	0
<b>ROUTINE SERVICES</b>														
105	Skilled Nursing Care			2,132,640	435,350	495,272	62,694	3,125,956	657,302	363,819	13,512	38,871	241,100	0
110	Intermediate Care			0	0	0	0	0	0	0	0	0	0	0
115	Mentally Disordered Care			0	0	0	0	0	0	0	0	0	0	0
120	Developmentally Disabled Care			0	0	0	0	0	0	0	0	0	0	0
125	Subacute Care			0	0	0	0	0	0	0	0	0	0	0
126	Subacute Care - Pediatric			0	0	0	0	0	0	0	0	0	0	0
128	Transitional Inpatient Care			0	0	0	0	0	0	0	0	0	0	0
130	Hospice Inpatient Care			0	0	0	0	0	0	0	0	0	0	0
135	Other Routine Services			0	0	0	0	0	0	0	0	0	0	0
<b>NONREIMBURSABLE</b>														
139	Residential Care			0	0	0	0	0	0	0	0	0	0	0
140	Beauty and Barber			0	1,181	8,314	555	10,051	2,113	1,170	43	125	775	0
145	Other Nonreimbursable			0	0	0	0	0	0	0	0	0	0	0
	<b>SUBTOTAL</b>	\$ 892,924		\$ 2,959,143	\$ 439,839	\$ 782,727	\$ 64,804	\$ 4,246,512	\$ 892,924					
	Total Administrative Costs							\$ 892,924		\$ 494,237	\$ 18,355	\$ 52,805	\$ 327,527	\$ -
	Unit Cost Multiplier							0.2102732						
	Accumulated Administration Costs (Sch 2 thru 5)			\$ 61,189	\$ 22,229	\$ 9,661	\$ 93,080							
	<b>TOTAL FACILITY COSTS</b>							\$ 5,232,516						

\*(To Schedule 1)

## STATISTICS FOR COST ALLOCATION

Provider Name:  
DELTA REHAB AND CARE CENTER

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Line No.	DESCRIPTION	Capital (SQ FT) VARIOUS (Adj )	Plant Ops (SQ FT) 5 (Adj )	Hskpng (SQ FT) 10 (Adj )	Laundry (LBS) 60 (Adj )	Dietary (MEALS) 65 (Adj )	Soc Svcs (DIRECT EXP) 155 (Adj )	Activities (DIRECT EXP) 160 (Adj )	Inserv. Ed (DIRECT EXP) 170 (Adj )	Admin. (TOTAL ACCUM COST)	Med Records (TOTAL ACCUM COST)
	<b>GENERAL SERVICES</b>										
005	Plant Operations and Maintenance	560									
010	Housekeeping	280	280								
060	Laundry and Linen	230	230	230							
065	Dietary	1,800	1,800	1,800							
155	Social Services	720	720	720							
160	Activities										
165	Administration	1,740	1,740	1,740							
166	Medical Records										
170	Inservice Education - Nursing										
	<b>ANCILLARY SERVICES</b>										
075	Patient Supplies									76,130	76,130
077	Specialized Support Surfaces									1,456	1,456
080	Physical Therapy	280	280	280						422,008	422,008
081	Respiratory Therapy									0	0
082	Occupational Therapy									309,926	309,926
083	Speech Pathology									102,680	102,680
085	Pharmacy									154,256	154,256
090	Laboratory									24,320	24,320
095	Home Health Services									0	0
100	Other Ancillary Services									19,730	19,730
101	Subacute Care Ancillary Services									0	0
102	Subacute Care - Pediatric Ancillary Services									0	0
	<b>ROUTINE SERVICES</b>										
105	Skilled Nursing Care	8,541	8,541	8,541	212,532	71,907	2,180,694	2,180,694	2,180,694	3,125,956	3,125,956
110	Intermediate Care						0	0	0	0	0
115	Mentally Disordered Care						0	0	0	0	0
120	Developmentally Disabled Care						0	0	0	0	0
125	Subacute Care						0	0	0	0	0
126	Subacute Care - Pediatric						0	0	0	0	0
128	Transitional Inpatient Care						0	0	0	0	0
130	Hospice Inpatient Care						0	0	0	0	0
135	Other Routine Services						0	0	0	0	0
	<b>NONREIMBURSABLE</b>										
139	Residential Care									0	0
140	Beauty and Barber	100	100	100						10,051	10,051
145	Other Nonreimbursable									0	0
	<b>TOTAL STATISTICS</b>	14,251	13,691	13,411	212,532	71,907	2,180,694	2,180,694	2,180,694	4,246,512	4,246,512
	TOTAL DIRECT SALARIES COSTS - SCH. 2 UNIT COST MULTIPLIER (DIRECT SALARIES)						\$ 45,725 0.020968095	\$ 60,619 0.027798031			
	TOTAL INDIRECT SALARIES COSTS - SCH. 3 UNIT COST MULTIPLIER (INDIRECT SALARIES)		\$ 40,617 2.96669345	\$ 118,629 8.84562480	\$ 76,633 0.36057080	\$ 200,094 2.78268003	\$ 8,505 0.00390008	\$ - 0.00000000	\$ 49,229 0.02257492	\$ 20,553 0.00484007	\$ 40,636 0.00956926
	TOTAL INDIRECT OTHER COSTS - SCH. 4 UNIT COST MULTIPLIER (INDIRECT OTHER)		\$ 140,177 10.23862391	\$ 18,294 1.36409028	\$ 15,302 0.07199680	\$ 201,319 2.79971193	\$ 15,552 0.00713165	\$ 7,539 0.00345716	\$ 2,064 0.00094649	\$ 20,189 0.00475419	\$ 2,040 0.00048039
	TOTAL CAPITAL COSTS - SCH. 5 UNIT COST MULTIPLIER (CAPITAL COSTS)	\$ 74,465 5.22524735	\$ 2,926 0.21372716	\$ 1,523 0.11355700	\$ 1,277 0.00600889	\$ 9,995 0.13899282	\$ 3,998 0.00183328	\$ - 0.00000000	\$ - 0.00000000	\$ 9,661 0.00227514	\$ - 0.00000000

SUMMARY OF AUDITED PROGRAM EXPENSES

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	Natural Class	ACCOUNT TITLE	ACCOUNT NUMBER	AS REPORTED	AUDIT ADJUSTMENTS 8A-1	AS AUDITED	
005		Plant Operations and Maintenance					
005	.01-.19	Salaries and Wages	6200	\$ 32,742	\$ 0	\$ 32,742	(Sch 3)
005	.20-.39	Fringe Benefits	6200	7,875	0	7,875	(Sch 3)
005	.79	Agency Staff	6200		0	0	(Sch 3)
005	.40-.99	Other - Nonlabor	6200	139,516	661	140,177	(Sch 4)
005		Plant Operations and Maintenance - Total	6200	\$ 180,133	\$ 661	\$ 180,794	
010		Housekeeping					
010	.01-.19	Salaries and Wages	6300	\$ 26,128	\$ 0	\$ 26,128	(Sch 3)
010	.20-.39	Fringe Benefits	6300	9,919	0	9,919	(Sch 3)
010	.79	Agency Staff	6300	81,751	0	81,751	(Sch 3)
010	.40-.99	Other - Nonlabor	6300	15,427	0	15,427	(Sch 4)
010		Housekeeping - Total	6300	\$ 133,225	\$ 0	\$ 133,225	
015		Depreciation: Buildings and Improvements	7110 - 7120	\$	\$ 0	\$ 0	(Sch 5)
020		Depreciation: Leasehold Improvements	7130	27,234	0	27,234	(Sch 5)
025		Depreciation: Equipment	7140	7,653	278	7,931	(Sch 5)
030		Depreciation and Amortization - Other	7150 - 7160		0	0	(Sch 5)
035		Leases and Rentals	7200		9,100	9,100	(Sch 5)
040		Property Taxes	7300	30,200	0	30,200	(Sch 5)
045		Property Insurance	7400	5,596	0	5,596	(Sch 6)
050		Interest - Property, Plant, and Equipment	7500		0	0	(Sch 5)
055		Interest - Other	7600	\$	\$ 1,322	\$ 1,322	(Sch 6)
057		<b>Subtotal 005 - 055</b>		\$ 384,041	\$ 11,361	\$ 395,402	
060		Laundry and Linen					
060	.01-.19	Salaries and Wages	6400	\$ 12,122	\$ 0	\$ 12,122	(Sch 3)
060	.20-.39	Fringe Benefits	6400	3,232	0	3,232	(Sch 3)
060	.79	Agency Staff	6400	58,562	0	58,562	(Sch 3)
060	.40-.99	Other - Nonlabor	6400	12,633	0	12,633	(Sch 4)
060		Laundry and Linen - Total	6400	\$ 86,549	\$ 0	\$ 86,549	
065		Dietary					
065	.01-.19	Salaries and Wages	6500	\$ 137,967	\$ 0	\$ 137,967	(Sch 3)
065	.20-.39	Fringe Benefits	6500	30,142	0	30,142	(Sch 3)
065	.79	Agency Staff	6500	10,723	0	10,723	(Sch 3)
065	.40-.99	Other - Nonlabor	6500	180,434	0	180,434	(Sch 4)
065		Dietary - Total	6500	\$ 359,266	\$ 0	\$ 359,266	
070		Provision for Bad Debts	7700	\$	0	\$ 0	
		<b>Ancillary Services</b>					
075		Patient Supplies					
075	.01-.19	Salaries and Wages	8100	\$	\$ 0	\$ 0	(Sch 2)
075	.20-.39	Fringe Benefits	8100		0	0	(Sch 2)
075	.79	Agency Staff	8100		0	0	(Sch 2)
075	.40-.99	Other - Nonlabor	8100	70,882	5,248	76,130	(Sch 4)
075		Patient Supplies - Total	8100	\$ 70,882	\$ 5,248	\$ 76,130	
077		Specialized Support Surfaces					
077	.01-.19	Salaries and Wages	8150	\$	\$ 0	\$ 0	N/A
077	.20-.39	Fringe Benefits	8150		0	0	N/A
077	.79	Agency Staff	8150		0	0	N/A
077	.40-.99	Other - Nonlabor	8150	306	1,150	1,456	(Sch 4)
077		Specialized Support Surfaces - Total	8150	\$ 306	\$ 1,150	\$ 1,456	

SUMMARY OF AUDITED PROGRAM EXPENSES

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	Natural Class	ACCOUNT TITLE	ACCOUNT NUMBER	AS REPORTED	AUDIT ADJUSTMENTS 8A-1	AS AUDITED	
080		Physical Therapy					
080	.01-.19	Salaries and Wages	8200	\$	\$ 0	\$ 0	(Sch 2)
080	.20-.39	Fringe Benefits	8200		0	0	(Sch 2)
080	.79	Agency Staff	8200	413,897	0	413,897	(Sch 2)
080	.40-.99	Other - Nonlabor	8200		0	0	(Sch 4)
080		Physical Therapy - Total	8200	\$ 413,897	\$ 0	\$ 413,897	
081		Respiratory Therapy					
081	.01-.19	Salaries and Wages	8220	\$	\$ 0	\$ 0	(Sch 2)
081	.20-.39	Fringe Benefits	8220		0	0	(Sch 2)
081	.79	Agency Staff	8220		0	0	(Sch 2)
081	.40-.99	Other - Nonlabor	8220		0	0	(Sch 4)
081		Respiratory Therapy - Total	8220	\$ 0	\$ 0	\$ 0	
082		Occupational Therapy					
082	.01-.19	Salaries and Wages	8250	\$	\$ 0	\$ 0	(Sch 2)
082	.20-.39	Fringe Benefits	8250		0	0	(Sch 2)
082	.79	Agency Staff	8250	309,926	0	309,926	(Sch 2)
082	.40-.99	Other - Nonlabor	8250		0	0	(Sch 4)
082		Occupational Therapy - Total	8250	\$ 309,926	\$ 0	\$ 309,926	
083		Speech Pathology					
083	.01-.19	Salaries and Wages	8280	\$	\$ 0	\$ 0	(Sch 2)
083	.20-.39	Fringe Benefits	8280		0	0	(Sch 2)
083	.79	Agency Staff	8280	102,680	0	102,680	(Sch 2)
083	.40-.99	Other - Nonlabor	8280		0	0	(Sch 4)
083		Speech Pathology - Total	8280	\$ 102,680	\$ 0	\$ 102,680	
085		Pharmacy					
085	.01-.19	Salaries and Wages	8300	\$	\$ 0	\$ 0	(Sch 2)
085	.20-.39	Fringe Benefits	8300		0	0	(Sch 2)
085	.79	Agency Staff	8300		0	0	(Sch 2)
085	.40-.99	Other - Nonlabor	8300	154,256	0	154,256	(Sch 4)
085		Pharmacy - Total	8300	\$ 154,256	\$ 0	\$ 154,256	
090		Laboratory					
090	.01-.19	Salaries and Wages	8400	\$	\$ 0	\$ 0	(Sch 2)
090	.20-.39	Fringe Benefits	8400		0	0	(Sch 2)
090	.79	Agency Staff	8400		0	0	(Sch 2)
090	.40-.99	Other - Nonlabor	8400	24,320	0	24,320	(Sch 4)
090		Laboratory - Total	8400	\$ 24,320	\$ 0	\$ 24,320	
095		Home Health Services					
095	.01-.19	Salaries and Wages	8800	\$	\$ 0	\$ 0	(Sch 2)
095	.20-.39	Fringe Benefits	8800		0	0	(Sch 2)
095	.79	Agency Staff	8800		0	0	(Sch 2)
095	.40-.99	Other - Nonlabor	8800		0	0	(Sch 4)
095		Home Health Services - Total	8800	\$ 0	\$ 0	\$ 0	
100		Other Ancillary Services					
100	.01-.19	Salaries and Wages	8900	\$	\$ 0	\$ 0	(Sch 2)
100	.20-.39	Fringe Benefits	8900		0	0	(Sch 2)
100	.79	Agency Staff	8900		0	0	(Sch 2)
100	.40-.99	Other - Nonlabor	8900	19,730	0	19,730	(Sch 4)
100		Other Ancillary Services - Total	8900	\$ 19,730	\$ 0	\$ 19,730	

SUMMARY OF AUDITED PROGRAM EXPENSES

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	Natural Class	ACCOUNT TITLE	ACCOUNT NUMBER	AS REPORTED	AUDIT ADJUSTMENTS 8A-1	AS AUDITED	
101		Subacute Care Ancillary Services					
101	.01-.19	Salaries and Wages	8100-8900	\$	\$ 0	\$ 0	(Sch 2)
101	.20-.39	Fringe Benefits	8100-8900		0	0	(Sch 2)
101	.79	Agency Staff	8100-8900		0	0	(Sch 2)
101	.40-.99	Other - Nonlabor	8100-8900		0	0	(Sch 4)
101		Subacute Care Ancillary Services - Total	8100-8900	\$ 0	\$ 0	\$ 0	
102		Subacute Care - Pediatric Ancillary Services					
102	.01-.19	Salaries and Wages	8100-8900	\$	\$ 0	\$ 0	(Sch 2)
102	.20-.39	Fringe Benefits	8100-8900		0	0	(Sch 2)
102	.79	Agency Staff	8100-8900		0	0	(Sch 2)
102	.40-.99	Other - Nonlabor	8100-8900		0	0	(Sch 4)
102		Subacute Care - Pediatric Ancillary Services - Total	8100-8900	\$ 0	\$ 0	\$ 0	
104		Subtotal 075 - 102		\$ 1,095,997	\$ 6,398	\$ 1,102,395	
		Routine Services					
105		Skilled Nursing Care					
105	.01-.19	Salaries and Wages	6110	\$ 1,644,207	\$ 0	\$ 1,644,207	(Sch 2)
105	.20-.39	Fringe Benefits	6110	381,477	0	381,477	(Sch 2)
105	.49	Agency Staff	6110	612	0	612	(Sch 2)
105	.40-.99	Other - Nonlabor	6110	204,797	(50,399)	154,398	(Sch 4)
105		Skilled Nursing Care - Total	6110	\$ 2,231,093	\$ (50,399)	\$ 2,180,694	
110		Intermediate Care					
110	.01-.19	Salaries and Wages	6120	\$	\$ 0	\$ 0	
110	.20-.39	Fringe Benefits	6120		0	0	
110	.49	Agency Staff	6120		0	0	
110	.40-.99	Other - Nonlabor	6120		0	0	
110		Intermediate Care - Total	6120	\$ 0	\$ 0	\$ 0	(Sch 2)
115		Mentally Disordered Care					
115	.01-.19	Salaries and Wages	6130	\$	\$ 0	\$ 0	
115	.20-.39	Fringe Benefits	6130		0	0	
115	.49	Agency Staff	6130		0	0	
115	.40-.99	Other - Nonlabor	6130		0	0	
115		Mentally Disordered Care - Total	6130	\$ 0	\$ 0	\$ 0	(Sch 2)
120		Developmentally Disabled Care					
120	.01-.19	Salaries and Wages	6140	\$	\$ 0	\$ 0	
120	.20-.39	Fringe Benefits	6140		0	0	
120	.49	Agency Staff	6140		0	0	
120	.40-.99	Other - Nonlabor	6140		0	0	
120		Developmentally Disabled Care - Total	6140	\$ 0	\$ 0	\$ 0	(Sch 2)
125		Subacute Care					
125	.01-.19	Salaries and Wages	6150	\$	\$ 0	\$ 0	(Sch 2)
125	.20-.39	Fringe Benefits	6150		0	0	(Sch 2)
125	.49	Agency Staff	6150		0	0	(Sch 2)
125	.40-.99	Other - Nonlabor	6150		0	0	(Sch 4)
125		Subacute Care - Total	6150	\$ 0	\$ 0	\$ 0	
126		Subacute Care - Pediatric					
126	.01-.19	Salaries and Wages	6160	\$	\$ 0	\$ 0	(Sch 2)
126	.20-.39	Fringe Benefits	6160		0	0	(Sch 2)
126	.49	Agency Staff	6160		0	0	(Sch 2)
126	.40-.99	Other - Nonlabor	6160		0	0	(Sch 4)
126		Subacute Care - Pediatric - Total	6160	\$ 0	\$ 0	\$ 0	

SUMMARY OF AUDITED PROGRAM EXPENSES

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	Natural Class	ACCOUNT TITLE	ACCOUNT NUMBER	AS REPORTED	AUDIT ADJUSTMENTS 8A-1	AS AUDITED
128		Transitional Inpatient Care				
128	.01-.19	Salaries and Wages	6170	\$	\$ 0	\$ 0
128	.20-.39	Fringe Benefits	6170		0	0
128	.49	Agency Staff	6170		0	0
128	.40-.99	Other - Nonlabor	6170		0	0
128		Transitional Inpatient Care - Total	6170	\$ 0	\$ 0	\$ 0 (Sch 2)
130		Hospice Inpatient Care				
130	.01-.19	Salaries and Wages	6180	\$	\$ 0	\$ 0
130	.20-.39	Fringe Benefits	6180		0	0
130	.49	Agency Staff	6180		0	0
130	.40-.99	Other - Nonlabor	6180		0	0
130		Hospice Inpatient Care - Total	6180	\$ 0	\$ 0	\$ 0 (Sch 2)
135		Other Routine Services				
135	.01-.19	Salaries and Wages	6190	\$	\$ 0	\$ 0
135	.20-.39	Fringe Benefits	6190		0	0
135	.49	Agency Staff	6190		0	0
135	.40-.99	Other - Nonlabor	6190		0	0
135		Other Routine Services - Total	6190	\$ 0	\$ 0	\$ 0 (Sch 2)
		<b>Other Nonreimbursable</b>				
139		Residential Care				
139	.01-.19	Salaries and Wages	9100	\$	\$ 0	\$ 0 (Sch 2)
139	.20-.39	Fringe Benefits	9100		0	0 (Sch 2)
139	.49	Agency Staff	9100		0	0 (Sch 2)
139	.40-.99	Other - Nonlabor	9100		0	0 (Sch 4)
139		Residential Care - Total	9100	\$ 0	\$ 0	\$ 0
140		Beauty and Barber				
140	.01-.19	Salaries and Wages	8900	\$	\$ 0	\$ 0 (Sch 2)
140	.20-.39	Fringe Benefits	8900		0	0 (Sch 2)
140	.49	Agency Staff	8900		0	0 (Sch 2)
140	.40-.99	Other - Nonlabor	8900	7,154	0	7,154 (Sch 4)
140		Beauty and Barber - Total	8900	\$ 7,154	\$ 0	\$ 7,154
145		Other Nonreimbursable				
145	.01-.19	Salaries and Wages	9100	\$	\$ 0	\$ 0 (Sch 2)
145	.20-.39	Fringe Benefits	9100		0	0 (Sch 2)
145	.49	Agency Staff	9100		0	0 (Sch 2)
145	.40-.99	Other - Nonlabor	9100		0	0 (Sch 4)
145		Other Nonreimbursable - Total	9100	\$ 0	\$ 0	\$ 0
146		<b>Subtotal 105 - 145</b>		\$ 2,238,247	\$ (50,399)	\$ 2,187,848
155		Social Services				
155	.01-.19	Salaries and Wages	6600	\$ 36,919	\$ 0	\$ 36,919 (Sch 2)
155	.20-.39	Fringe Benefits	6600	8,806	0	8,806 (Sch 2)
155	.49	Agency Staff	6600		0	0 (Sch 2)
155	.40-.99	Other - Nonlabor	6600	7,198	0	7,198 (Sch 4)
155		Social Services - Total	6600	\$ 52,923	\$ 0	\$ 52,923

SUMMARY OF AUDITED PROGRAM EXPENSES

Provider Name:  
DELTA REHAB AND CARE CENTER

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Line No.	Natural Class	ACCOUNT TITLE	ACCOUNT NUMBER	AS REPORTED	AUDIT ADJUSTMENTS 8A-1	AS AUDITED	
160		Activities					
160	.01-.19	Salaries and Wages	6700	\$ 50,027	\$ 0	\$ 50,027	(Sch 2)
160	.20-.39	Fringe Benefits	6700	10,592	0	10,592	(Sch 2)
160	.49	Agency Staff	6700		0	0	(Sch 2)
160	.40-.99	Other - Nonlabor	6700	7,539	0	7,539	(Sch 4)
160		Activities - Total	6700	\$ 68,158	\$ 0	\$ 68,158	
165		Administration					
165	.01-.19	Salaries and Wages	6900	\$ 166,749	\$ 0	\$ 166,749	(Sch 6)
165	.20-.39	Fringe Benefits	6900	56,817	0	56,817	(Sch 6)
165	.49	Agency Staff	6900		0	0	(Sch 6)
165	.40-.99	Other - Nonlabor	6900	250,621	13,132	263,753	(Sch 6)
165		Administration - Total	6900	\$ 474,187	\$ 13,132	\$ 487,319	
166		Medical Records					
166	.01-.19	Salaries and Wages	6900	\$ 30,309	\$ 0	\$ 30,309	(Sch 3)
166	.20-.39	Fringe Benefits	6900	10,327	0	10,327	(Sch 3)
166	.49	Agency Staff	6900		0	0	(Sch 3)
166	.40-.99	Other - Nonlabor	6900	2,040	0	2,040	(Sch 4)
166		Medical Records - Total	6900	\$ 42,676	\$ 0	\$ 42,676	
167		CDPH Licensing Fees	6900	\$ 18,355	\$ 0	\$ 18,355	(Sch 6)
168		Professional Liability Insurance	6900	\$ 54,127	\$ (1,322)	\$ 52,805	(Sch 6)
169		Quality Assurance Fees	6900	\$ 327,527	\$ 0	\$ 327,527	(Sch 6)
170		Inservice Education - Nursing					
170	.01-.19	Salaries and Wages	6800	\$ 36,766	\$ 0	\$ 36,766	(Sch 3)
170	.20-.39	Fringe Benefits	6800	12,463	0	12,463	(Sch 3)
170	.49	Agency Staff	6800		0	0	(Sch 3)
170	.40-.99	Other - Nonlabor	6800	2,064	0	2,064	(Sch 4)
170		Inservice Education - Nursing - Total	6800	\$ 51,293	\$ 0	\$ 51,293	
174		Caregiver Training					
174	.01-.19	Salaries and Wages	6900	\$	\$ 0	\$ 0	(Sch 6)
174	.20-.39	Fringe Benefits	6900		0	0	(Sch 6)
174	.49	Agency Staff	6900		0	0	(Sch 6)
174	.40-.99	Other - Nonlabor	6900		0	0	(Sch 6)
174		Caregiver Training - Total	6900	\$ 0	\$ 0	\$ 0	
		<b>Subtotal 155 - 174</b>		\$ 1,089,246	\$ 11,810	\$ 1,101,056	
200		<b>Total</b>		\$ 5,253,346	\$ (20,830)	\$ 5,232,516	

210	0.24	Total Facility Group Health Insurance *	6900			\$ 40,609	
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\* For informational purposes only, this amount is included in various cost centers above.















Provider Name:  
DELTA REHAB AND CARE CENTER

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Line No.	Sub No.		AUDIT ADJ 9	AUDIT ADJ 10	AUDIT ADJ 11	AUDIT ADJ 12	AUDIT ADJ 13	AUDIT ADJ 14	AUDIT ADJ 15	AUDIT ADJ 16	AUDIT ADJ 17
174	3	Caregiver Training - Agency Staff									
174	4	Caregiver Training - Other - Nonlabor									
200		Total	<u>0</u>	<u>0</u>	<u>278</u>	<u>(1,110)</u>	<u>(1,054)</u>	<u>(405)</u>	<u>(1,893)</u>	<u>(1,974)</u>	<u>(2,500)</u>







Provider Name:  
DELTA REHAB AND CARE CENTER

Provider NPI:  
1851392500

OSHPD Facility Number:  
206391887

Fiscal Period:  
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011

Line No.	Sub No.		AUDIT ADJ 18	AUDIT ADJ 19	AUDIT ADJ 20	AUDIT ADJ 21	AUDIT ADJ				
174	3	Caregiver Training - Agency Staff									
174	4	Caregiver Training - Other - Nonlabor									
200		Total	<u>(1,136)</u>	<u>(99)</u>	<u>(238)</u>	<u>(10,699)</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

Provider Name							Fiscal Period	Provider NPI		Adjustments
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011	1851392500		25
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
Cost Report			Audit Report							
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No				
<u>MEMORANDUM ADJUSTMENT</u>										
A	N/A			8	210	N/A	Total Facility Group Health Insurance To include Group Health Insurance in the audit report for informational purposes only. 42 CFR 413.20 and 413.24 CMS Pub 15-1, Sections 2300 and 2304	\$0	\$40,609	\$40,609

Provider Name							Fiscal Period	Provider NPI		Adjustments	
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011	1851392500		25	
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted	
Cost Report			Audit Report								
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No					
<b><u>RECLASSIFICATIONS OF REPORTED COSTS</u></b>											
1	10.5	005	4	8A-1	005	4	Plant Operations and Maintenance - Other - Nonlabor	\$139,516	\$661	\$140,177	
	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	204,797	(661)	204,136 *	
							To reclassify door alarm expense to the appropriate cost center for proper cost determination. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300, 2302.4, and 2302.8				
2	10.5	035	4	8A-1	035	4	Leases and Rentals	\$0	\$9,100	\$9,100	
	10.5	165	4	8A-1	165	4	Administration - Other - Nonlabor	250,621	(9,100)	241,521 *	
							To reclassify PointClickCare software rental from the using cost centers to the Leases and Rentals cost center. 42 CFR 413.20 and 413.24 / CMS Pub. 15-1, Sections 2300 and 2304 CCR, Title 22, Sections 52000(e) and 52501 OSHPD, LTC Manual, Chapter 3220.3, Section 7200				
3	10.5	055	4	8A-1	055	4	Interest - Other	\$0	\$1,322	\$1,322	
	10.5	168	4	8A-1	168	4	Administration - Professional Liability Insurance	54,127	(1,322)	52,805	
							To reclassify finance fees associated with liability insurance to the appropriate cost center. 42 CFR 413.24 / CMS Pub. 15-1, Section 2162 CCR, Title 22, Sections 52000(b) and 52501				
4	10.5	075	4	8A-1	075	4	Patient Supplies - Other - Nonlabor	\$70,882	\$1,679	\$72,561 *	
	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	* 204,136	(1,679)	202,457 *	
							To reclassify oxygen expenses from Skilled Nursing to an ancillary cost center. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2202.8 and 2203.2 CCR, Title 22, Section 51511(C)				

\*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period	Provider NPI	Adjustments		
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011	1851392500	25		
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted	
Cost Report			Audit Report								
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No					
<b><u>RECLASSIFICATIONS OF REPORTED COSTS</u></b>											
5	10.5	075	4	8A-1	075	4	Patient Supplies - Other - Nonlabor	*	\$72,561	\$2,421	\$74,982 *
	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	*	202,457	(2,421)	200,036 *
							To reclassify pharmaceuticals expense from Skilled Nursing to an ancillary cost center 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2202.8 and 2203.2 CCR, Title 22, Section 51511(C)				
6	10.5	075	4	8A-1	075	4	Patient Supplies - Other - Nonlabor	*	\$74,982	\$1,000	\$75,982 *
	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	*	200,036	(1,000)	199,036 *
							To reclassify Minor Equipment expense from Skilled Nursing to an ancillary cost center. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2202.8 and 2203.2 CCR, Title 22, Section 51511(C)				
7	10.5	075	4	8A-1	075	4	Patient Supplies - Other - Nonlabor	*	\$75,982	\$148	\$76,130
	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	*	199,036	(148)	198,888 *
							To reclassify oxygen expenses from Skilled Nursing to an ancillary cost center. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2202.8 and 2203.2 CCR, Title 22, Section 51511(C)				
8	10.5	077	4	8A-1	077	4	Specialized Support Surfaces		\$306	\$1,150	\$1,456
	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	*	198,888	(1,150)	197,738 *
							To reclassify bed rental expenses from Skilled Nursing to an ancillary cost center. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2202.8 and 2203.2				

\*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period	Provider NPI		Adjustments	
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011	1851392500		25	
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted	
Cost Report			Audit Report								
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No					
<b><u>RECLASSIFICATIONS OF REPORTED COSTS</u></b>											
9	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	*	\$197,738	(\$4,200)	\$193,538 *
	10.5	165	4	8A-1	165	4	Administration - Other - Nonlabor	*	241,521	4,200	245,721 *
							To reclassify Medliance LLC consulting costs to the appropriate cost center for proper cost determination. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300, 2302.4, and 2302.8 OSHPD, LTC Manual, Chapter 3220.2, Section 6900				
10	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor	*	\$193,538	(\$30,204)	\$163,334 *
	10.5	165	4	8A-1	165	4	Administration - Other - Nonlabor	*	245,721	30,204	275,925 *
							To reclassify post monthly home office costs to the appropriate cost center for proper cost determination. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300, 2302.4, and 2302.8 OSHPD, LTC Manual, Chapter 3220.2, Section 6900				

\*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period		Provider NPI		Adjustments
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011		1851392500		25
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted	
Cost Report			Audit Report								
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No					
<b><u>ADJUSTMENTS TO REPORTED COSTS</u></b>											
11	10.5	025	4	8A-1	025	4	Depreciation - Equipment To include COMS Interactive depreciation expense in conjunction with adjustment 17. 42 CFR 413.20 and 413.134 CMS Pub. 15-1, Sections 104.8, 108.1, 108.2 and 2300	\$7,653	\$278	\$7,931	
12	10.5	105	4	8A-1	105	4	Skilled Nursing Care - Other - Nonlabor  To eliminate flowers expense not related to patient care. 42 CFR 413.9(c)(3) / CMS Pub. 15-1, Sections 2102.3 and 2105	* \$163,334	(\$1,110)		
13							To eliminate memory boxes expense not related to patient care. 42 CFR 413.9(c)(3) / CMS Pub. 15-1, Sections 2102.3 and 2105		(1,054)		
14							To eliminate minor equipment expense due to lack of documentation. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 W&I Code 14124.2(b)		(405)		
15							To eliminate equipment rental expenses due to lack of documentation. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 W&I Code 14124.2(b)		(1,893)		
16							To eliminate patient television cost. 42 CFR 413.9(c)(3), 413.24, and 413.50 CMS Pub. 15-1, Sections 2106.1 and 2304		(1,974)		
17							To eliminate COMS Interactive expense for asset that should have been capitalized, in conjunction with adjustment 11. 42 CFR 413.20 and 413.134 CMS Pub. 15-1, Sections 104.8, 108.1, 108.2 and 2300		<u>(2,500)</u> (\$8,936)	\$154,398	

\*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period		Provider NPI		Adjustments
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011		1851392500		25
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted	
Cost Report			Audit Report								
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No					
<b><u>ADJUSTMENTS TO REPORTED COSTS</u></b>											
18	10.5	165	4	8A-1	165	4	Administration - Other - Nonlabor	*	\$275,925		
							To eliminate travel expenses due to lack of documentation. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 W&I Code 14124.2(b)			(\$1,136)	
19							To eliminate dues and subscriptions expenses due to lack of documentation. 42 CFR 413.20 and 413.24 CMS Pub. 15-1, Sections 2300 and 2304 W&I Code 14124.2(b)			(99)	
20							To eliminate newspaper subscription expense not related to patient care. 42 CFR 413.9(c)(3) / CMS Pub. 15-1, Sections 2102.3 and 2105			(238)	
21							To adjust reported home office costs to agree with the Riverside Health Care Home Office Audit Report for fiscal period ended June 30, 2011. 42 CFR 413.17 and 413.24 / CMS Pub. 15-1, Sections 2150.2 and 2304			(10,699) (\$12,172)	\$263,753

\*Balance carried forward from prior/to subsequent adjustments

Provider Name							Fiscal Period			Provider NPI		Adjustments
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011			1851392500		25
Report References							Explanation of Audit Adjustments			As Reported	Increase (Decrease)	As Adjusted
Cost Report				Audit Report								
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No						
<u>ADJUSTMENT TO REPORTED PATIENT DAYS</u>												
22	Not Reported			1	16	N/A	Medi-Cal Managed Care Days To include Medi-Cal Managed Care days as agreed upon by provider. 42 CFR 413.20 and 413.50 CMS Pub. 15-1, Sections 2205 and 2304			0	577	577

Provider Name							Fiscal Period	Provider NPI		Adjustments
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011	1851392500		25
Report References							Explanation of Audit Adjustments	As Reported	Increase (Decrease)	As Adjusted
Cost Report			Audit Report							
Adj. No.	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No				
<b><u>ADJUSTMENT TO REPORTED MEDI-CAL SETTLEMENT DATA</u></b>										
23	4.1	5	2	1	15	N/A	Medi-Cal Patient Days To adjust reported Medi-Cal Nursing Facility days based on the following Fiscal Intermediary Payment Data: Service Period: November 1, 2010 through October 31, 2011 Payment Period: November 1, 2010 through November 19, 2012 Report Date: November 20, 2012 42 CFR 413.20, 413.24, 413.50, 413.53, 413.60, 413.64, and 433.139 CMS Pub. 15-1, Sections 2300, 2304, 2404, and 2408 CCR, Title 22, Section 51541	13,471	(577)	12,894

Provider Name							Fiscal Period			Provider NPI		Adjustments		
DELTA REHAB AND CARE CENTER							NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2011			1851392500		25		
Report References							Explanation of Audit Adjustments					As Reported	Increase (Decrease)	As Adjusted
Adj. No.	Cost Report			Audit Report										
	MC530 Page or Exhibit	Line	Col.	Sch.	Line	Sub No								
<b><u>ADJUSTMENTS TO OTHER MATTERS</u></b>														
24	Not Reported			1	14	N/A	Overpayments					\$0		
							To recover outstanding Medi-Cal credit balances.						\$5,264	
							42 CFR 413.20 and 413.24							
							CMS Pub. 15-1, Sections 2300 and 2304							
							CCR, Title 22, Sections 50761 and 51458.1							
25							To recover Medi-Cal overpayments because the Share of Cost was not properly deducted from the amount billed.						8,883	
							42 CFR 413.5 and 413.20						\$14,147	\$14,147
							CMS Pub. 15-1, Sections 2300 and 2409							
							CCR, Title 22, Sections 50786 and 51458.1							