1. INCORRECT REDUCTION CLAIM TITLE

Firefighter's Cancer Presumption Program

2. CLAIMANT INFORMATION

City of Los Angeles
Name of Local Agency or School District

Sola Oniyide
Claimant Contact

Management Analyst II
Title

700 East Temple Street, Room 210
Street Address

Los Angeles, California, 90012
City, State, Zip

213-473-3341
Telephone Number

213-473-3333
Fax Number

Sola.Oniyide@lacity.org
E-Mail Address

3. CLAIMANT REPRESENTATIVE INFORMATION

Claimant designates the following person to act as its sole representative in this incorrect reduction claim. All correspondence and communications regarding this claim shall be forwarded to this representative. Any change in representation must be authorized by the claimant in writing, and sent to the Commission on State Mandates.

Steven Presberg
Claimant Representative Name

Senior Personnel Analyst II
Title

City of Los Angeles, Personnel Department
Organization

700 East Temple Street, Room 210
Street Address

Los Angeles, California, 90012
City, State, Zip

213-473-9123
Telephone Number

213-473-3333
Fax Number

Steve.Presberg@lacity.org
E-Mail Address

For CSM Use Only

Filing Date

RECEIVED
JAN 2 6 2010
COMMISSION ON STATE MANDATES

IRC #: 09-4081-I-01

4. IDENTIFICATION OF STATUTES OR EXECUTIVE ORDERS

Please specify the subject statute or executive order that claimaint alleges is not being fully reimbursed pursuant to the adopted parameters and guidelines.

Firefighter's Cancer Presumption Program

Chapter 1568, Status of 1982

5. AMOUNT OF INCORRECT REDUCTION

Please specify the fiscal year and amount of reduction. More than one fiscal year may be claimed.

Fiscal Year	Amount of Reduction
2003-04	$516,132.00
TOTAL:	

6. NOTICE OF INTENT TO CONSOLIDATE

Please check the box below if there is intent to consolidate this claim.

☐ **Yes, this claim is being filed with the intent to consolidate on behalf of other claimants.**

Sections 7 through 11 are attached as follows:

7. Written Detailed Narrative: pages 1 to 2.

8. Documentary Evidence and Declarations: Exhibit N/A.

9. Claiming Instructions: Exhibit A.

10. Final State Audit Report or Other Written Notice of Adjustment: Exhibit B.

11. Reimbursement Claims: Exhibit C.

12. CLAIM CERTIFICATION

*Read, sign, and date this section and insert at the end of the incorrect reduction claim submission.**

This claim alleges an incorrect reduction of a reimbursement claim filed with the State Controller's Office pursuant to Government Code section 17561. This incorrect reduction claim is filed pursuant to Government Code section 17551, subdivision (d). I hereby declare, under penalty of perjury under the laws of the State of California, that the information in this incorrect reduction claim submission is true and complete to the best of my own knowledge or information or belief.

City of Los Angeles	Management Analyst II
Print or Type Name of Authorized Local Agency or School District Official	Print or Type Title
[signature]	1/8/2010
Signature of Authorized Local Agency or School District Official	Date

** If the declarant for this Claim Certification is different from the Claimant contact identified in section 2 of the incorrect reduction claim form, please provide the declarant's address, telephone number, fax number, and e-mail address below.*

WRITTEN DETAILED NARRATIVE

RE: Firefighter's Cancer Presumption Program (July 1, 2003 through June 30, 2007)

Having reviewed the audit report on the above referenced program, we take the strongest possible exception to, and appeal the determination of the State Controller's office to disallow $516,132 in what is characterized as "unclaimed costs" on the FY 2003-04 claims year.

An arithmetic discrepancy was found by Audit Manager, Mr. Steve W. Van Zee, and was brought to the attention of this Department's analyst, Mr. Sola Oniyide. We assert that the characterization of this amount as "unclaimed" is completely erroneous and inaccurate.

On Schedule 1 – Summary of Program Costs – July 1, 2003 through June 30, 2007, under the period July 1, 2003 through June 30, 2004, your schedule indicates $985,119 in "Disability benefit costs." A simple recap, or calculator summary of the line-by-line entries on your Form FCP-2 demonstrates, as the auditor found, that this amount is $516,132 less than it should be.

Government Code Section 17561 indicates that these reimbursements are mandatory, unless, as per subsection (d)(1)(C)(ii), "... the Controller determines (that a claim) is excessive or unreasonable." No such determination has been made. In fact, the State audit simply characterizes this amount ($516,132) as "unclaimed." This is clearly inaccurate, as the itemized claims were in fact submitted. "Disallowing" this amount on any basis other than a determination that they were either excessive or unreasonable is not a ground supported by the Government Code.

State audit's reference by footnote to the filing deadline having expired for FY 2003-04 is similarly erroneous. There is no factual dispute that these claims, each and every itemized individual claim, were timely submitted. I note that Government Code Section 17561, subsection (d)(2)(C) states, "The Controller shall adjust the payment to correct for any underpayments or overpayments that occurred in previous fiscal years." There is no time limit attached to this provision, and I am certain that any overpayment, regardless of date, would be the subject of a subsequent offset or recovery by the Controller's office. Under the terms of the statute, the amount "disallowed" should have been recalculated and included in the amount claimed.

It is in the interest of carrying out the substantive intent of the statute and program, the dictates of the legislature and expectations of reimbursement on behalf of all of the residents of the City of Los Angeles, and basic fairness, that I strongly urge your reconsideration of this matter.

FIREFIGHTERS CANCER PRESUMPTION

1. Summary of Chapter 1568, Statutes of 1982

On February 23, 1984 the Board of Control (successor agency is the Commission On State Mandates) determined that fire departments will incur "costs mandated by the state" as a result of Chapter 1568 of the Statutes of 1982, which added Section 3212.1 to the Labor Code and that such costs are reimbursable pursuant to Government Code Section 17561. This section states that cancer that has developed or manifested itself in peace officers will be presumed to have arisen out of and in the course of employment, unless the presumption is controverted by other evidence. The presumption is extended to a peace officer following termination of service for a period of three calendar months for each year of requisite service, but not to exceed sixty (60) months in any circumstance, commencing with the last date actually worked in the specified capacity.

2. Eligible Claimants

Any fire department of a city, a county, a city and county, a local fire prevention district, a public municipal corporation or political subdivision of the state which employs firefighters and incurs increased costs as a result of this mandate is eligible to claim reimbursement of those costs.

3. Appropriations

Claims may only be filed with the State Controller's Office for programs that have been funded in the State Budget or in Special Legislation. To determine if current funding is available for this program, refer to the "Appropriation for State mandated Cost Programs" schedule presented in the "Annual Claiming Instructions for State Mandated Costs" issued in mid-September of each year to city fiscal officers, county auditors and administrators of special districts.

4. Type of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement claim and/or an estimated claim. a reimbursement claim details the costs actually incurred for the previous fiscal year. An estimated claim show the costs to be incurred for the current fiscal year.

A claim for reimbursement or an estimate must exceed $200 per fiscal year. However, any county, as fiscal agent for the special district, may submit a combined claim in excess of $200 on behalf of one or more districts within the county even if the individual district's claim does not exceed $200. A combined claim must show the individual claim costs for each district. Once a combined claim is field, all subsequent fiscal years relating to the same mandate must be filed in a combined form. The county receives the reimbursement payment and is responsible for disbursing funds to each participating district. A district may withdraw from the combined claim form by providing a written notice to the county and the State Controller's Office, at least 180 days prior to the deadline for filing the claim, of its intent to file a separate claim.

B. Filing Deadline

Refer to item 3 "Appropriations" to determine if the program is funded for the current fiscal year. If funding is available, an estimated claim may be filed.

(1) Refer to item 3 "Appropriations" to determine if the program is funded for the current fiscal year. If funding is available, an estimated claim may be filed.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by November 30 following the fiscal year in which costs were incurred. If the claim is filed after the deadline, but by November 30 of the succeeding fiscal year, the approved claim will be reduced by a late penalty of 10% but not to exceed $1,000. If the claim is filed more than one year after the deadline, the claim cannot be accepted.

If a local agency received payment for an estimated claim, a reimbursement claim must be filed by November 30 regardless if the amount received was more or less than the actual costs. If the agency fails to file a reimbursement claim, monies received must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim by November 30 detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. See item 3 above.

5. Reimbursement

Eligible claimants will be reimbursed at fifty percent (50%) of costs incurred as defined as follows:

A. All the following conditions must be met in order to claim reimbursement for a presumption of cancer case under Chapter 1171/89.

(1) The worker is a fire fighter within the meaning of Penal code Section 830.1 who was primarily engaged in active law enforcement activities;

(2) The worker has cancer which has caused the disability;

(3) The worker's cancer developed or manifested itself during a period while the worker was in the service of the employer, or within the extended period provided for in Labor Code Section 3212.1;

(4) The worker was exposed, while in the service of the employer, to one or more known carcinogens as defined by the International Agency for Research on Cancer, or the Director of the Department of Industrial Relations; and

(5) The one or more carcinogens to which the worker was exposed are reasonable linked to the disabling cancer, as demonstrated by competent medical evidence.

B. A case meeting all the conditions in 5.A., the local agency will be reimbursed at 50% of the increased costs incurred. More specifically, insured local agencies, local agencies covered by a joint powers agreement, or self-insured local agencies must claim costs as follows:

(1) Insured Local Agencies

If an insured local agency (insured through State Compensation Insurance Fund) incurred any increased costs as a result of Chapter 1586/82, they would be entitled to seek reimbursement for such costs which are specifically attributable to Labor Code Section 3212.1.

If the local entity can show that its experience modification premium was increased or its dividends were decreased, 50% of those respective increases or decreases will be reimbursed.

(2) Local Agencies Covered by a Joint Powers Agreement or Other Carrier

Local agencies covered by a joint powers agreement or other insurance carrier for workers' compensation may claim in the same manner as above for insured local agencies provided;

(a) Insurance premiums or contributions are based on the Workers' Compensation Insurance Rating Bureau rates and the current loss experience modification factor, and

(b) The insurer is responsible for claims of terminated or withdrawn local agencies if such claims arose while insured by the insurer.

(3) Self-Insured Local Agencies

Fifty percent (50%) of all actual costs of a claim based on the presumption set forth in Labor Code Section 3212.1 are reimbursable, including but not limited to the following:

(a) Administrative Costs

--Salaries and employee benefits
--Costs of supplies
--Legal counsel costs
--Clerical support
--Travel expenses
--Amounts paid to adjusting agencies
--Overhead costs

(b) Benefit Costs

Actual benefit costs under this presumption shall be 50% reimbursable and shall include, but are not limited to:

--Permanent disability benefits
--Death benefits
--Temporary disability benefits or full salary in lieu of temporary disability benefits as required by Labor Code Section 4850, or other local charter provision or ordinance in existence on January 1, 1983. Provided, however, that salary in lieu of temporary disability benefits were payable under local charter provision or ordinance shall be reimbursable only to the extent that those benefits do not exceed the benefits required by Labor Code Section 4850.

6. Reimbursement Limitations

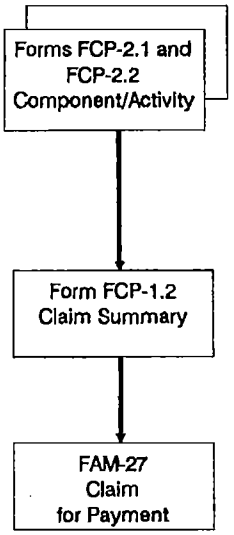
Any offsetting savings the claimants experience as a direct result of this statute must be deducted from the cost claimed. Such offsetting savings shall include, but not be limited to, savings in the cost of personnel, service or supplies, or increased revenues obtained by the claimant. In addition, reimbursements received from any source (e.g., federal, state, etc.) for this mandate shall be identified and deducted from the claim.

7. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for Forms FCP-1.1 or FCP-1.2, FCP-2.1 and FCP-2.2, provided the format of the report and data fields contained with the report are identical to the claim forms included in these instructions. The claim forms provided in this chapter should be duplicated and used by the

Illustration of Claim Forms

Self Insured Method

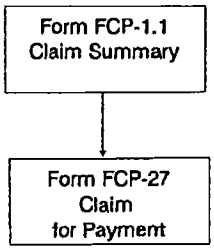


Forms FCP-2 .1 and FCP-2.2 Component/Activity Cost Detail
This form is to be used with Self Insured Method ONLY.

A. Disability Benefit Costs

B. Administrative Costs.

Insured Method



Form FCP-1.1, Claim Summary,
This form is to be used with Insured Method ONLY.

claimant to file an estimated or reimbursement claim. The State Controller's Office will revise the manual and claim forms as necessary.

A. Form FAM -27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the local agency. All applicable information from form FCP-1.1 or FCP-1.2 must be brought forward to this form in order for the State Controller's Office to process the claim for payment.

B. Form FCP-1.1, Claim Summary

An insured agency must complete this form that shows the increased premium cost and/or decreased dividend cost. In addition, provide the name of each injured peace officer, termination date of service, length of service (years and months), and date of injury. Only fifty percent (50%) of the increased costs derived from this form is carried to form FAM-27, line (13) for the Reimbursement Claim, or line (07) for the Estimated Claim.

C. Form FCP-1.2, Claim Summary

A self-insured agency must complete this form that summarizes the increased disability and administrative costs incurred as a result of the mandate. Allowable indirect costs for administrative costs are computed on this form. In addition, provide the name of each injured fire fighter, termination date of service, length of service (years and months), and date of injury. The direct costs summarized on this form are carried forward to forms FCP-2.1 and FCP-2.2. Only fifty percent (50%) of the increased costs derived from this form is carried forward to form FAM-27, line (13) for the Reimbursement Claim, or line (07) for the Estimated Claim.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have their own ICRP.

D. Form FCP-2.1, Component/Activity Cost Detail

A self-insured agency must complete this form that shows the amount of disability benefit payments made to peace officers as required by Labor Code Section 4850, or other charter provision or ordinance in existence on January 1, 1983.

E. Form FCP-2.2, Component/Activity Cost Detail

A self-insured agency must complete this form to claim increased administrative costs as a result of the mandate. Costs reported on this form must be detailed as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed by each employee and specify the actual time spent, the productive hourly rate, and related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on this mandate.

(2) Office Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders and other documents evidencing the validity of the expenditures.

(3) Contracted Services

Give the name(s) of the contractor(s) who performed the services. Describe the activities performed by each named contractor, actual time spent on this mandate, inclusive dates when services were performed, and itemize all costs for services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

(4) Travel

Travel expenses for mileage, per diem, lodging and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Give the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points and costs.

Source documents required to be maintained by the claimant may include, but are not limited to, receipts, employee travel expense claims, and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

CITY OF LOS ANGELES

Audit Report

FIREFIGHTER'S CANCER PRESUMPTION PROGRAM

Chapter 1568, Statutes of 1982

July 1, 2003, through June 30, 2007

JOHN CHIANG
California State Controller

September 2009

JOHN CHIANG
California State Controller

September 4, 2009

The Honorable Antonio R. Villaraigosa, Mayor
City of Los Angeles
200 N. Spring Street
Los Angeles, CA 90012

Dear Mayor Villaraigosa:

The State Controller's Office audited the costs claimed by the City of Los Angeles for the legislatively mandated Firefighter's Cancer Presumption Program (Chapter 1568, Statutes of 1982) for the period of July 1, 2003, through June 30, 2007.

The city claimed $3,492,879 for the mandated program. Our audit disclosed that $3,345,460 is allowable and $147,419 is unallowable. The costs are unallowable because the city claimed non-mandate-related, unsupported, and duplicate costs. The State paid the city $2,990,966. Allowable costs claimed exceed the amount paid by $354,494.

If you disagree with the audit finding, you may file an Incorrect Reduction Claim (IRC) with the Commission on State Mandates (CSM). The IRC must be filed within three years following the date that we notify you of a claim reduction. You may obtain IRC information at the CSM's Web site at www.csm.ca.gov/docs/IRCForm.pdf.

If you have any questions, please contact Jim L. Spano, Chief, Mandated Cost Audits Bureau, at (916) 323-5849.

Sincerely,

JEFFREY V. BROWNFIELD
Chief, Division of Audits

JVB/vb

cc: The Honorable Wendy Greuel, Controller
City of Los Angeles
Miguel A. Santana, City Administrative Officer
City of Los Angeles
Margaret M. Whelan, General Manager
Personnel Department
City of Los Angeles
David Noltemeyer, Chief
Workers' Compensation Division
City of Los Angeles
Todd Jerue, Program Budget Manager
Corrections and General Government
Department of Finance

Contents

Audit Report

Summary

The State Controller's Office (SCO) audited the costs claimed by the City of Los Angeles for the legislatively mandated Firefighter's Cancer Presumption Program (Chapter 1568, Statutes of 1982) for the period of July 1, 2003, through June 30, 2007.

The city claimed $3,492,879 for the mandated program. Our audit disclosed that $3,345,460 is allowable and $147,419 is unallowable. The costs are unallowable because the city claimed non-mandate-related, unsupported, and duplicate costs. The State paid the city $2,990,966. Allowable costs claimed exceed the amount paid by $354,494.

Background

Labor Code section 3212.1 (added and amended by Chapter 1568, Statutes of 1982) states that cancer that has developed or manifested itself in firefighters will be presumed to have arisen out of and in the course of employment, unless the presumption is controverted by other evidence. The presumption is extended to a firefighter following termination of service for a period of three calendar months for each year of requisite service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

On February 23, 1984, the Board of Control, (now the Commission on State Mandates [CSM]) determined that Chapter 1568, Statutes of 1982, imposed a reimbursable mandate under Government Code section 17561.

The program's parameters and guidelines establish the state mandate and define reimbursement criteria. CSM adopted the parameters and guidelines on October 24, 1985, and last amended it on March 26, 1987. In compliance with Government Code section 17558, the SCO issues claiming instructions to assist local agencies and school districts in claiming mandated program reimbursable costs.

Objective, Scope, and Methodology

We conducted the audit to determine whether costs claimed represent increased costs resulting from the Firefighter's Cancer Presumption Program for the period of July 1, 2003, through June 30, 2007.

Our audit scope included, but was not limited to, determining whether costs claimed were supported by appropriate source documents, were not funded by another source, and were not unreasonable and/or excessive.

We conducted this performance audit under the authority of Government Code sections 12410, 17558.5, and 17561. We did not audit the city's financial statements. We conducted the audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We limited our review of the city's internal controls to gaining an understanding of the transaction flow and claim preparation process as necessary to develop appropriate auditing procedures.

Conclusion

Our audit disclosed instances of noncompliance with the requirements outlined above. These instances are described in the accompanying Summary of Program Costs (Schedule 1) and in the Finding and Recommendation section of this report.

For the audit period, the City of Los Angeles claimed $3,492,879 for costs of the Firefighter's Cancer Presumption Program. Our audit disclosed that $3,345,460 is allowable and $147,419 is unallowable.

For the fiscal year (FY) 2003-04 claim, the State made no payment to the city. Our audit disclosed that $501,913 is allowable. The State will pay that amount, contingent upon available appropriations.

For the FY 2004-05 and FY 2005-06 claims, the State paid the city $1,550,989. Our audit disclosed that the entire amount is allowable.

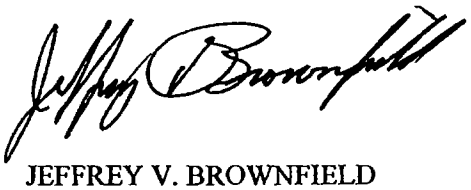
For the FY 2006-07 claim, the State paid the city $1,439,977. Our audit disclosed that $1,292,558 is allowable. The State will offset $147,419 from other mandated program payments due to the city. Alternatively, the city may remit this amount to the State.

Views of Responsible Official

We issued a draft audit report on July 17, 2009. Margaret Whelan, General Manager, Personnel Department, responded by letter dated August 6, 2009 (Attachment), disagreeing with the audit results. This final audit report includes the city's response.

Restricted Use

This report is solely for the information and use of the City of Los Angeles, the California Department of Finance, and the SCO; it is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit distribution of this report, which is a matter of public record.



JEFFREY V. BROWNFIELD
Chief, Division of Audits

September 4, 2009

Schedule 1—
Summary of Program Costs
July 1, 2003, through June 30, 2007

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment [1]
July 1, 2003, through June 30, 2004			
Administrative costs	$ 18,683	$ 18,683	$ —
Disability benefit costs	985,119	1,443,198	458,079
Mathematical error	25	—	(25)
Subtotal	1,003,827	1,461,881	458,054
Less allowable costs that exceed costs claimed [2]	—	(458,054)	(458,054)
Total direct costs	1,003,827	1,003,827	—
Reimbursable percentage	× 50%	× 50%	× 50%
Total program costs [3]	$ 501,913	501,913	$ —
Less amount paid by the State		—	
Allowable costs claimed in excess of (less than) amount paid		$ 501,913	
July 1, 2004, through June 30, 2005			
Administrative costs	$ 10,437	$ 10,437	$ —
Disability benefit costs	1,195,993	1,502,173	306,180
Subtotal	1,206,430	1,512,610	306,180
Less allowable costs that exceed costs claimed [2]	—	(306,180)	(306,180)
Total direct costs	1,206,430	1,206,430	—
Reimbursable percentage	× 50%	× 50%	× 50%
Total program costs [3]	$ 603,215	603,215	$ —
Less amount paid by the State		(603,215)	
Allowable costs claimed in excess of (less than) amount paid		$ —	
July 1, 2005, through June 30, 2006			
Administrative costs	$ 20,748	$ 20,748	$ —
Disability benefit costs	1,874,799	1,886,807	12,008
Subtotal	1,895,547	1,907,555	12,008
Less allowable costs that exceed costs claimed [2]	—	(12,008)	(12,008)
Total direct costs	1,895,547	1,895,547	—
Reimbursable percentage	× 50%	× 50%	× 50%
Total program costs [3]	$ 947,774	947,774	$ —
Less amount paid by the State		(947,774)	
Allowable costs claimed in excess of (less than) amount paid		$ —	

Schedule 1 (continued)

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment [1]
July 1, 2006, through June 30, 2007			
Administrative costs	$ 120,260	$ 120,260	$ —
Disability benefit costs	2,759,693	2,464,856	(294,837)
Total direct costs	2,879,953	2,585,116	(294,837)
Reimbursable percentage	× 50%	× 50%	× 50%
Total program costs [3]	$ 1,439,977	1,292,558	$ (147,419)
Less amount paid by the State		(1,439,977)	
Allowable costs claimed in excess of (less than) amount paid		$ (147,419)	
Summary: July 1, 2003, through June 30, 2007			
Administrative costs	$ 170,128	$ 170,128	$ —
Disability benefit costs	6,815,604	7,297,034	481,430
Mathematical error	25	—	(25)
Subtotal	6,985,757	7,467,162	481,405
Less allowable costs that exceed costs claimed [2]	—	(776,242)	(776,242)
Total direct costs	6,985,757	6,690,920	(294,837)
Reimbursable percentage	× 50%	× 50%	× 50%
Total program costs [3]	$ 3,492,879	3,345,460	$ (147,419)
Less amount paid by the State		(2,990,966)	
Allowable costs claimed in excess of (less than) amount paid		$ 354,494	

[1] See the Finding and Recommendation section.

[2] Government Code section 17561 stipulates that the State will not reimburse any claim more than one year after the filing deadline specified in the SCO's claiming instructions. That deadline has expired for FY 2003-04, FY 2004-05, and FY 2005-06.

[3] Calculation differences due to rounding.

Finding and Recommendation

FINDING— Unallowable and unclaimed disability benefits costs

The city claimed unallowable costs totaling $529,707. The city did not claim additional mandate-related costs totaling $1,011,137. For the audit period, the city understated allowable costs by $481,430.

Unallowable costs

The city claimed non-mandate-related, unsupported, and duplicate costs. The non-mandate-related costs are costs attributable to ailments other than cancer. The unsupported costs are costs that were not documented in the city's payment history system (LINX) or were not supported by source documentation. The city claimed duplicate costs by claiming the same costs in two fiscal years. This occurred because the city's contracted administrator did not use a consistent methodology to identify reimbursable costs by fiscal year. The contractor's employees identified some costs by the date service was provided and other costs by the payment date. In some cases, these dates occurred in different fiscal years, causing the city to claim associated costs twice. In other cases, the city claimed duplicate costs by claiming the same cost under two separate cost elements (such as attorney fees claimed as both legal costs and disability costs).

Unclaimed costs

The city made mathematical errors on claim form FCP-2.1 for its FY 2003-04 and FY 2004-05 claims. The mathematical errors resulted in unclaimed costs totaling $516,132 for FY 2003-04, and $5,440 for FY 2004-05. In addition, the city did not claim all costs that its accounting records support. This occurred primarily because the city's contracted administrator prepared summary and detailed cost worksheets that did not reconcile with each other and/or did not agree with costs documented in LINX.

The following table summarizes the audit adjustment:

	Fiscal Year				
	2003-04	2004-05	2005-06	2006-07	Total
Non-mandate-related costs	$ (1,350)	$ (3,603)	$ (59,208)	$(146,684)	$ (210,845)
Unsupported costs	(52,991)	(2,179)	(10,170)	(121,088)	(186,428)
Duplicate costs	(82,597)	(17,277)	(4,649)	(27,911)	(132,434)
Unclaimed costs	595,017	329,239	86,035	846	1,011,137
Total audit adjustment	$ 458,079	$ 306,180	$ 12,008	$(294,837)	$ 481,430

The program's parameters and guidelines state that reimbursement requires a demonstration that the worker (1) has cancer which has caused the disability, and (2) that the worker's cancer developed or manifested itself while the worker was in the service of the employer or within the extended period provided for in Labor Code section 3212.1. In addition, the parameters and guidelines state that all costs claimed must be traceable to source documents or worksheets that show evidence of the validity of such costs.

Recommendation

We recommend that the city develop and implement an adequate recording and reporting system to ensure that all claimed costs are properly supported and reimbursable under the mandated program. Specifically, the city should ensure that:

- Costs claimed reconcile with the city's LINX payment system;
- It claims only mandate-reimbursable costs (i.e., those medical and disability costs specifically related to cancer);
- It consistently identifies each fiscal year's reimbursable costs by the payment date;
- It includes all mandate-reimbursable costs on its mandated cost claims; and
- All claim forms are mathematically correct.

City's Response

> . . .we take the strongest possible exception to, and appeal the determination of your office to disallow $516,132 in what is characterized as "unclaimed costs" on the FY 2003-04 claims year. . . .
>
> We assert that your characterization of this amount as "unclaimed" is completely erroneous and inaccurate.
>
> On Schedule 1 - Summary of Program Costs – July 1, 2003 through June 30, 2007, under the period July 1, 2003 through June 30, 2004, your schedule indicates $985,119 in "Disability benefit costs." A simple recap, or calculator summary of the line-by-line entries on your Form FCP-2 demonstrates, as your auditor found, that this amount is $516,132 less than it should be.
>
> Government Code Section 17561 indicates that these reimbursements are mandatory, unless, as per subsection (d)(l)(C)(ii), "... the Controller determines (that a claim) is excessive or unreasonable." No such determination has been made. In fact, your draft audit simply characterizes this amount ($516,132) as "unclaimed." This is clearly inaccurate, as the itemized claims were in fact submitted. "Disallowing" this amount on any basis other than a determination that they were either excessive or unreasonable is not a ground supported by the Government Code.
>
> Your draft audit's reference by footnote to the filing deadline having expired for FY 2003-04 is similarly erroneous. There is no factual dispute that these claims, each and every itemized individual claim, were timely submitted. I note that Government Code Section 17561, subsection (d)(2)(C) states "The Controller shall adjust the payment to correct for any underpayments or overpayments that occurred in previous fiscal years." There is no time limit attached to this provision, and I am certain that any overpayment, regardless of date, would be the subject of a subsequent offset or recovery by your office. Under the terms of the statute, the amount "disallowed" should have been recalculated and included in the amount claimed.

SCO's Comment

Our finding and recommendation are unchanged. The city submitted its FY 2003-04 mandated cost claim on January 10, 2005. The city submitted mandated claim forms FAM-27 (claim for payment), FCP-1.2 (claim summary), and FCP-2.1 (component/activity cost detail). On all these claim forms, the city identified disability benefit costs totaling $985,119. On forms FAM-27 and FCP-1.2, the city identified administrative costs totaling $18,683, actual mandate-related direct costs totaling $1,003,827, and reimbursable costs totaling $501,913 (the mandated program reimburses 50% of total mandate-related costs).

Our audit report shows that we allowed the reimbursable costs that the city claimed. Government Code section 17560 states that the city may file an annual reimbursement claim for actual mandated costs that it incurred. It is the city's responsibility to ensure that it files accurate mandated cost claims within the statutory time allowed. Government Code section 17568 states, "In no case shall a reimbursement claim be paid that is submitted more than one year after the deadline specified in [Government Code] section 17560." The city did not amend its FY 2003-04 mandated cost claim within the statutory timeframe permitted.

The city cites Government Code section 17561, subdivision (d)(2)(C) out of context. The statutory language addresses the SCO's responsibility to pay annual mandated cost reimbursement claims that local agencies submit. For past underpayments or overpayments, any correction is based on the claims that the city submitted. For FY 2003-04, the city submitted a claim for $501,913, which our audit report concludes is allowable.

CITY OF LOS ANGELES
CALIFORNIA

ANTONIO R. VILLARAIGOSA
MAYOR

PERSONNEL DEPARTMENT
PERSONNEL BUILDING
700 EAST TEMPLE STREET
LOS ANGELES, CA 90012

Margaret Whelan
GENERAL MANAGER

August 6, 2009

Jim L. Spano, Chief
Compliance Audits Bureau
Division of Audits
State Controller's Office
P.O. Box 942850
Sacramento, CA 94258

BY FAX, MAIL, and OVERNIGHT DELIVERY

Firefighter's Cancer Presumption Program (July 1, 2003 through June 30, 2007)

Having reviewed the draft audit report on the above referenced program, we take the strongest possible exception to, and appeal the determination of your office to disallow $516,132 in what is characterized as "unclaimed costs" on the FY 2003-04 claims year.

An arithmetic discrepancy was found by your Audit Manager, Mr. Steve W. Van Zee, and brought to the attention of this Department's analyst, Mr. Sola Oniyide. We assert that your characterization of this amount as "unclaimed" is completely erroneous and inaccurate.

On Schedule 1 – Summary of Program Costs – July 1, 2003 through June 30, 2007, under the period July 1, 2003 through June 30, 2004, your schedule indicates $985,119 in "Disability benefit costs." A simple recap, or calculator summary of the line-by-line entries on your Form FCP-2 demonstrates, as your auditor found, that this amount is $516,132 less than it should be.

Government Code Section 17561 indicates that these reimbursements are mandatory, unless, as per subsection (d)(1)(C)(ii), "... the Controller determines (that a claim) is excessive or unreasonable." No such determination has been made. In fact, your draft audit simply characterizes this amount ($516,132) as "unclaimed." This is clearly inaccurate, as the itemized claims were in fact submitted. "Disallowing" this amount on any basis other than a determination that they were either excessive or unreasonable is not a ground supported by the Government Code.

Your draft audit's reference by footnote to the filing deadline having expired for FY 2003-04 is similarly erroneous. There is no factual dispute that these claims, each and every itemized individual claim, were timely submitted. I note that Government Code Section 17561, subsection (d)(2)(C) states "The Controller shall adjust the payment to correct for any underpayments or overpayments that occurred in previous fiscal years." There is no time limit attached to this provision, and I am certain that any overpayment, regardless of date, would be the subject of a subsequent offset or recovery by your office. Under the terms of the statute, the amount "disallowed" should have been recalculated and included in the amount claimed.

It is in the interest of carrying out the substantive intent of the statute and program, the dictates of the legislature and expectations of reimbursement on behalf of all of the residents of the City of Los Angeles, and basic fairness, that I strongly urge your reconsideration of this matter.

Margaret Whelan

MARGARET WHELAN
General Manager

C: Honorable John Chiang, California State Controller
Jeffrey V. Brownfield, Chief, Division of Audits, State Controller's Office
Honorable Wendy Greuel, Controller, City of Los Angeles
Honorable Carmen Trutanich, City Attorney, City of Los Angeles
Raymond P. Ciranna, Interim City Administrative Officer, City of Los Angeles

Exhibit C

State Controller's Office — Mandated Cost Manual

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
FIREFIGHTERS' CANCER PRESUMPTION

For State Controller Use Only
(19) Program Number 00023
(20) Date Filed ___/___/___
(21) LRS Input ___/___/___

Program **023**

LABEL HERE

(01) Claimant Identification Number

(02) Claimant Name

County of Location

Street Address or P.O. Box — Suite

City — State — Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 20___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Prior Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) FCP-1.1, (05)(3)	
(23) FCP-1.1, (06)(3)	
(24) FCP-1.2, (04)(1)(d)	
(25) FCP-1.2, (04)(2)(d)	
(26) FCP-1.2, (05)	
(27) FCP-1.2, (06)	
(28) FCP-1.2, (07)	
(29) FCP-1.2, (08)	
(30) FCP-1.2, (09)	
(31) FCP-1.2, (10)	
(32)	
(33)	
(34)	
(35)	
(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer — Date

Type or Print Name — Title

(38) Name of Contact Person for Claim — Telephone Number ( ) - Ext.

E-Mail Address

Form FAM-27 (Revised 09/03)

Program 023	FIREFIGHTERS' CANCER PRESUMPTION Certification Claim Form Instructions	FORM FAM-27

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form FCP-1.1 or FCP-1.2, as applicable, and enter the total claimed amount. If more than one form is completed due to multiple department involvement in this mandate, add the total claimed amounts from each form as applicable.

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from forms FCP-1.1 and FCP-1.2, lines (10) and (11), respectively. The total claimed amount must exceed $1,000.

(14) Reimbursement claims must be filed by January 15 of the following fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor 0.10 (10% penalty), or $1,000, whichever is less.

(15) If filing a reimbursement claim and a claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount in line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., FCP-1.1, (05)(03), means the information is located on form FCP-1.1, block (05), line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. **Completion of this data block will expedite the payment process.**

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification. (To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Program 023	MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY	FORM FCP-1.1

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	20___/20___

Insured Method

(03) Firefighter Names	Service Termination Dates	Length of Service (Years/Months)	Dates of Injury

(04) Type of Insurance Carrier:

1. State Compensation Insurance Fund (SCIF) ☐
2. Joint Powers Agency (JPA) ☐ Name:
3. Private Insurance Carrier (PIC) ☐ Name:

	(a) SCIF	(b) JPA	(c) PIC
(05) Cost of Increased Experience Modified Premium:			
1. Actual Premium			
2. Increased Experience Modified Premium Percentage			
3. Increased Premium Cost			
(06) Cost of Decreased Dividends:			
1. Total Dividends			
2. Less: Dividends Received During the Fiscal Year			
3. Decreased Dividends			

(07) Total Increased Costs, Insured Method	[(Line (05)(3) + line (06)(3)]	
Cost Reduction		
(08) Less: Offsetting Savings, if applicable		
(09) Less: Other Reimbursements, if applicable		
(10) Total Claimed Amount	[Line (07) - {line (08) + line (09)}] x 0.5	

Program 023	FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY Instructions	FORM FCP-1.1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form FCP-1.1 must be filed for a reimbursement claim. Do not complete form FCP-1.1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form FCP-1.1 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) List the name of each firefighter, service termination date, length of service (years/months), and date of injury. Only workers compensation filings subsequent to January 1, 1983 that are related to cancer and presumed to have arisen out of and in the course of employment qualify for reimbursement.

(04) Type of Insurance Carrier. Check a box to indicate if the claimant is insured with the State Compensation Insurance Fund (SCIF), a Joint Powers Agency (JPA), or a Private Insurance Carrier (PIC). If the claimant is insured by a JPA or a PIC, enter the name of the carrier.

For those who are insured by the SCIF, the SCIF will provide their clients with an appropriate modification factor and dividend amount for each applicable policy year upon written request to complete this schedule. Address: State Compensation Insurance Fund, Claims/Rehabilitation Department Operations, 1275 Market Street, San Francisco, CA 94103. In order for SCIF to provide this information, you must include with the request the above names and dates of injury. Please allow SCIF 30 days for this information. Normally, there is no impact on the modification factor until 18 to 24 months after injury. Following this period of time, the modification factor may be impacted for three consecutive policy years.

For those who are insured by a JPA or a private insurance carrier, claimants may wish to contact their insurance representative for assistance to determine what that lower experience modification premium percentage and total dividends would be had the agency not had any cancer presumption cases under Labor Code Section 3212.1. Attach a statement showing the calculations and any cost data provided by the insurance carrier.

(05) Cost of Increased Experience Modified Premium:

1. Enter the actual premium before the experience modified premium percentage was applied. Show the premium on a fiscal year basis and submit copies of billing statements with the claim. If necessary, prorate the premium amounts between the two policy years.
2. Enter the difference between the percentage that is shown on the final insurance premium billing statement and what the percentage would have been had there not been any cancer presumption cases under Labor Code Section 3212.1.
3. Multiply line (05)(1) by line (05)(2). If the premium was prorated, multiply each prorated portion by the modification percentage determined in line (05)(2), which relates to that portion of the premium. Show both calculations on a separate schedule.

(06) Cost of Decreased Dividends:

1. Enter the total dividends that would have been received for the fiscal year of cost had there not been any cancer presumption cases under Labor Code Section 3212.1.
2. Enter the dividends received during the fiscal year of cost.
3. Subtract the Dividends Received During the Fiscal Year of cost, line (06)(2), from the total Dividends, line (06)(1).

(07) Total Increased Cost. Multiply the sum lines (05)(3) and (06)(3).

(08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a schedule of detailed savings with the claim.

(09) Less: Other Reimbursements, if applicable. Enter total other reimbursements received from any source, i.e., federal, other state programs, etc. Submit a schedule of detailed reimbursements with the claim.

(10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Costs, line (07), and multiply by 0.5, since only 50% of the costs are reimbursable. Enter the result on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 023	MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY	FORM FCP-1.2

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	20___/20___

Self-Insured Method

(03) Firefighter Names	Service Termination Dates	Length of Service (Years/Months)	Dates of Injury

Direct Costs	**Object Accounts**			
(04) Reimbursable Components	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. Disability Benefit Costs				
2. Administrative Costs				
(05) Total Direct Costs				

Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]	
(08) Total Increased Costs, Self-Insured Method	[(Line (05)(d) + line (07)]	

Cost Reduction	
(09) Less: Offsetting Savings, if applicable	
(10) Less: Other Reimbursements, if applicable	
(11) Total Claimed Amount	[Line (08) - {line (09) + line (10)}] x 0.5

Program 023	FIREFIGHTERS CANCER PRESUMPTION CLAIM SUMMARY Instructions	FORM FCP-1.2

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form FCP-1.2 must be filed for a reimbursement claim. Do not complete form FCP-1.2 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form FCP-1.2 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) List the name of each firefighter, service termination date, length of service (years/months), and date of injury. Only workers compensation filings subsequent to January 1, 1983 that are related to cancer and presumed to have arisen out of and in the course of employment qualify for reimbursement.

(04) Reimbursable Components. For reimbursable component (04)(1), Disability Benefit Costs, enter Total Benefit Payments from form FCP-2.1, line (05)(h), to line (04)(1)(d) of this form.

For reimbursable component (04)(2), Administrative Costs, enter Total Administrative Costs from form FCP-2.2, line (05), columns (d), (e), and (f) to line (04)(2), columns (a), (b), and (c) of this form. Total each row.

(05) Total Direct Costs. Total columns (a) through (d) and enter on line (05).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, without preparing an ICRP. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim.

(07) Total Indirect Costs. If the 10% flat rate is used for indirect costs, multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If an ICRP is submitted and both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06). If more than one department is reporting costs, each must have its own ICRP for the program.

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 023	MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL	FORM FCP-2.1

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Disability Benefit Costs

(04) Description of Expenses: Complete columns (a) through (h).

(a) Employee Name	(b) Medical Expenses	(c) Temporary Disability Payments	(d) Permanent Disability Payments	(e) Life Pension	(f) Death Benefits	(g) Travel Expenses	(h) Total Benefit Payments

(05) Total ☐ Subtotal ☐ Page:____of____

Program 023	FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL Instructions	FORM FCP-2.1

Note: This form is to be used in conjunction with form FCP-1.1.

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Component: Disability Benefit Costs. This line identifies the costs that may be claimed on form FCP-2.1.

(04) In order to claim increased costs incurred for the fiscal year of the claim, the firefighter must meet the requirements as specified in Labor Code Section 3212.1.

(a) Enter the firefighter's name to which the disability benefits were paid.

(b) Enter all medical expenses paid for the firefighter.

(c) Enter temporary disability benefits or full salary paid in lieu of temporary disability benefits as required by Labor Code Section 4850, or other local charter provisions or ordinances that were in existence on January 1, 1983.

Provided, however, that salary in lieu of temporary disability benefits were payable under local charter provision or ordinance shall be reimbursable only to the extent that those benefits do not exceed the benefits required by Labor Code Section 4850.

(d) Enter all permanent disability benefits paid to the firefighter.

(e) Enter all life pension benefits paid to the firefighter.

(f) Enter all death benefits paid to the beneficiaries of the firefighter.

(g) Enter necessary and reasonable travel and related expenses paid to the firefighter.

(h) For each firefighter, total the benefit payments in columns (b) through (g).

(05) Add Total Benefit Payments, line (04), column (h), and enter the total on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter the total from line (05), column (h) to form FCP-1.2, line (04)(1)(d).

Program 023	MANDATED COSTS FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL	FORM FCP-2.2

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Administrative Costs

(04) Description of Expenses: Complete columns (a) through (f).			Object Accounts		
(a) Employee Names, Job Classifications, Functions Performed, and Description of Services and Supplies	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Services and Supplies
(05) Total ☐ Subtotal ☐ Page:____of____					

Program 023	FIREFIGHTERS CANCER PRESUMPTION COMPONENT/ACTIVITY COST DETAIL Instructions	FORM FCP-2.2

Note: This form is to be used in conjunction with form FCP-1.2.

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Component: Administrative Costs. This line identifies the costs that may be claimed on form FCP-2.2.

(04) Description of Expenses. Administrative costs incurred by self-insured agencies for processing cancer presumption case are reimbursable. The following table identifies the type of information required to support reimbursable costs. Enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, travel expenses, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name Title Activities	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits		Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries		
Services and Supplies Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Cost = Hourly Rate x Hours Worked or Total Cost	Invoice
Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode			Total Travel Cost = Rate x Days or Miles	

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/ activity costs, number each page. Enter the totals from line (05), columns (d), (e), and (f) to form FCP-1.2, line (04)(2).

State Controller's Office | Mandated Cost Manual

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561

FIREFIGHTERS' CANCER PRESUMPTION

For State Controller's Office Only | Program
(19) Program Number 00023
(20) Date Filed ___/___/___
(21) LRS Input ___/___/___
023

LABEL HERE

(01) Claimant Identification Number: 9819487
(02) Claimant Name: City of Los Angeles
County of Location: Los Angeles
Street Address or P.O. Box: 700 E. Temple Street | Suite: 210
City: Los Angeles | State: CA | Zip Code: 90012

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated [X]	(09) Reimbursement [X]
	(04) Combined [ ]	(10) Combined [ ]
	(05) Amended [ ]	(11) Amended [ ]
Fiscal Year of Cost	(06) 2004/2005	(12) 2003/2004
Total Claimed Amount	(07) $552,104.79	(13) $501,913.45
Less: 10% Late Penalty, not to exceed $1,000		(14)
Less: Prior Claim Payment Received		(15)
Net Claimed Amount		(16) 501,913.45
Due from State	(08)	(17) 501,913.45
Due to State		(18)

Reimbursement Claim Data	
(22) FCP-1.1, (05)(3)	
(23) FCP-1.1, (06)(3)	
(24) FCP-1.2, (04)(1)(d)	$985,118.76
(25) FCP-1.2, (04)(2)(d)	18,683.11
(26) FCP-1.2, (05)	
(27) FCP-1.2, (06)	
(28) FCP-1.2, (07)	
(29) FCP-1.2, (08)	
(30) FCP-1.2, (09)	
(31) FCP-1.2, (10)	
(32)	
(33)	
(34)	
(35)	
(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer: RS for Margaret M. Whelan
Date: 1/10/05

Margaret M. Whelan
Type or Print Name

General Manager
Title

(38) Name of Contact Person for Claim: Sola Oniyide
Telephone Number: (213) 847-9044 Ext:
E-Mail Address: SOniyide@per.lacity.org

Form FAM-27 (Revised 09/03)

FORM FCP-1.2

MANDATED COSTS
FIRE FIGHTER'S CANCER PRESUMPTION
CLAIM SUMMARY

(01) Claimant: City of Los Angeles **(02) Type of Claim: Reimbursement**

Fiscal Year: 2003-2004

SELF INSURED METHOD

	(03) FIRE FIGHTER'S NAME	ORIGINAL APPOINTMENT	TERMINATION DATE	LENGTH OF SERVICE (YEARS & MONTHS)	DATES OF INJURY
1.		1/16/65	9/14/04	39	1/16/65
2.		7/22/73	ACTIVE	23.9	7/2273
3.		12/4/71	ACTIVE	33	12/4/71
4.		5/16/70	ACTIVE	34	5/16/70
5.		4/30/66	12/3/95	29.7	4/30/66
6.		4/12/81	ACTIVE	23.9	4/12/81
7.		2/9/63	1/13/02	38.1	2/9/63
8.		9/1/62	2/29/96	33.5	9/1/62
9.		2/16/75	ACTIVE	29	2/16/75
10.		8/13/01	ACTIVE	3	8/13/01
11.		6/11/90	ACTIVE	14.6	2/5/99
12.		2/1/55	6/17/90	35.4	2/1/55
13.		12/14/80	ACTIVE	24	12/14/80
14.		7/25/70	7/2/04	34	7/25/70
15.		1/6/73	11/4/00	27	1/6/73
16.		11/7/59	1/24/96	36.2	11/7/59
17.		8/10/80	ACTIVE	24	8/10/80
18.		8/29/64	7/24/02	36	8/29/64
19.		4/1/73	ACTIVE	31.9	4/1/73
20.		2/27/77	ACTIVE	26.1	2/27/77
21.		7/24/65	ACTIVE	39	7/24/65
22.		11/7/77	11/18/99	22	11/16/77
23.		12/16/75	11/7/02	27	12/16/75
24.		2/4/61	9/19/83	22.7	1/1/67

25.		2/16/75	ACTIVE	29	2/16/75
26.		2/16/75	ACTIVE	29.7	2/16/75
27.		12/14/80	ACTIVE	23	12/14/80
28.		11/7/77	ACTIVE	27	11/7/77
29.		5/1/69	ACTIVE	35	5/1/69
30.		7/9/79	ACTIVE	24	7/9/79
31.		1/6/73	1/11/03	30	2/9/99
32.		4/27/75	7/13/03	28.2	9/27/75
33.		2/16/75	ACTIVE	28.1	2/16/75
34.		4/13/68	8/21/00	32.4	4/13/68
35.		4/20/80	ACTIVE	24.9	4/20/80
36.		7/23/87	ACTIVE	17.6	9/10/87
37.		7/25/70	4/30/04	33	7/25/70
38.		4/14/68	7/11/01	33	4/14/68
39.		4/20/63	9/1/02	41	4/20/63
40.		10/14/73	ACTIVE	31	5/2/01
41.		4/1/73	ACTIVE	31.9	10/4/99
42.		1/16/65	7/27/00	35	1/16/65
43.		10/18/69	ACTIVE	35.1	10/18/69
44.		10/14/73	ACTIVE	29	10/14/73
45.		2/9/63	ACTIVE	41.8	2/9/63
46.		4/7/68	7/7/96	28.3	4/7/68
47.		2/16/75	ACTIVE	28.1	2/16/75
48.		11/7/77	ACTIVE	27	11/7/77
49.		4/27/75	ACTIVE	29.9	4/27/75
50.		5/15/77	ACTIVE	27.5	5/15/77
51.		4/28/75	ACTIVE	29	4/28/75
52.		4/27/75	11/21/02	27.6	4/28/75
53.		4/7/85	ACTIVE	19	4/7/85
54.		7/22/73	ACTIVE	31	7/22/73
55.		1/29/78	ACTIVE	27	1/13/99
56.		5/19/58	2/7/04	46	5/19/58
57.		4/13/68	9/10/96	28.5	4/13/68
58.		1/15/79	ACTIVE	25.8	1/15/79
59.		9/4/84	ACTIVE	20.5	8/14/98

60.		5/13/73	1/1/02	29	5/13/73
61.		12/14/80	ACTIVE	23.9	12/14/80
62.		4/13/68	ACTIVE	36	4/13/68
63.		2/5/72	4/1/04	30	2/5/72
64.		8/10/80	ACTIVE	24	8/10/80
65.		9/1/62	8/19/04	42	9/1/62
66.		4/20/80	ACTIVE	24.6	4/20/80
67.		11/6/77	ACTIVE	27.2	11/6/77
68.		7/3/89	ACTIVE	15	7/3/89
69.		4/12/81	9/1/95	22.9	4/12/81
70.		12/24/79	ACTIVE	24.9	12/24/79
71.		2/20/71	ACTIVE	33.1	2/21/71
72.		12/14/80	ACTIVE	24.1	12/14/80
73.		1/6/77	ACTIVE	27.2	11/6/77
74.		1/29/78	ACTIVE	26.8	1/29/78
75.		6/21/54	4/30/86	32	6/21/54
76.		5/3/82	ACTIVE	22	5/3/82
77.		6/28/69	ACTIVE	26.1	4/24/75
78.		2/4/61	8/4/91	30	2/6/87
79.		4/8/61	7/14/91	30.3	4/8/61
80.		7/7/74	2/24/02	27.7	7/7/74
81.		7/20/86	ACTIVE	18.6	12/29/97
82.		2/27/77	ACTIVE	27	2/27/77
83.		10/31/88	ACTIVE	16	10/31/88
84.		7/12/61	1/10/02	40.6	1/6/00
85.		12/4/71	ACTIVE	38.9	12/4/71
86.		3/10/62	6/29/92	30.3	3/10/62
87.		3/1/81	ACTIVE	23	3/1/81
88.		2/5/72	ACTIVE	32.1	2/5/72
89.		5/13/84	ACTIVE	20	5/13/84
90.		8/10/80	ACTIVE	24.5	8/10/80
91.		2/20/71	ACTIVE	33	2/20/71
92.		4/27/75	2/18/04	29	4/27/75
93.		6/16/66	1/26/02	35.5	4/27/00
94.		4/20/80	ACTIVE	24.6	4/20/80
95.		12/4/71	7/14/02	31	12/4/71
96.		9/23/57	1/11/02	45.3	8/18/99

97.		4/20/80	ACTIVE	24	4/20/80
98.		5/13/72	ACTIVE	32.5	5/13/72
99.		7/24/65	2/3/99	33.7	7/25/65
100.		1/2/62	7/9/00	38.6	1/2/62
101.		2/9/63	3/6/97	34.1	4/1/96
102.		3/1/81	3/2/04	23	3/1/81
103.		6/27/59	2/1/02	42.6	6/27/59
104.		5/5/74	ACTIVE	30.5	5/5/74
105.		3/2/89	ACTIVE	15.7	3/2/89
106.		1/27/85	ACTIVE	20	4/7/85
107.		4/20/63	ACTIVE	41.7	4/20/63
108.		9/1/62	6/21/00	42	9/1/62
109.		7/22/73	ACTIVE	31	7/22/73
110.		7/25/70	ACTIVE	34	7/25/70

DIRECT COSTS	Object Accounts		
	(a) Salaries	(b) Benefits	(d) Total
(04) Reimbursable Components:			
1. Disability Benefit Costs:			$985,118.76
2. Administrative Costs	$10,104.30	$8,578.81	$18,683.11
(05) TOTAL DIRECT COSTS:			$1,003,826.90
INDIRECT COSTS			
(06) Indirect Cost Rate (from ICRP)			0
(07) TOTAL INDIRECT COSTS: (Total Salaries x Indirect Cost Rate)			0
(08) TOTAL DIRECT AND INDIRECT COSTS, SELF INSURED METHOD			$1,003,826.90
COST REDUCTION			
(09) Less: Offsetting Savings, if applicable			Not Applicable
(10) Less: Other Reimbursements, if applicable Not Applicable			Not Applicable
(11) TOTAL CLAIMED AMOUNT (50% of (08) Total Direct and Indirect Costs)			$501,913.45

MANDATED COSTS

FIREFIGHTER'S CANCER PRESUMPTION

COMPONENT/ACTIVITY COST DETAIL

FORM FCP-2.

(01) Claimant: **City of Los Angeles**

(02) Fiscal Year Costs Were Incurred: **2003-2004**

(03) Reimbursable Component: **DISABILITY BENEFIT COSTS**

(04) Description of Expenses

EMPLOYEE NAME	MEDICAL EXPENSE	TEMP DISABILIT PAYMENT	PERM DISABILITY PAYMENTS	AWARD	IOD BENEFITS	DEATH BENEFITS	LEGAL EXPENSE	TRAVEL EXPENSE	PHOTOCOPYING EXPENSE	REHAB EXPENSE	TOTAL BENEFIT PAYMENTS
	$1,810.42	$0.00	$0.00	$0.00	$44,162.43	$7,500.00	$0.00	$0.00	$203.15	$0.00	$53,676.00
	89.38	0	0	0	0	0	0	0	0	0	$89.38
	969.08	0	0	0	0	0	0	0	165.53	0	$1,134.61
	2112.84	0	1680	0	0	0	0	0	0	0	$3,792.84
	18519.55	0		0	0	0	0		0	0	$18,519.55
	4199.15	0	0	0	0	0	0	0	0	0	$4,199.15
	875.11	0	0	0	0	0	0	0	0	0	$875.11
	1023.68			0	0	0	0	640.9	0	0	$1,664.58
	29375.81	0	0	0	0	0	0	11.51	0	0	$29,387.32
	0	0	0	0	0	0	0	4.08	108.75	0	$112.83
	3604.06	0	0	0	0	0	0	0	0	0	$3,604.06
	2831.61	0	0	0	0	0	0	0	0	0	$2,831.61
	1079.91	0	0	0	0	0	0	0	0	0	$1,079.91
	992.88	0	0	0	0	0	0	10	473.06	0	$1,475.94
	979.63	0	0	0	0	0	0	164.16	91.77	0	$1,235.56
	98.26	0	0	0	0	0	0	0	0	0	$98.26
	0	0	0	0	0	0	0	0	0	0	$0.00
	1088.88	0	0	0	0	0	57.66	0	0	0	$1,146.54
	7958.12	0	12561.5	0	32997.82	0	0	0	663.34	0	$54,180.78
	36171.65	0	0	0	36175.89	0	163.08	0	0	0	$72,510.62

	0	0	0.00	0.00	0.00	0	0	0	0	0	$0.00
	0	0	0		0	0		0	223.98	0	$223.98
	0.00	0	0	0	0	0	0	0	0	0	$0.00
	653.88	0	0		0	0	0	0	0	0	$653.88
	500	0	0	0	0	0	0	62.97	0	0	$562.97
	412.5	0	533.37	0		0	415.17	40.55	113.15	0	$1,514.74
	1090.92	0	0	0	0	0	0	0	0	0	$1,090.92
	362.88	0	0	0	0	0	0	0	0	0	$362.88
	2217.86	0	0	0	0	0	1482.5	164.22	493.71	0	$4,358.29
	19.44	0	0	0	0	0	0	0	0	0	$19.44
	457.02	0	0	0	0	0	0	0	0	0	$457.02
	249.14	0	0	0	0	0	0	0	0	0	$249.14
	383.93	0	0	0	0	0	0	0	0	0	$383.93
	0	0	0	0	0	0	0	0	0	0	$0.00
	4,182.96	0	0	0	0	0	0	0	0	0	$4,182.96
	7,723.20	0	0	0	0	0	0	0	154.83	0	$7,878.03
	0.00	0	0	0	0	0	0	26.18	0	0	$26.18
	1106.06	0	0	1302	2325.57	0	944.15	13.6	0	0	$5,691.38
	198.91	0	0	0	0	0	0	0	0	0	$198.91
	1,200.00	0	0	17277.03	0	0	2759.99	0	141.44	0	$21,378.46
	0.00	0	0	0	0	0	0	0	0	0	$0.00
	133.74	0	1590	0	0	0	0	0	0	0	$1,723.74
	4083.27	0	0	0	0	0	0	0	0	0	$4,083.27
	4884.95	0	0	9133.23	0	0	5603.58	0	0	0	$19,621.76
	5505.48	0	0	0	0	0	0	368.09	0	0	$5,873.57
	1,706.35	0	0	0	0	0	0	0	0	0	$1,706.35
	45.9	0	0	112.98	0	0	0	0	0	0	$158.88
	10313.56	0	0	20348.81	0	0	0	21.76	187.15	0	$30,871.28
	623.99	0	0	0	0	0	0	9.52	0	0	$633.51
	130.72	0	0	0	0	0	0	0	0	0	$130.72
	622.86	0	0	0	0	0	121.9	0	0	0	$744.76
	898.85	0	8160	0	0	0	0	0	0	0	$9,058.85
	199.1	0	0	0	0	0	0	0	0	0	$199.10
	0	0	0	0	0	0	0	20	60.39	0	$80.39
	3034.96	0	0	0	28792.77	0	0	65.2	1865.95	0	$33,758.88

	4190.72	0	0	0	1972.5	0		0	0	0	$6,163.22
	0	0	0	0	0	19100	0	0	0	0	$19,100.00
	618.29	0	0	0	0	0	0	0	0	0	$618.29
	424.58	0	0	0	0	0	0	0	0	0	$424.58
	1005.57	0	0	0	0	0	0	225	1058.05	0	$2,288.62
	2013.48	0	0	0	0	0	0	0	0	0	$2,013.48
	2634.9	0	1260	1260	561.69	0	0	0	0	0	$5,716.59
	0	0	0	0	42941.07	32870	0	21	761.08	0	$76,593.15
	595.67	0	0	0	0	0	0	0	0	0	$595.67
	19494.88	0	0		20239.73	0	0	26	53.76	0	$39,814.37
	5113.78	0	0		73828.56	0	0	31	1179.93	0	$80,153.27
	24044.62	0	0	0	0	0	0	0	292.4	0	$24,337.02
	0	1266.46	510	3174.76	0	0	0	3856.72	6.47	1236.49	$8,814.41
	96227.48	0	0	0	0	0	0	482.8	0	0	$96,710.28
	1578.79	0	0	0	0	0	575.6	0	0	0	$2,154.39
	6263.58	0	1578.79	0	5077.11	0	401.2	0	0	0	$13,320.68
	2408.62	0	0	0	0	0	0	0	0	0	$2,408.62
	452.69	0	0	0	0	0	0	417.6	0	0	$870.29
	2110.13	0	0	0	0	0	0	0	0	0	$2,110.13
	594.5	0	0	0	0	0	0	0	0	0	$594.50
	3998.77	0	0	0	0	0	0	0	0	0	$3,998.77
	52130.55	0	0	0	0	0	241.5	0	0	0	$52,372.05
	17081.67	0	0	0	0	0	0	0	0	0	$17,081.67
	502.44	0	0	0	0	0	0	0	0	0	$502.44
	3261.25	0	0	0	0	0	0	0	0	0	3261.25
	151.97	0	0	0	0	0	0	0	0	0	151.97
	1372.73	0	0	0	466.19	0	0	0	0	0	1838.92
	357.81	0	0	0	0	0	0	0	0	0	357.81
	2669.78	0	0	0	0	0	0	0	0	0	2669.78
	391697.2	0	0	7300	55415.99	7500	1852.39	0	0	0	463765.58
	2433.31	0	0	0	0	0	0	0	0	0	2433.31
	167.64	0	0	0	0	0	0	0	0	0	167.64
	409.48	0	0	0	0	0	0	0	0	0	409.48
	23199.04	0	0	0	0	0	0	0	0	0	23199.04
	500	0	0	0	0	0	0	0	0	0	500

	886.59	0	0	0	0	0	0	0	0	0	886.59
	47.6	0	0	0	0	0	0	0	0	0	47.6
	243.4	0	0	0	0	0	0	56.52	0	0	299.92
	333.55	0	0	8840	0	0	0	0	0	0	9173.55
	1460.02	0	0	0	0	0	0	12.13	0	0	1472.15
	1890.12	0	0	0	0	0	0	0	0	0	1890.12
	136.56	0	0	0	0	0	0	0	0	0	136.56
	817.13	0	0	0	0	0	0	0	221.64	0	1038.77
	521.22	0	0	0	0	0	0	0	0	0	521.22
	234.09	0	0	0	0	0	0	0	0	0	234.09
	765.26	0	4926.38	460	0	0	0	0	0	0	6151.64
	575.75	0	0	0	0	0	0	0	0	0	575.75
	0	0	0	0	0	0	0	0	52.44	0	52.44
	5170.6	0	945.28	0	0	0	0	30.23	87.43	0	6233.54
	2786.6	0	0	0	0	0	0	0	0	0	2786.6
	32395.23	0	0	0	20223.67	0	0	39.95	115.96	0	52774.81
	1436.17	0	0	0	0	0	0	0	0	0	1436.17
	1700.37	0	0	0	0	0	0	0	0	0	1700.37
	676.52	0	10873.11	6768.66	0	0	4350.62	0	0	0	22668.91
	5343.83	0	0	0	16763.63	0	0	550.99	0	0	22658.45
	270.45	0	0	0	0	0	0	0	0	0	270.45
(05) TOTAL	411658.99	$1,266.46	$27,873.66	$75,977.47	$381,944.62	$51,970.00	$18,969.34	$6,682.86	$8,775.36	$1,236.49	$985,118.76

FORM CPO-2.2

MANDATED COSTS
FIREFIGHTERS CANCER PRESUMPTION
COMPONENT/ACTIVITY COST DETAIL

(01) Claimant: City of Los Angeles

(02) Fiscal Year Costs Were Incurred: **2003-2004**

(03) Reimbursable Component: **ADMINISTRATIVE COSTS**

(04) Description of Expenses:

TPA Contractor - PRESIDIUM				Object Accounts		
EMPLOYEE NAME	POSITION TITLE	HOURLY RATE	HOURS WORKED	SALARIES	BENEFITS	**TOTAL**
Please see attached detail.						
CONTRACTUAL SERVICES TOTAL:				$10,104.30	$8,578.81	$18,683.11
PERSONNEL DEPARTMENT TOTAL:						
(05) ❑ Total ❑ Subtotal		**Page:____ of ____**				**$18,683.11**

NOTES: 1. Refer to the attached Job Description and/or Classification Specification for the job classification and activities performed by each employee.

2. Refer to the attached Cost Allocation Plan Rates for the fringe benefit rate for Personnel Department staff (28.78%) and Contractual Services staff (20.25%).

PRESIDIUM - FIRE - ATTACHMENT ECP 2.2 - 08-04

EMPLOYEE	POSITION TITLE	HOURLY RATE	HOURS WORKED	SALARIES	BENEFITS	TOTAL
PATRICIA EBRAHIM	SUPERVISOR	$30.17	21.83	$658.61	$27.56	$686.17
DEDORAH HOWARD	SUPERVISOR	$31.26	63.04	$1,970.63	$1,799.97	$3,770.60
ISABELA RIVERA	ADJUSTER	$24.66	17.22	$424.65	$387.87	$812.52
ROBRT LEWIS	ADJUSTER	$22.56	10.3	$232.37	$212.24	$444.61
YOLANDA JAMES	ADJUSTER	$31.79	7.56	$240.33	$219.52	$459.85
ANNIE ALINDOGAN	ADJUSTER	$21.77	16.46	$358.33	$327.30	$685.63
GINA DELGADO	ADJUSTER	$25.58	37.65	$963.09	$879.68	$1,842.77
VICTORIA BENJAMIN	ADJUSTER	$50.00	13.36	$668.00	$610.15	$1,278.15
ALISE KINGSBY	ADJUSTER	$49.70	12.76	$634.17	$579.25	$1,213.42
LINDA LEBLANCE	ADJUSTER	$20.51	5.94	$121.83	$111.28	$233.11
MARTY MARQUEZ	ADJUSTER	$19.23	10.52	$202.30	$184.78	$387.08
EUGENE MARTINEZ	ADJUSTER	$50.00	7.57	$378.50	$345.72	$724.22
ROGER MUNOZ	ADJUSTER	$26.07	14.31	$373.06	$340.75	$713.81
SANDY VUKOJEVICH	ADJUSTER	$32.77	5.5	$180.24	$164.63	$344.87
RUTH ARGUELLO	ASSISTANT	$16.41	1.91	$31.34	$28.63	$59.97
EVELILN BLANCO	ASSISTANT	$14.81	3.97	$58.80	$53.70	$112.50
LISA CLAPPER	ASSISTANT	$10.68	10.35	$110.54	$100.97	$211.51
BILLY COO	ASSISTANT	$10.69	8.38	$89.58	$81.82	$171.40
JAMES ROOP	ASSISTANT	$15.52	2.3	$35.70	$32.60	$68.30
DORIS THOMAS	ASSISTANT	$17.20	3.48	$59.86	$54.64	$114.50
ANN VAN STRIEN	NURSE	$32.69	6.82	$222.95	$203.64	$426.59
RITA MCGOWAN	NURSE	$30.55	15.75	$481.16	$439.49	$920.65
LANA GIORDANO	CLERICAL SUPERVIS	$22.12	4.78	$105.73	$20.20	$125.93
KIMBERLY MICHELS	REGIONAL MANAGER	$43.08	6.54	$281.74	$257.34	$539.08
CHRISTINE GATES	ASSISTANT MANGER	$35.98	33.93	$1,220.80	$1,115.08	$2,335.88
TOTAL				$10,104.30	$8,578.81	$18,683.11

PRESIDIUM - FIRE - ATTACHMENT ECP 22-03-04

EMPLOYEE	POSITION TITLE	HOURLY RATE	HOURS WORKED	SALARIES	BENEFITS	TOTAL
PATRICIA EBRAHIM	SUPERVISOR	$30.17	21.83	$658.61	$27.56	$686.17
DEDORAH HOWARD	SUPERVISOR	$31.26	63.04	$1,970.63	$1,799.97	$3,770.60
ISABELA RIVERA	ADJUSTER	$24.66	17.22	$424.65	$387.87	$812.52
ROBRT LEWIS	ADJUSTER	$22.56	10.3	$232.37	$212.24	$444.61
YOLANDA JAMES	ADJUSTER	$31.79	7.56	$240.33	$219.52	$459.85
ANNIE ALINDOGAN	ADJUSTER	$21.77	16.46	$358.33	$327.30	$685.63
GINA DELGADO	ADJUSTER	$25.58	37.65	$963.09	$879.68	$1,842.77
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CHRISTINE GATES	ASSISTANT MANGER	$35.98	33.93	$1,220.80	$1,115.08	$2,335.88
TOTAL				$10,104.30	$8,578.81	$18,683.11

CAMBRIDGE
JOB DESCRIPTIONS

JOB TITLE: Workers' Compensation Claims Examiner

I BASIC FUNCTION:

Under the direct supervision of the Workers' Compensation Supervisor, it is the responsibility of the Claims Examiner to investigate and coordinate timely issuance of benefits. While maintaining aggressive medical management, the Claims Examiner is responsible for controlling severity, directing legal counsel and outside vendors, and resolving all claim issues for the purpose of bringing each file to a final conclusion.

II DUTIES & RESPONSIBILITIES:

1. Review of first report and all other information received after creation of the file.

2. Investigation of all information involving the file.

3. Request appropriate forms, such as wage statement from employer, C.I.B., return to work date and whatever additional forms are required for each jurisdiction.

4. File proper forms with the state, on a timely basis, as required.

5. Make all necessary payments where warranted.

   1. Lost time payment (Indemnity)
   2. Hospital bills, doctor bills and other medical expenses, etc.
   3. Payment of all allocated expenses consistent with good claims practice.

6. Schedule independent medical exams (IME) when necessary.

7. Raise proper issues before the Workers' Compensation Commission when necessary.

8. Refer all cases in excess of authority and all cases that have a potential of being controverted to Supervisor.

9. When old established cases come up on diary, review for litigation management and medical cost control and update diary.

10. HCM Bill Review - All medical bills in fee schedule states as well as usual customary should be referred for review.

11. Subrogation - The possibility of subrogation will be considered on all Workers' Compensation claims. Where there is evidence of third-party negligence as a cause of the accident, a thorough investigation is to be conducted. Also second injury fund or apportionment issues which exist.

12. All claims must be diaried for no longer than 90 days, at which time the file status and reserve must be checked.

III REQUIREMENTS:

1. Minimum of one (1) to three (3) years of claim handling experience.

2. Prior customer service experience.

JOB DESCRIPTION

JOB TITLE: Workers' Compensation Claims Assistant/M.Q. Clerk

I BASIC FUNCTION:

Provide technical assistance on Workers' Compensation claims and administrative assistance in the Workers' Compensation Department.

II DUTIES & RESPONSIBILITIES

1. Receive and respond to telephone inquiries regarding medical and indemnity payments. Initiate telephone calls to health care providers to follow up for return to work information, medical records, treatment plans and final medical reports as directed. Follow up with employers for return to work verification, wage information and personnel records as directed. Record telephone First Reports.

2. Review, authorize and issue payment/denial of medical bills within authority. Request records to document charges and/or casual relationship, refer questionable bills to technician for approval; directly input payments and form letters and mail out with enclosures.

3. Maintain telephone contact with claimant, physician and insured to verify ongoing disability; advise technician of questionable disability and change in medical condition.

4. Complete all internal and external forms, index inquiries and state forms.

5. Calculate and issue temporary partial disability payments and permanent partial disability payments.

6. Prepare legal referrals; send appropriate file material and assist technician with follow-up handling.

7. Schedule independent medical examinations; notify all parties and send necessary medical records.

8. Prepare rehabilitation referrals; complete state forms and forward medical records.

III REQUIREMENTS

1. Prior customer service experience.
2. Claim handling experience desirable.
3. One (1) to three (3) years experience in clerical.

JOB DESCRIPTION

JOB TITLE: Workers' Compensation Supervisor

I BASIC FUNCTION:

Under the supervision of the Manager, directs and monitors the daily work flow and production of the assigned unit to ensure qualitative and quantitative compliance with the guidelines established by HCM Claim Management and Client. Counsels and provides direction to examiners on more complex claim issues, assesses and sets standards for individual employee performance and development needs.

II DUTIES & RESPONSIBILITIES:

1. Assists Management in establishing claim policy and procedures.
2. Provides initial investigative direction on claims assigned to unit and conducts qualitative and quantitative reviews of work products to insure compliance with the guidelines established by HCM and Client.
3. Counsels and provides guidance to employees on more complex claims.
4. Monitors and reviews open pending of unit to ensure their timely disposition and proper control of allocated expenses.
5. Maintains performance records and assesses individual employee performance, develops annual performance objectives and incorporates employee developmental needs into the management appraisal objectives.
6. Communicates and assists with the resolution of vendor disputes.

III REQUIREMENTS:

1. Minimum of five (5) to seven (7) years claim handling experience.
2. Three (3) to five (5) years minimum of Supervisory experience in a Workers' Compensation environment.

JOB DESCRIPTION

JOB TITLE: Assistant Manager

I BASIC FUNCTION:

Under the supervision of the Manager, the Assistant Manager provides direction to the dedicated Unit of claim professionals, working through the supervisor.
Provides senior leadership and acts as unit head during the manager's absence. Expected to assess and set standards for individual performance and developmental needs.

II DUTIES & RESPONSIBILITIES:

1. Assists in establishment and enforcement of policy & procedures.
2. Performs quality audits and checks insuring compliance with client procedures as well as Presidium Best Practices.
3. Actively interfaces with client representatives as well as vendor panels.
4. Monitors vendor panel performance and compliance regarding disadvantaged business goal participation.

III REQUIREMENTS:

1. Minimum seven (7) to ten (10) years claim handling experience.
2. Three (3) to five (5) years in management position within workers' compensation environment, with some experience in public entity management.
3. California Self-Insurance License Required
4. College degree preferred, but not required.

JOB DESCRIPTION FOR MEDICAL CASE MANAGEMENT

BASIC FUNCTION:

To provide advice and counseling to the Workers' Compensation Examiners regarding appropriateness of medical treatment by treating physicians. Assist in early intervention of complicated, serious and major injury cases to provide optimum care and cost containment.

Duties and Responsibilities:

* Assist the examiner in early intervention of serious and major injuries so as to determine appropriate treatment authorization. Helps the Examiner provide the injured worker with a sense of security and direction.

* Coordinates and interfaces with the treating physician on serious injury cases and evaluates the necessity of treatment provided.

* Assist the examiners in making timely and reasonable decisions relative to the injured worker's recovery, direction and control of the medical aspect of the claim.

* Reviews all surgical candidates to insure appropriate surgical intervention.

* Reviews all lost time cases, to insure a speedy return to work, providing suggestions for early return to work options.

Qualifications:

* Must be a Registered Nurse
* At least three years experience as an Occupational Health Nurse
* Must have experience working with injured workers and dealing with the psychological factors relative to the injury.
* Well informed in Workers' Compensation process of benefits.
* Ability to interface with other members of case management group and ability to make timely decisions.
* Knowledge of vocational rehabilitation
* Excellent organizational and people skills

Note: The position is a management and advisory position, giving the examiners support and assistance in medical management and cost containment. The position is not intended to maintain a caseload involving unusual illnesses or conditions. The Nurse however, is required to keep a diary of the lost time, serious and major injury claims.