Legislative Budget and Finance Committee

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

Offices: Room 400 Finance Building, 613 North Street, Harrisburg
Mailing Address: P.O. Box 8737, Harrisburg, PA 17105-8737
Tel: (717) 783-1600 • Fax: (717) 787-5487 • Web: http://lbfc.legis.state.pa.us

A Performance Audit of the Emergency Medical Services Operating Fund

Conducted Pursuant to HR 2012-315

September 2013

Table of Contents

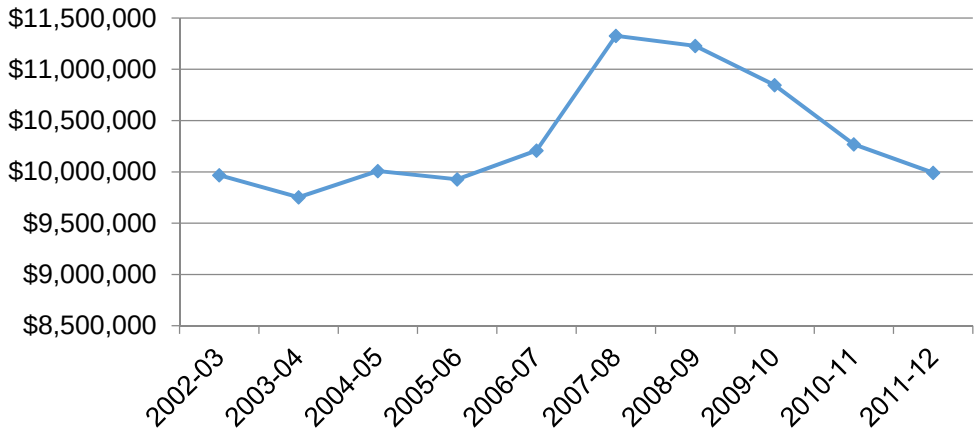
Summary and Recommendations

We found:

The Pennsylvania Department of Health (DOH) is responsible for administering the annual special fund appropriation from the Emergency Medical Services Operating Fund (EMSOF). These funds are used to support the Commonwealth's 15[1] regional councils, the Pennsylvania Emergency Health Services Council, and the Catastrophic Medical and Rehabilitation Fund. By law, 25 percent of EMSOF funds are allocated to the Catastrophic Medical and Rehabilitation Fund, a restricted revenue account used to finance programs for victims of traumatic injury. The remaining 75 percent[2] is used to fund the Commonwealth's regional EMS councils and the Pennsylvania Emergency Health Services Council (PEHSC), a statewide advisory council to the Department of Health. Of the $10.97 million spent out of the EMS portion of the EMSOF in FY 2011-12, the regional councils received $10.48 million (95.5 percent) and PEHSC received $491,949 (4.5 percent).

Funding for the Commonwealth's EMS system has been declining in recent years, from $11.3 million in FY 2007-08 to $10.0 million in FY 2011-12. This decline has been driven primarily by a decline in the revenues generated by the fines on traffic violations and fees on ARD admissions which are deposited into the Emergency Medical Services Operating Fund.

EMS Funding From the Emergency Medical Services Operating Fund
(FY 2002-03 Through FY 2011-12)



Developed by LB&FC staff with Comparative Financial Statement data provided by the PA Department of Health.

[1] Prior to beginning this audit there had been 16 regional councils statewide. In November, 2012 Bradford Susquehanna Regional Council merged with Northeastern Regional Council.

[2] No state General Funds are used to support the EMS system other than the Department of Health's General Government Operations appropriation, which is used for the administrative and operational costs of the Bureau of Emergency Medical Services, which is approximately $1 million annually.

Act 2009-37 requires the department to consider the availability of other funds and the priorities set forth in the statewide EMS plan as factors to be utilized in EMSOF funding allocation decisions, but this is not done. EMS regulations reiterate these factors and list several others (one of which is financial need of the applicant) the Department is to consider in this process. However, the state Bureau of Emergency Medical Services (BEMS) instead allocates available EMSOF funding among the 15 regional EMS councils using a formula that is based only on the total population, rural population, and square mileage of the council's service area. The formula allocates 50 percent of available funding on the basis of total population, 30 percent on the basis of rural population, and 20 percent based on the region's square mileage. The formula and weightings used are not referenced in statute, regulation, or written department program policy.

Regional EMSOF Allocation = A + B + C, when

A = (region population + state population) x 50 percent of available funds
B = (region rural population + state rural population) x 30 percent of available funds
C = (region square miles + state area) x 20 percent of available funds

The extent to which individual regional EMS councils rely on EMSOF funding varies significantly and is largely dependent upon the sources and amounts of "secondary income," including county funds, available to them. Relative dependency of EMSOF funds varies from a low of 11 percent in Chester County to a high of almost 93 percent at EMMCO East. In seven of the regions (mostly rural in nature), EMSOF revenues account for over 75 percent of their total revenues. Since our last audit of EMSOF, the overall dependency on EMSOF funds for regional council expenditures has risen from 29.6 percent to 59.3 percent, statewide.

EMSOF Revenues as a Percent of Total Regional EMS Council Revenues
(FY 2011-12)

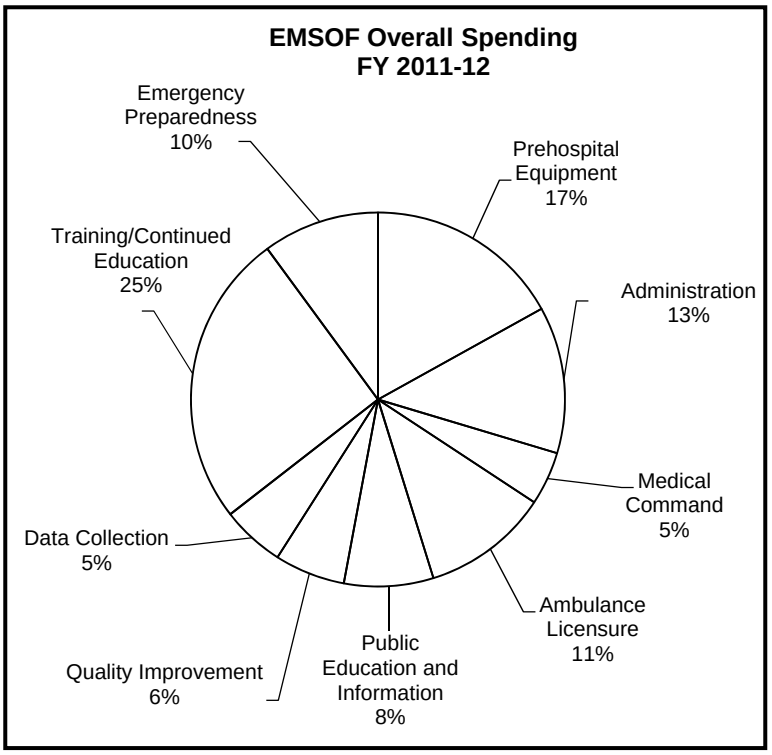
Regional Council	EMSOF Revenue	Total Revenue	EMSOF as % of Total FY 2011-12 Revenue	EMSOF as % of Total FY 1997-98 Revenue
Bradford Susquehanna	$ 239,897.00	$ 284,097.00	84.4%	66.3%
Bucks County	337,827.00	877,527.00	38.5	59.7
Chester County	296,040.00	2,664,561.04	11.1	3.3
Delaware County	249,723.00	426,743.45	58.5	85.5
Eastern PA	1,020,917.00	1,375,514.00	74.2	93.5
EHS Federation	1,447,220.00	1,902,732.00	76.1	99.0
EMMCO East	556,686.00	601,818.44	92.5	97.3
EMMCO West	816,933.00	1,066,702.00	76.6	85.8
EMS Institute	2,030,827.00	2,356,027.00	86.2	98.8
Lycoming, Tioga & Sullivan .	328,724.00	428,344.00	76.7	53.5
Montgomery County	369,387.00	1,175,084.00	31.4	49.8
Northeastern PA	753,775.00	1,109,976.00	67.9	92.6
Philadelphia	649,892.00	1,227,543.89	52.9	3.8
Seven Mountains	380,219.00	712,868.00	53.3	75.7
Southern Alleghenies	688,839.00	1,073,901.00	64.1	85.4
Susquehanna	315,102.00	387,990.00	81.2	84.6
Total	$10,482,008.00	$17,671,428.82	59.3%	29.6%

Regional EMS councils in largely rural areas receive three to four times as much in EMSOF funds on a per capita basis as councils in largely urban areas. Act 37, recognizing that rural areas need additional financial help to serve their populations, provides that at least 10 percent of the EMSOF allocation to the regional councils is to be allocated based on the councils' rural population. The three regional EMS councils that serve primarily rural areas receive $2.22 per capita in EMSOF funds versus $1.11 per capita in mixed urban/rural councils and $0.63 per capita for those EMS councils that serve mostly urban areas. This is largely due to the department awarding 30 percent of the EMSOF funds based on rural population. An additional 20 percent is awarded based on the square mileage covered by the council, which also helps rural counties as then tend to be geographically large relative to their population. EMMCO East, for example, which receives $2.37 per capita in EMSOF funds, encompasses 11.4 percent of the Commonwealth's total square mileage but is home to only 1.9 percent of the state's population. The average statewide allocation per capita is $0.85.

Regional EMS Council EMSOF Allocation Per Capita

Regional EMS Council	FY 2011-12 EMSOF Allocation Per Capita
Bradford Susquehanna	$ 2.28
Bucks County	.56
Chester County	.68
Delaware County	.45
Eastern PA	.78
EHS Federation	.85
EMMCO East	2.37
EMMCO West	1.28
EMS Institute	.76
Lycoming, Tioga & Sullivan	1.95
Montgomery County	.49
Northeastern PA	1.15
Philadelphia	.43
Seven Mountains	1.56
Southern Alleghenies	1.46
Susquehanna	1.23
Total	.85

On average, the 15 regional EMS councils use 55.2 percent of the EMSOF monies they receive for staff salaries and benefits and 14.6 percent to provide equipment to prehospital providers. In FY 1996-97, when we last reported on the EMS system, 42.6 percent of the EMSOF monies received by the regional councils was used for staff salaries and benefits and 23.5 percent for equipment to prehospital providers. The figures shown on the pie chart represent overall spending of EMSOF monies by all the regional councils during FY 2011-12 utilizing expenditure categories established by the Department of Health's Bureau of EMS. These percentages should be viewed with caution, however, as the regional councils have other sources of income which, depending on how they choose to spend that money, could change the percent of EMSOF funds used in any given category.



As shown in the table below, there is wide variation among the councils in how they expended available EMSOF funding.

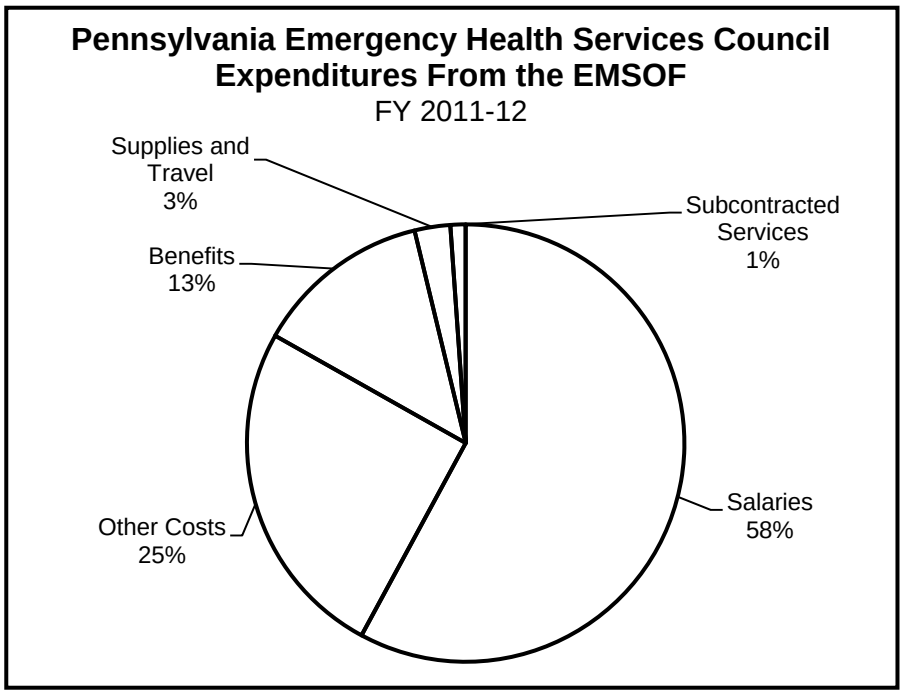
How the EMSOF Dollar Was Used
Regional EMS Councils
(FY 2011-12)

	Amount of EMSOF Dollar Used for:					
Regional Council	Salaries and Benefits[a]	Prehospital Provider Equipment	Training	Travel	Consultant Services	Other Costs
Bradford Susquehanna	48.4%	11.5%	4.2%	1.8%	0.0%	34.1%
Bucks County	51.2	14.8	8.4	2.5	5.0	18.1
Chester County	42.0	27.2	27.2	0.0	0.0	3.5
Delaware County	76.4	0.0	18.6	0.4	0.0	4.6
Eastern PA	63.6	1.0	3.2	2.8	0.0	29.3
EHS Federation	41.6	27.1	8.3	0.3	1.8	21.0
EMMCO East	49.8	18.1	3.0	3.3	0.0	25.8
EMMCO West	62.3	8.9	2.3	1.7	0.2	24.6
EMS Institute	43.2	19.3	4.9	1.2	1.8	29.6
Lycoming, Tioga & Sullivan	51.1	29.0	3.3	2.4	0.0	14.1
Montgomery County	78.0	22.0	0.0	0.0	0.0	0.0
Northeastern PA	69.1	0.7	10.1	1.0	0.0	19.0
Philadelphia	61.6	22.7	4.3	0.2	0.0	11.1
Seven Mountains	67.6	4.8	4.2	3.3	0.0	20.2
Southern Alleghenies	65.1	3.8	2.0	2.0	0.0	27.1
Susquehanna	61.0	2.2	2.6	2.4	0.0	31.7
Statewide Averages FY 2011-12	55.2	14.6	5.8	1.5	0.8	22.1
Statewide Averages FY 1996-97	42.6	23.5	11.7	1.5	1.5	19.2

[a] FY 2011-12 actuals used except for Philadelphia, where FY 2012-13 actuals were used.

Although the percentage of EMSOF funds used for pre-hospital provider equipment (PPE) has decreased from 23.5 percent to 14.6 percent since FY 1997-98, the impact of this decrease may not be particularly significant because EMSOF funds comprise only a small fraction of ambulance company revenues.
We estimated that in FY 2011-12, Pennsylvania's 1,073 ambulance service providers received about $461 million in service revenue from Medicare, Medicaid, commercial insurers, and private payments. By comparison, they received only about $1.5 million in EMSOF monies ($1.1 million to non-regional council providers). There is no set amount (percentage) or methodology mandated by the department to the regional councils requiring them to make awards of PPE funds. The percent of grant funds given to PPE's may have been impacted by the removal of statutory language that previously required that 75 percent of funds had to be spent on "direct support of EMS systems," a phrase the department never defined.

The Pennsylvania Emergency Health Services Council (PEHSC) expended $491,949, or about 4.5 percent of the total spent from the EMSOF's EMS account, in FY 2011-12. The Board of Directors of the Pennsylvania Emergency Health Services Council is designated in law as the state's EMS advisory council (generally referred to as the State Advisory Counci1 or Board). While the State Advisory Council has traditionally received EMSOF funding, an amendment to the EMS Act in 1994 specifically provided for this disbursement. EMSOF funds accounted for about 71.6 percent of PEHSC's total revenue of $686,660 in FY 2011-12. About 71 percent (58 percent in FY 1997-98) of EMSOF monies received by the PEHSC were used for salary and fringe benefit costs. Other major cost items include equipment leasing, office rent, conference expenses, supplies, telephone charges, and consultant services.



The statewide Emergency Medical Services Plan, the most recent version of which was drafted in 2010, is of limited use because it does not include specific time frames to accomplish objectives, often does not identify the parties responsible/accountable to achieve the objectives, and does not include cost estimates to achieve the plan's priorities. Without these types of details and guidance as to how they will be achieved, the plan is little more than a list of statewide goals and priorities.

Regional EMS plans are not incorporated into the statewide EMS plan. Act 2009-37 states that regional councils are to develop their own EMS plans and that these regional plans are to be incorporated officially into the statewide EMS plan. While we found that the regional EMS councils do develop annual work plans that are reviewed and approved by the Bureau of Emergency Medical Services, these

plans are not formally integrated into the statewide plan, nor does the statewide plan provide for such integration.

Lack of automation in the BEMS makes it difficult to monitor regional EMS council expenditures. BEMS still maintains a manual filing system for regional EMS council records. As a consequence, to calculate even basic management information, such as total EMSOF expenditure by council or EMSOF expenditures by purpose, required manual calculations.

BEMS appears to be doing a good job in monitoring and communicating with the regional EMS councils. Our previous review (1998) of the EMS program found that BEMS was not adequately monitoring and enforcing a number of provisions in the contracts with the regional EMS councils. Due to changes in the "boilerplate" language of the regional EMS contracts and other administrative changes, this situation appears to have improved significantly.

DOH regulations provide that the department is to "evaluate the performance and effectiveness of each regional council on a periodic basis." These evaluations, however, are not occurring. In addition to contract monitoring, the DOH is to conduct "performance and effectiveness" reviews to assure that each council is appropriately meeting the emergency medical service needs of its region. Although the department does periodically review the progress reports regions submit on their annual work plans, the department reports its does not have the staff resources to conduct the more comprehensive assessments as outlined in the Department's regulations.

The department has dropped restrictions on the use of secondary income. Until recently, the department's contracts with the regional EMS councils required that the councils report any income generated by secondary activities (i.e., activities not specified in the council's approved work plan). The department would then approve or deny the council's planned use of those funds. This requirement was to ensure that any funds generated through the use of EMSOF monies could only be used for purposes that had been approved by the Department. The department has dropped the requirement that councils report such secondary income, presumably because the councils viewed the requirement as burdensome and served as a disincentive to seek secondary income.

For the most part, the salaries and benefits the regional EMS councils and PEHSC offer their employees appeared reasonably in line with what might be expected if they were Commonwealth employees. Exceptions might include: relatively low salaries (below $65,000) for five regional directors and relatively high for three others (above $90,000), no required employee contribution for health care insurance in six regional councils (and for PEHSC employees), vacation leave payouts upon leave of service of up to two years (the maximum for state employees is 45 days), and unlimited payouts for sick leave accumulation for some employees (at a

60 percent reimbursement rate) at one council (state employees are reimbursed for up to 300 days at a 30-50 percent rate).

Although the required annual audits are being performed by the regional councils, their usefulness is limited due to the lack of a standard template on how they are to be performed and presented. We found that regional councils required to submit audits are submitting them to the department on a timely basis. However, we were unable to compare them to the budgeted EMSOF-funded expenditure information contained in the regional councils' individual grant agreements. This situation is caused by the lack of standards/direction from the department on what information is to be presented in the audit and how expenditures are to be categorized (even though the grant agreements place budgeted amounts into specific set categories, the auditors often moved expenditures into other categories). Additionally, the audit almost always presented total expenditures regardless of funding source (e.g., state, federal, or local grant and secondary income), making it impossible to determine if the EMSOF funds were spent as provided for in the grant agreements. Comparing the agreements and the audits to the regional council's 501(c)(3) tax filings (Federal Form 990) proved to be just as difficult.

The amount deposited into the EMSOF from fines on traffic violations and fees on ARD admissions has fallen from $15.1 million in FY 2007-08 to $13.3 million in FY 2011-12. The decline appears to be due primarily to lower collection rates of fines and fees after they are assessed. This is particularly true for fines assessed at the Common Pleas level. Collection rates at the Common Pleas level have dropped from 63 percent in FY 2006-07 to 34 percent in FY 2011-12 for traffic fines and from 89 percent to 70 percent for ARD admissions. Collection rates at the Magisterial District Justice level (excludes Philadelphia) have also fallen, but less dramatically, from 98 percent in FY 2006-07 to 93 percent in FY 2011-12. Because the Magisterial Districts account for the large majority of assessments, the overall collection rate has fallen from 96 percent in FY 2006-07 to 89 percent in FY 2011-12.

The year-end balance in the EMSOF has declined from $23.0 million in FY 2005-06 to $14.6 million in FY 2011-12. The balance is projected to decline further to only $2.6 million in FY 2016-17. The $10 EMSOF fine for traffic tickets and the $25 ARD fee have not changed since they were first enacted in 1985 and 1988, respectively. Stagnant revenues from these fines and fees, combined with anticipated expenditures in excess of revenues, results in a declining fund balance. If new sources of revenue cannot be found, allocations to the regional EMS councils (and/or to the catastrophic injury program) will need to be reduced over the next several years.

States use a wide variety of funding sources to support their EMS programs. Most states contribute at least some General Fund monies for EMS purposes. EMS professional credentialing fees, ambulance fees, and EMS agency fees

are among the ways other states fund their EMS programs. Pennsylvania does not currently charge fees in any of these areas.

Recommendations

We recommend:

1. **DOH establish parameters on the use of EMSOF funds for salaries and benefits.** While DOH is quite prescriptive in some areas of EMSOF funds utilized (for example, the regional councils must follow Commonwealth travel guidelines), it sets no parameters for the regional councils and PEHSC on salary ranges and benefits offered to employees, allowing a wide degree of latitude in the categories of expenditures that consume the bulk of the EMSOF fund every year (55.2 percent in FY 2011-12). As independent organizations, some flexibility at the council level is understandable. But as entities created under state statute and largely funded with state dollars, it is also reasonable to expect the regional councils will adhere, at least within certain parameters, to key Commonwealth personnel policies and guidelines. While we found this to generally be the case, we did note some wide disparity from council to council, particularly with regard to executive director's salary levels, employee contributions for health care benefits for themselves and their dependents, and vacation and sick leave payouts upon separation from service. We recommend the DOH, in consultation with the Pennsylvania Emergency Health Services Council, review the compensation and benefit structures of the regional councils and PEHSC to ensure they are generally equitable from council to council and in line with those of most Commonwealth employees. If DOH and PEHSC find certain regional councils significantly exceed the guidelines which apply to most Commonwealth employees, changes should be made to the annual contracts between DOH and the regional councils to bring these policies in line.

2. **DOH and PEHSC add greater specificity to the state EMS plan and incorporate the regional EMS plans into the statewide plan.** Timelines, specific identification of the parties responsible to take action, and estimated costs are key factors in any planning document. We recommend DOH and PEHSC review the state EMS plan and add these factors wherever possible. Act 37 also requires that the regional EMS plans be incorporated into the statewide plan, but this has not been done.

3. **DOH, in consultation with the Pennsylvania Emergency Health Services Council, incorporate additional factors into the regional EMS funding allocation decisions, including funds set aside for special projects.** Act 37 and the Department's regulations list multiple factors that are to be

considered when making regional council allocations (e.g., priorities established in the state plan, the availability of other income, and the financial need of the applicant). We found, however, that the department instead allocates funds to the regional councils on a formula basis (50 percent based on total population, 30 percent based on rural population, and 20 percent based on square mileage) without consideration of the other factors listed in either the statute or the regulations. While it may be unrealistic, and possibly unnecessary, for the department to consider all of the factors, conformance to the state plan and the financial need of the applicant would appear to be two of the more important factors that should be considered, especially as they are specifically referenced in Act 37. We also recommend the process used to allocate funds to the regional councils be committed to writing and made available to the public, either through the regulation process or through program guidelines or manuals.

4. **The Department of Health commit to writing the process and decision factors used to allocate funds to the Pennsylvania Emergency Health Services Council.** Currently the amount DOH allocates to PEHSC is determined through an unwritten negotiation process. To promote transparency and help maintain its status as an independent advisor to the department, we recommend the process and decision factors used during these negotiations be placed in writing.

5. **BEMS work to computerize EMS records.** As was the case in 1998 when we reviewed the Commonwealth's EMS program, much of BEMS's data requests and record-keeping is still done using paper-based records and filing systems. Automated electronic record-keeping should improve the efficiency of both the regional councils and the BEMS staff in managing records and improve the BEMS's ability to monitor the operations of the regional councils.

6. **BEMS review the performance of the regional councils, perhaps on a rotating basis, as part of its contracting process.** Act 37 and the Department's regulation contemplate a more in-depth analysis of the efficiency and effectiveness of the regional councils than the periodic annual work plan progress reports submitted by the regional councils. These reviews could be meaningful in that the department has the ability to contract with another entity if a regional council's performance is deemed unsatisfactory.

7. **BEMS prescribe a standard auditing format, including separate identification of EMSOF funded expenditures.** Since BEMS has not prescribed a specific format or otherwise provided audit guidance, the councils, PEHSC, and their auditors are presenting the audited financial infor-

mation in ways that are not consistent from council to council (e.g., expenditure categories utilized, level of detail, and identification of source of funding). This results in audits that not only are inconsistent in their presentation from council to council, but also do not allow the department to determine whether a council had properly accounted for its revenue, and more importantly, spent its EMSOF allocations as specified in the grant agreement. Obtaining copies of the Federal IRS Form 990 would allow the department further information for reviewing regional councils' and PEHSC's fiscal performance.

8. **DOH reconsider, with PEHSC's input, imposing restrictions on the use of income from the regional councils' secondary activities.** With the gradual loss of EMSOF funds likely to continue, at least on an inflation-adjusted basis, regional councils should be encouraged to generate secondary income. However, when this secondary income is generated through the use of Commonwealth-funded resources, the department has a legitimate interest in ensuring that the secondary income is used for purposes directly related to the maintenance or improvement of the EMS system. We recommend the DOH consult with the PEHSC to determine an appropriate level of accountability over such secondary income and that the accountability mechanism be incorporated into the DOH contracts with the regional councils and PEHSC.

9. **The General Assembly consider options to bolster EMSOF revenues.** In FY 2011-12, the EMSOF receipts from fines, fees, and interest was $13.8 million. Disbursements, however, were $16.2 million, which reduced the balance in the Fund from $18.1 million at the beginning of the fiscal year to $15.6 million at the year's end. The department expects expenditures to exceed revenues for the next several years, reaching a year-end balance of only $2.6 million in FY 2016-17. Declining collection rates, particularly at the Common Pleas level, partially explains this downward trend. Additionally, the $10 fine on traffic violations and the $25 fee for ARD admissions have not been increased since they were first initiated in 1985 and 1988, respectively. We also note that many states charge fees for such services as professional credentialing of EMS personnel and ambulance inspections as ways to help fund their state EMS programs.

I. Introduction

This audit, performed pursuant to HR 315 of legislative session 2011-12, is the latest in a series of Legislative Budget and Finance Committee (LB&FC) reviews of the Emergency Medical Services Operating Fund (EMSOF). As required by HR 315, this review was done in conjunction with the Joint State Government Commission (JSGC). Our review focuses primarily on the financial aspects of the program, whereas the JSGC's task was focused on EMS system structural and service delivery issues.

Audit Objectives

Consistent with HR 315, this audit had the following objectives pertaining to the Legislative Budget and Finance Committee:

1. To conduct a performance review of the financial administration of the emergency medical services system under the Emergency Medical Services Operating Fund. The performance review shall include an analysis of the Bureau of Emergency Medical Services, the Pennsylvania Emergency Health Services Council and the regional emergency medical services councils.
2. To analyze the revenue generating capacity of current state EMS funding mechanisms and the current and projected financial condition of the EMSOF.
3. To prepare a comprehensive listing of both the expenditures of the Emergency Medical Services Operating Fund and a comprehensive listing of all compensation packages of all employees of the regional emergency medical services councils including the Pennsylvania Emergency Health Services Council (PEHSC).
4. To evaluate the Department's implementation of recommendations related to funding and expenditures contained in previous LB&FC audits of the EMSOF.

Scope and Methodology

This audit focused on the administration and use of the EMS portion of the state's Emergency Medical Services Operating Fund. While this report often utilizes financial information reported in our previous study released in 1998 for comparison purposes, the audit focuses on the administration and use of the Fund from FY 2006-07 through FY 2011-12, with particular attention given to EMSOF allocations and expenditures during FY 2011-12. The EMSOF account which funds the Pennsylvania Head Injury Program (referred to as the Catastrophic Medical and

Rehabilitation Fund) was not within the scope of this audit. Also, we did not conduct a financial audit of the Fund or of EMSOF recipients. Accordingly, we express no opinion on the financial statements presented in this report.

Audit activities included a series of meetings and interviews with officials and staff of the Department of Health, the Pennsylvania Emergency Health Services Council, and with the state's 15[1] regional EMS councils. Department of Health employees also obtained additional information, at our request, from the regional councils and PEHSC including, but not limited to, the information necessary to develop the comprehensive listing of all compensation packages of all employees of the regional emergency medical services councils and PEHSC.

Members of the audit team conducted examinations and analyses of EMSOF and EMS program files including copies of each council's EMSOF contract, profile information on each region and its EMS resources, copies of planning documents and work programs, and revenue and expenditure data. Field visits were made to prehospital providers, as well. In some instances, LB&FC staff conducted follow-up work to determine the status of findings and recommendations made in prior Committee reviews of the EMSOF.

To obtain legislative input, LB&FC staff spoke directly with staff of the standing committees having jurisdiction on the subject matter in both the House of Representatives and the Senate (Veterans Affairs and Emergency Preparedness). To obtain comparative information on EMS systems and funding, we contacted the National Association of State EMS Directors and performed online research.

Using FY 2011-12 as a sample year, we applied the Department's formula and examined allocation records to test the accuracy of the amounts disbursed to the regional councils. We also examined the method used to allocate EMSOF monies to the State Advisory Council and the process through which the DOH establishes EMSOF spending priorities. Budget requests, grant agreements and contracts, expenditures, program files, and financial audit reports were then used to compile data on the purposes for which these EMSOF funds were expended.

To analyze the revenue-generating capacity of current state EMS funding mechanisms, LB&FC staff obtained current and past data on annual revenue collections from the Act 45 funding mechanisms ($10 EMS fine and $25 ARD admission fee) from the Administrative Office of Pennsylvania Courts (AOPC). To assess the EMSOF's current and projected financial condition, we examined the Fund's comparative financial statement and five-year projections. Current and projected fund balances were also evaluated in the context of trend data on traffic violations and ARD admissions and in relation to total estimated EMS system current funding needs. We were unable to relate this data to funding needs according to the State

[1] Bradford Susquehanna EMS Council merged with Northeastern EMS, in November 2012.

EMS Development Plan because cost estimates to put the plan in place were not derived.

To examine and evaluate the administration of EMSOF funds and the resulting EMS program by the Department of Health, we documented all aspects of EMSOF administration including, (1) planning for EMS system development, including the creation and implementation of the State EMS Development Plan and the expenditure of EMSOF monies; (2) awarding of contracts; (3) allocating EMSOF monies; (4) establishing EMS spending priorities; (5) providing program direction and guidance; (6) administering and monitoring contracts; and (7) evaluating regional council performance and performing quality assurance activities.

Acknowledgments

LB&FC staff gratefully acknowledge the cooperation and assistance which the Department of Health program and administrative officials and staff, the state's 15 regional EMS councils' directors and staff, and the Pennsylvania Emergency Health Services Council executive director and board members, provided during the audit. Numerous individuals representing organizations from all facets of the EMS community in Pennsylvania also contributed to the completion of this report.

LB&FC staff also acknowledge the assistance provided by representatives of the Administrative Office of the Pennsylvania Courts, the Office of Administration, the PA Ambulance Association, and the National Association of State EMS Directors.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as indicating that the Committee's members endorse all the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. EMS Funding in Pennsylvania and the Role of the Emergency Medical Services Operating Fund (EMSOF)

Nationally, emergency medical services (EMS) systems are funded by a combination of public and private funds. Primary among EMS revenue sources are governmental subsidies in the form of tax dollars, subscription revenues, and service fees. Additionally, some states fund at least a portion of EMS costs from alternative revenue sources, such as fees on vehicle or driving licenses, motor vehicle violations, and other special taxes and fees. Today, EMS funding in Pennsylvania includes special state revenues, federal funding, local government contributions, subscription revenues, donations, and service fees.

EMS Funding Sources

State General Fund Expenditures

Pennsylvania's statewide EMS system no longer receives direct funding support from the General Fund. The EMS program received a separate line-item EMS appropriation until FY 1989-90. This appropriation peaked at $1.9 million in FY 1985-86. In its final year, the amount of this appropriation was $1.4 million. Since that time, General Fund monies have been available to the EMS program only from the Department of Health's (DOH) General Government Operations (GGO) appropriation and are used only for the administrative and operational costs of the Bureau of Emergency Medical Services.

Members of the EMS community have often questioned the absence of General Fund monies for EMS program purposes. Although not stated in Act 2009-37 or its predecessor statute, Act 1985-45, or related legislative discussion at the time of their respective passages, many persons believed that EMSOF monies were to supplement rather than replace General Fund support of the statewide EMS system.

Dedicated State Revenues

The Emergency Medical Services Operating Fund was created by Act 1985-45, 35 P.S. §6921 et seq., at §6934(c). This law was subsequently repealed and replaced by Act 2009-37. The General Assembly annually appropriates monies from this fund to the DOH to finance both the statewide EMS system and the state's Catastrophic Medical and Rehabilitation Program. In its capacity as the Commonwealth's EMS lead agency, the Department of Health is responsible for statewide EMS system development, including administration of the EMSOF. This mission is carried out through the department's Bureau of Emergency Medical Services

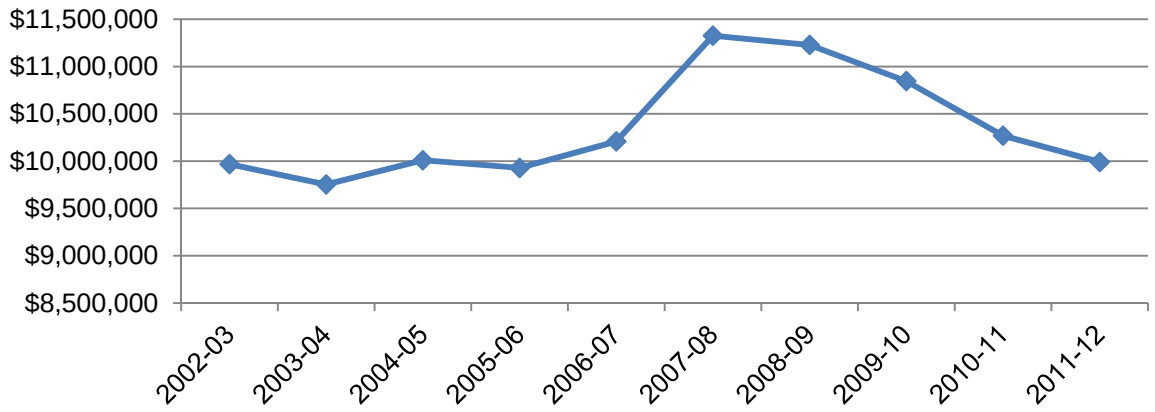
(BEMS), 16 regional EMS councils,[1] and the statewide advisory board (Pennsylvania Emergency Health Services Council.)

Sources of EMSOF Revenue. EMSOF revenues are derived from fines first enacted in 1985. One is a $10 fine that is levied on all traffic violations exclusive of parking offenses under 75 Pa.C.S. §3121. The second is a $25 fee that is imposed upon all persons who are admitted to programs for Accelerated Rehabilitative Disposition (ARD) for offenses relating to driving under the influence of alcohol or controlled substances levied under 75 Pa.C.S. §3807(b)(1)(ix). These revenues are collected by the court imposing the fines and fees and are forwarded to the Treasury Department for deposit into the EMSOF. Section 8153 of Act 37 also provides that all fees, fines, and civil penalties collected by the department under this chapter, appropriations from the General Assembly, any interest earned on the Fund balance, and any contributions shall also be deposited into the Fund.

During FY 2011-12, a total of $13.768 million was derived from all of these sources. Of this amount, $13.322 million was derived from fines and fees, therefore 75 percent, or $9.991 million, was available for EMS operational activities. Exhibit 1, below, shows the pattern of EMSOF revenues for EMS operational activities from FY 2002-03 through FY 2011-12.

Exhibit 1

MS Funding From the Emergency Medical Services Operating Fund
(FY 2002-03 Through FY 2011-12)



Source: Developed by LB&FC staff from Comparative Financial Statements prepared by the PA Department of Health for the Emergency Medical Services Operating Fund.

Purposes of EMSOF Expenditures. Act 37 provides that fund monies be deposited into two separate accounts. Twenty-five percent of the EMSOF fine money collected is allocated to a restricted revenue account known as the Catastrophic

[1] The current number of regional councils is 15 due to the merger of the Bradford Susquehanna Council into the Northeastern PA Council effective November 12, 2012. Because our analysis is based on FY 2011-12 data they are included as a separate region for purposes of this report.

Medical and Rehabilitation Fund. This account finances the department's programs for victims of traumatic injury. The remaining 75 percent of the EMSOF revenues are allocated to the Fund's EMS operational account. As established in section §8153(c) of the law, the monies in the EMS portion of the Fund shall be disbursed by the department for only the following uses:

(1) To eligible EMS agencies for applicable purposes stated under section 8112(c) (relating to contracts and grants), with at least 10% of these funds to be allocated to provide additional financial assistance for those EMS systems serving rural areas.
(2) To the board for the performance of duties imposed upon it under this chapter.
(3) To regional EMS councils for the development, maintenance and improvement of EMS systems, including ambulance and communications equipment, and for training, education and EMS agency licensure purposes.
(4) To other contractors and grantees as authorized under section 8112(j).

The law requires that at least 10 percent of this 75 percent be allocated to provide additional financial assistance to emergency medical services systems serving rural areas. The Health Department allocates this 75 percent share of the EMSOF monies to the Pennsylvania Emergency Health Services Council and to the regional EMS councils. EMSOF monies are also used to fund special EMS projects which have statewide interest and impact.

Act 37 also continues to maintain a provision (§8153(e)) that was added to the Commonwealth's EMS law in 1988, which calls for the Auditor General to audit collections and expenditures made under this section and report its findings to the General Assembly annually. The audit shall include a review of the collections and expenditures of the regional EMS councils. Although these annual audits have not been performed as of the writing of this report, the Auditor General's office informed us that they are beginning to work on an audit of the EMSOF.

As of June 30, 2012, the balance in the EMSOF was $14.56 million, of which approximately $10.92 million was available in the EMS account. However, currently, EMS expenditures outpace revenues. Further information on the fund's financial condition and fund projections are presented in Chapter VI of this report.

Federal Funds

For many years, state preventive health services received federal assistance through several categorical grant programs. Federal monies for emergency medical services continued to be available from the Preventive Health and Human Services (PHHS) block grant through FY 1986-87. The transfer of block grant monies to the EMS program was discontinued once the EMSOF was created in 1985. Also, with

the establishment of the EMSOF in 1985, National Highway Traffic Safety Administration (NHTSA) monies formerly available to the DOH for emergency medical services were redirected to other programs at PennDOT.

Currently, federal funding for EMS purposes in Pennsylvania is available mainly through the U. S. Department of Health and Human Services, specifically through the Hospital Preparedness Program (HPP). The HPP provides leadership and funding through grants and cooperative agreements to states to improve surge capacity and enhance community and hospital preparedness for public health emergencies. The majority of these grant funds are passed through, in varying amounts, to the regional councils to be utilized for regional planning coordinator positions and related activities (portable hospital and Mobile Emergency Communications trailers, mobile kitchens, strike team capabilities, and various miscellaneous activities, including burn management and additional funds to Eastern MEDCOM Center). A portion of these federal funds are retained by the bureau to fund five full-time positions there that work on these programs.

The department also receives an ongoing grant from the Department of Health and Human Services for activities to enhance EMS for children. Entitled Pediatric Prehospital Emergency Care, funding from this source focuses on EMS activities for the pediatric target population which requires special care. For FFY October 1, 2006, through September 30, 2012, the department was awarded a total of approximately $538,000 for this purpose. These funds are currently regranted to the Pennsylvania Emergency Health Services Council to administer the program. Exhibit 3 shows the amount of federal funds the state's EMS system has received (approximately $22.7 million) for all of these purposes from FY 2006-07 through FY 2011-12. A further breakdown of the federal funds awarded to the specific regional councils, which totaled slightly over $18.5 million for these same fiscal years, is found on Table 15 on page 62.

Table 1

EMS Funding to Pennsylvania From Federal Sources
(FY 2006-07 Through FY 2011-12)

	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	Total
B of EMS Total	$ 140,986	$ 149,248	$ 672,867	$1,650,498	$ 603,664	$ 412,911	$ 3,630,174
BEMS Personnel Portion.....	124,721	116,454	344,338	313,247	342,642	308,436	1,549,838
Regional Councils ..	2,460,000	2,185,497	3,542,124	5,703,381	2,344,500	2,287,391	18,522,893
PEHSC [a] ..	111,624	90,000	68,376	90,000	90,000	90,000	540,000
Total	$2,712,610	$2,424,745	$4,283,367	$7,443,879	$3,038,164	$2,790,302	$22,693,067

[a]EMSC grant, regranted from the Bureau of Emergency Medical Services to PEHSC.

Source: Bureau of EMS and PEHSC revenue by source data.

Additional Regional EMS Council Income

Many of the state's regional EMS councils receive funding from sources other than the Emergency Medical Services Operating Fund. This "secondary income" has been formally defined in previous three-year contracts as

> ... funds available to the contractor from non-state funding sources pertaining to emergency medical services ... [which] include the outlay of cash and in-kind services by or to the contractor or toward the operation of any emergency medical services system by private, public, or governmental third parties including the federal government…

Secondary income supplements the EMSOF funding for regional EMS council administrative and operating costs. Regional EMS councils receive secondary income from a variety of sources, including county governments, hospitals and community colleges, conferences, textbook sales, training tuition and related charges, and miscellaneous sales (e.g., sale of a vehicle and EMS patches). In some cases, this income takes the form of in-kind services. For example, some councils receive in-kind assistance from their county governments in the form of office and facility space, utilities, postage, and other operating and administrative services.

The regional councils reported secondary income totaling approximately $4.9 million in FY 2011-12. A discussion and breakdown of secondary income by regional EMS council is shown in Chapter IV of this report.

The grant agreements in effect in FY 2011-12 are silent on the issue of the generation and approved uses for secondary income the regions generate from secondary activities, as the BEMS removed previously used language from the agreements. Previous agreements had defined secondary activity as "any activity or work not specified in the approved Work Program," and contained several requirements governing its generation and use that had been in place at the time of our previous report. One such requirement was that the contractor was not to engage in any activity that uses a resource (manpower, equipment, supplies, rental space, etc.) that has been funded with EMSOF monies without the approval of the DOH.

The previous contracts also required that once secondary income was generated, the regional councils had to deposit these monies into a separate, insured, interest bearing account. Further, the use of certain secondary income[2] had to be preapproved, in writing, by the Department of Health. Finally, all secondary income, including the interest it earns, which was not used at the end of the contract period, had to be returned to the Department of Health or, at the discretion of the department, be rolled over into a subsequent contract.

During our previous review, a number of regional EMS personnel expressed concerns about the contract provisions dealing with secondary income, believing that they were burdensome and served as a disincentive for regional councils to seek secondary income. This may be why all reference to secondary income and the previously required reports were removed from the standard contract language before the current contracts were negotiated. We were notified by the department, in writing, that the language requiring the submittal of secondary income and activities reports by the regional councils and PEHSC will be contained in the contracts for the 2013-14 fiscal year.

Licensed Ambulance Services Revenue

The Commonwealth's 1,073 licensed ambulance services (down from 1,128 licensed ambulance services in 1998) generate revenues through subscription fees, service charges, and various fund-raising activities. While comprehensive information is not available on total revenues generated and expended by the ambulance services, it is possible to estimate revenues generated from service charges to patients through third-party reimbursement systems.

Utilizing information obtained from trip reports made by Pennsylvania's ambulance providers for Medicare reimbursement purposes, we found that there were 7,420,000 billable Medicare claims by Pennsylvania ambulance providers in FFY 2011-12. These claims represent 6,520,039 trip miles and 899,961 billable Medicare

[2] Those funds which are the result of secondary activities which required Department approval also need to be approved by DOH prior to their use.

trips. These Medicare trips provided a total of $319,350,150 ($253,617,029 in federal payments and $63,870,030 in required match payments) in revenue to Pennsylvania's ambulance service providers. Table 2 shows the breakdown of these Medicare reimbursed dollars in Pennsylvania in FFY 2011-12.

Table 2

Medicare Reimbursements to Pennsylvania Ambulance Providers
(FFY 2011-12)

Description	Allowed Claims	Allowed Dollars	80% Dollars Paid[a]	20% Dollars Paid
Ground Mileage	6,416,884	$ 47,090,834	$ 37,646,137	$ 9,418,167
ALS Non-Emergency	13,763	3,515,776	2,790,051	703,155
ALS Emergency	212,624	85,855,941	67,939,519	17,171,188
BLS Non-Emergency	503,314	111,310,272	88,702,044	22,262,054
BLS Emergency	161,702	55,420,910	43,751,711	11,084,182
Fixed Wing	3	8,394	6,715	1,679
Helicopter	2,345	9,680,684	7,644,198	1,936,137
ALS-2	3,940	2,316,045	1,834,621	463,209
Specialty Care Transport	2,270	1,249,250	996,195	249,850
Fixed Wing Mileage	678	5,461	4,369	1,092
Helicopter Mileage	102,477	2,896,582	2,301,467	579,316
Total	7,420,000	$319,350,150	$253,617,029	$63,870,030

[a] Dollars paid do not always equal 80 percent in each category so 80 percent/20 percent paid does not equal allowed dollars.

Source: PEHSC, May 2013.

A 2007 study found that about 55 percent of revenues for an average EMS system come from Medicare, 15 percent from Medicaid, 25 percent from the commercially insured, and 5 percent from private payment.[3] Put another way, 60 percent of billable trips are Medicare trips, 20-25 percent of billable trips are covered by commercial insurance companies, private payers pay for another 15 percent of billable trips, and Medicaid covers approximately 5 percent of the billable trips. Nine to 10 percent of trips are considered uncollectable/bad debt.

Using these assumptions, we estimate that approximately $461,121,871 was provided in service charge related revenue to ambulance providers in Pennsylvania from all sources in FY 2011-12. Since the Medicare reimbursement rate has been considered as a base rate for the private insurance industry, our estimate assumes that private insurance companies, at a minimum, reimburse the Medicare rate. In 1994, the Department of Health calculated that revenues from all sources for services rendered by licensed ambulance providers generated a minimum of $274,885,000, showing an increase of 68 percent in revenues in approximately the last 20 years.

[3] "Management and Financing of Emergency Medical Services," NC Med, July/August 2007, p. 259.

The Department of Health provided statistics obtained from the Centers for Medicaid and Medicare Services, which showed a total of 1,678,255 billable ambulance responses in Pennsylvania in FY 2011-12 as reported by the ambulances providers through the National EMS Information System. This is 68 percent higher (up from 1 million billable trips) than reported to us in CY 1994. In estimating licensed ambulance services' revenue, however, consideration must be given to the charges that may not be recovered due to patients who are uninsured or personally responsible for payment, reported above to be about 9-10 percent of billable trips annually.

A portion of local service provider income is sometimes used as local matching funds for EMSOF monies provided to them. For FY 2011-12, the required match ratio was 60 EMSOF/40 local for providers in rural areas and 50 EMSOF/50 local for providers in urban areas.

Overview of Pennsylvania's Prehospital Response System

An EMS system is the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of emergency medical services required in the prevention and management of incidents which occur either as a result of a medical emergency or an accident, natural disaster, or similar situation.

Prehospital Personnel

First Responders, EMTs, and EMT-Paramedics make up the first line of response in the emergency medical care system. First Responders are individuals who are certified by the Pennsylvania DOH to provide the initial level of care within an EMS system as defined by the *EMS Education and Practice Blueprint.* EMTs and EMT-Paramedics are individuals trained and certified to provide prehospital emergency medical treatment in accordance with the National Standard Curriculum for EMTs and the Paramedic National Standard Curriculum as adopted by the U.S. Department of Transportation.

In 1975, the first year after the DOH implemented EMT and EMT-Paramedic training programs, 4,397 EMTs and 620 Paramedics were certified. As shown on Table 3, the Commonwealth currently has 4,840 First Responders, 38,435 EMTs, 10,146 EMT-paramedics, 1,628 prehospital RNs, and 388 prehospital physicians. Table 3 compares these figures to those we reported in our 1998 report. Although the total number of certified personnel existing in 2012 has grown overall, when you factor in corresponding population growth, the number of certified personnel in all categories per 100,000 population has fallen marginally, from approximately 452 to 436 statewide.

Table 3

EMS Prehospital Personnel in PA, by Certification Level
(1985, 1997, and 2012)

	Number			Per 100,000 Population		
Certification Level	1985	1997	2012	1985	1997	2012[a]
First Responders	2,955	10,223	4,840	24.9	84.7	38.1
EMTs	24,092	37,055	38,435	203.0	307.0	302.6
EMT Paramedics	3,143	6,733	10,146	26.5	55.8	79.9
Prehospital RNs	-	589	1,628	-	4.9	12.8
Physicians	-	-	388			3.0
Total	30,190	54,600	55,437	254.4	452.4	436.4

[a] Total Pennsylvania population used was 12,702,379 as per the 2010 U.S. census.

Source: Developed by LB&FC staff from information maintained by the Department of Health.

Licensed Ambulance Services

As lead agency for EMS, the DOH has the authority to establish minimum standards for ambulance services. In their earliest form, these standards were established as part of the department's Voluntary Ambulance Service Certification (VASC) program. The VASC program recognized those ambulance services which voluntarily met certain minimum requirements, including vehicle design standards, at least one EMT participation on each emergency call, essential medical equipment, and communications capabilities.

In 1990, the Commonwealth adopted a mandatory ambulance licensure program. The objective of this program is to ensure that all ambulance services comply with the Emergency Medical Services Act and its rules and regulations in order to meet the requirements for licensure to ensure they provide at least a minimum standard of care. Table 4 shows the number of ambulance services and vehicles by regional council for calendar year 2012.

Table 4

Number of Ambulance Services and Ambulance Vehicles By Regional Council
(CY 2012)

Regional Council	Ambulance Services	Ambulance Vehicles
Bucks County	73	306
Chester County	32	150
Delaware County	53	223
Eastern PA	94	479
EHS Federation	135	598
EMMCO East	37	153
EMMCO West	71	200
EMS Institute	142	703
Lycoming, Tioga, Sullivan	39	97
Montgomery County	76	335
Northeastern PA[a]	130	481
Philadelphia	76	470
Seven Mountains	25	83
Southern Alleghenies	62	198
Susquehanna	28	83
Total	1,073	4,559

[a] Includes totals for Bradford Susquehanna due to merger in November 2012.

Source: Developed by LB&FC staff from data provided by the Department of Health, Bureau of EMS.

Each EMS service, along with its vehicle(s), is subject to inspection by the DOH or its representative. Such inspections are to be conducted from time to time as deemed appropriate or necessary, but not less than once every three years. As Table 4 shows, as of 2012 there were 1,073 standalone distinct ambulance services in Pennsylvania and 4,559 ambulance vehicles, all of which are licensed.

III. EMSOF Administration by the Department of Health

The Pennsylvania Emergency Medical Services Act, Act 2009-37, was enacted to ensure that residents of and visitors to the Commonwealth have prompt and unimpeded access to emergency medical care at both the basic and the advanced life support levels. To promote access to such services, Act 37 provides for the development of a comprehensive statewide EMS system and designated the Pennsylvania Department of Health (DOH) as the Commonwealth's lead EMS agency. As lead agency, the department is to plan, guide, assist, and coordinate the development of area-wide EMS systems into a unified statewide system and to coordinate that system with similar systems in neighboring states.

The Bureau of Emergency Medical Services

Within the Department of Health, the Bureau of Emergency Medical Services has primary lead agency responsibilities for the state's EMS system, reporting directly to the Deputy Secretary for Health Planning and Assessment. The bureau is responsible for administering the statewide system, including the Emergency Medical Services Operating Fund (EMSOF), in conjunction with 16 (15 as of November 2012) contracted regional EMS councils and the Pennsylvania Emergency Health Services Council. The bureau's responsibilities include EMS training and certification, technical assistance, data collection and quality assurance, ambulance inspection and licensure, EMS communications development, preparation of a comprehensive EMS development plan, and the award and administration of contracts with EMS regional councils and service providers. Specifically under §8105 of Act 2009-37, as lead agency, the department is required to:

> §8105. Duties of department.
>
> (a) Duty. It shall be the duty of the department to assist in the development of local EMS systems; plan, guide and coordinate the development of regional EMS systems into a unified Statewide system; and coordinate systems in this Commonwealth with similar systems in neighboring states.
>
> (b) Authority. The department shall be the lead agency for EMS in this Commonwealth. The department is authorized to:
>
> (1) Coordinate a program for planning, developing, maintaining, expanding, improving and upgrading EMS systems in this Commonwealth.
>
> (2) Establish, by regulation, standards and criteria governing the awarding and administration of contracts and grants under this chapter for initiation, maintenance and improvement of regional EMS systems.
>
> (3) Require collection and maintenance of patient data and information in EMS patient care reports by EMS agencies.

(4) Collect, as deemed necessary and appropriate, data and information regarding patients who utilize emergency departments without being admitted to the facility and patients admitted through emergency departments, trauma centers or directly to special care units, in a manner that protects and maintains the confidential nature of patient records. The data and information shall be reasonable in detail and shall be collected pursuant to regulations issued by the department. Data and information shall be limited to that which may be used for specific planning, research and quality improvement purposes and shall not be duplicative of data and information already available to the department.

(5) Prepare and revise a Statewide EMS system plan under section 8111 (relating to comprehensive plan).

(6) Define and approve training programs and accredit educational institutions for EMS training of EMS providers.

(7) Provide technical assistance to local governments, EMS agencies and other entities for the purpose of assuring effective planning and execution of EMS.

(8) Administer contracts and grants authorized under this chapter and other grants pertaining to EMS.

(9) Establish standards for the licensing, registration and operation of EMS agencies and inspect EMS agencies for compliance with this chapter and regulations adopted under this chapter.

(10) Maintain a quality improvement program for the purpose of monitoring and improving the delivery of EMS.

(11) Promulgate regulations to establish standards and criteria for EMS systems.

(12) Integrate all trauma centers accredited pursuant to section 8107 (relating to Pennsylvania Trauma Systems Foundation) into the Statewide EMS system.

(13) Recommend to 911 and other EMS agency dispatchers protocols with respect to the type and quantity of EMS resources to dispatch to emergencies.

(14) Investigate, based upon complaints and information received, possible violations of this chapter and regulations under this chapter and take disciplinary actions, seek injunctions and refer matters for criminal prosecution.

(15) Investigate complaints concerning delivery of services by trauma centers and forward investigation results to the appropriate accrediting entity with a recommendation for action.

(16) Enter into agreements with other states which may include, as appropriate to effectuate the purposes of this chapter, the acceptance of EMS resources of other states that do not fully

satisfy the requirements of this chapter or regulations adopted under this chapter.

The statute, at §8105(c), also mandates that the department establishes EMS transport and treatment criteria and protocols to ensure that patients receive appropriate EMS care. Further regional EMS councils are not eligible for contracts or grant funds or State EMS Operating Fund disbursements unless they assist in ensuring regional implementation of the criteria and protocols.

As of January 2013, the Bureau of EMS had an authorized complement of 16 positions, 3 of which were vacant as of June 2013. This is an increase of six positions from early 1998, the date of our previous study. The organization of the complement at the time of this audit is shown on Exhibit 2. As of the time of this writing, the Director of the Bureau of Emergency Medical Services was also acting in the capacity of Director of the Bureau of Public Health Preparedness due to a vacancy.

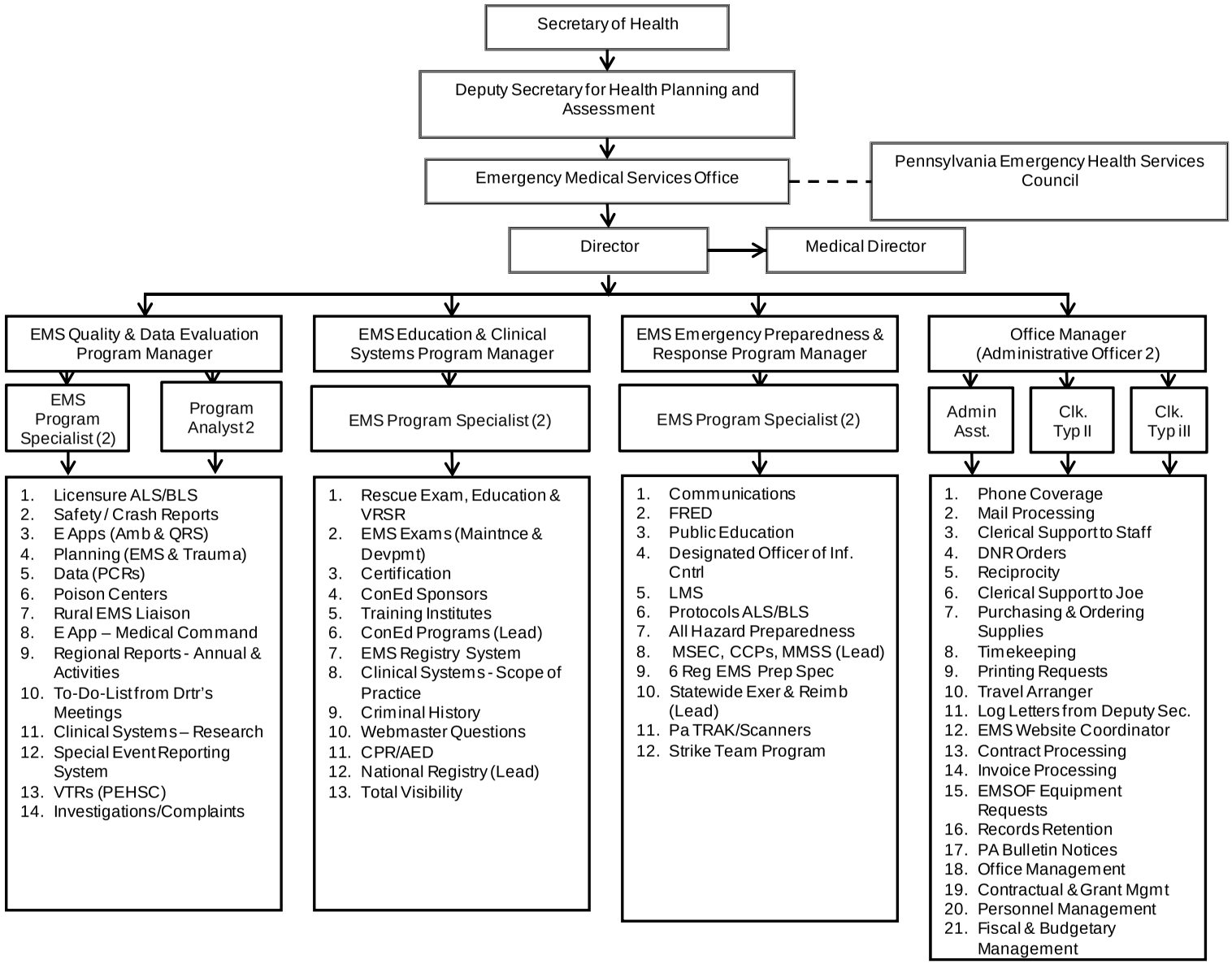
Bureau Funding. The operation of the DOH's Bureau of Emergency Medical Services (BEMS) is funded solely from the department's Appropriation 181, known as the General Government Operations (GGO) appropriation. In FY 2011-12, the BEMS had a budget of $1,001,107. This is an increase of 96 percent from the FY 1996-97 expenditures of $511,362. Personnel services, salaries, and benefits accounted for 75 percent of the Office's total spending, while 20 percent of expenditures are related to items such as printing, travel expenses, and office supplies.

Under §8153(c) of the law, no EMSOF monies are available to fund the Bureau of EMS programs or operations. While not expressly prohibited from using EMSOF monies, it appears that the intent of Act 37 is to restrict the use of EMSOF monies to the regional EMS councils, the State Advisory Council, and local prehospital providers.

> …the monies in the EMS portion of the fund shall be disbursed by the department for *only* (emphasis added) the following uses:
>
> (1) To eligible EMS agencies for applicable purposes stated under section 8112(c) (relating to contracts and grants), with at least 10% of these funds to be allocated to provide additional financial assistance for those EMS systems serving rural areas.
>
> (2) To the board for the performance of duties imposed upon it under this chapter.
>
> (3) To regional EMS councils for the development, maintenance and improvement of EMS systems, including ambulance and communications equipment, and for training, education and EMS agency licensure purposes.
>
> (4) To other contractors and grantees as authorized under section 8112(j).

Exhibit 2

DOH Bureau of Emergency Medical Services Organization Chart



Source: Developed by LB&FC staff from information provided by the Bureau of Emergency Medical Services.

Although this section of the statute was amended by Act 1994-82 to specifically authorize the use of EMSOF monies for the State Advisory Council, the General Assembly did not add language authorizing its use for the BEMS's administrative and operating costs.

Current program regulations promulgated by the department for disbursement of EMSOF funds, 28 Pa. Code §1001.1 et seq., do not address the use of EMSOF by the department for administrative costs. The regulations specify the criteria to be used by the department in funding potential contractors and the factors to be used by the department in determining who shall receive funding and in what amount.

EMSOF Administration

The DOH's Bureau of EMS has primary responsibility for administering the Emergency Medical Services Operating Fund. To assess the department's performance in administering the Fund, we examined the following components of program administration: (1) planning for EMS system development and the expenditure of EMSOF monies, (2) awarding of contracts, (3) allocating EMSOF monies, (4) establishing EMS spending priorities, (5) contract administration and monitorship, and (6) evaluating regional council performance and performing quality assurance activities.

Planning for the Expenditure of EMSOF Monies

Act 2009-37 requires the department, with the assistance of PEHSC, to "prepare a Statewide EMS system plan, which plan shall include both short-range and long-range goals and objectives."[4] According to the Act, the Statewide Plan is to contain, at a minimum:

1. An inventory of EMS resources available within this Commonwealth.
2. An assessment of the effectiveness of the existing EMS system and a determination of the need for changes to the EMS system.
3. Performance measures for delivery of EMS to all persons in this Commonwealth.
4. Methods to be used in achieving the stated performance measures.
5. A schedule for achievement of the stated performance measures.
6. A method for monitoring and evaluating whether the stated performance measures are being achieved.
7. Estimated costs for achieving the stated performance measures.[5]

[4] Act 2009-37, Subchapter B, §8111(a)(1).
[5] Act 2009-37, Subchapter B, §8111(b).

The requirement for DOH to develop an EMS Plan did not begin with Act 2009-37 and has been in existence since Act 1985-45. Through the years, however, the department has had difficulty complying with this requirement in a timely manner and since the mid-1990s has chosen to include the development of the state system plan in the activities that it contracts to PEHSC.

The most recent version of the plan was published by the Pennsylvania Emergency Health Service Council, at the direction of the Department of Health, in June 2010.[6] The work on the plan had begun two years earlier and was modeled on a national planning model put forth by the National Highway Traffic Safety Administration.[7] This document was modified to "reflect the particular attributes and needs of EMS within the Commonwealth."[8] The plan was developed with the assistance of a multidisciplinary task force established by PEHSC and recruited from stakeholders across the state. Stakeholders included EMS providers, agencies, representatives from hospitals, trauma centers, nursing, and DOH representatives.[9]

The plan notes, on page 2, that over 32 focus group meetings were held across the state, and an online assessment tool survey was sent to EMS providers to gain the field providers perspective on the components and indicators that are included in the plan (See Table 5). The task force reviewed and incorporated the information received from the focus groups and from the online survey "to provide a current analysis of the status of EMS within the Commonwealth and to develop the content of the final plan."[10]

This work culminated in the selection of the 10 major plan components, seen in Table 5. According to DOH, "The State Plan provides a vision for the future that will preserve and enhance the quality of care for all residents and visitors of Pennsylvania. The State Plan is the result of a process that included hundreds of volunteer hours discussing all of the major aspects of the plan—its goals, strategies, and application."[11]

The 2010 plan's ten major components are then further subdivided into 67 indicators, chosen collectively based on a composite rating for each indicator. An action plan was developed for each indicator, including performance measures for years 3, 5, and 10. The introduction to the document asserts that additional information, such as inventory of current resources, estimated costs, summary of field comments, needed data, and content experts were included in the plan for each indicator. As addressed later, several of these elements, especially cost estimates,

---

[6] This plan replaced an earlier *State EMS Development Plan* that was published by DOH in January 2004.
[7] *A Model EMS System,* developed by the National Highway Traffic Safety Administration and National Association of State EMS Officials, PA's EMS System Plan, June 2010, p. 5.
[8] PA's EMS System Plan, June 2010, p. 2.
[9] Ibid, p. 2.
[10] Ibid, p. 2.
[11] Pennsylvania Department of Health web page describing the Statewide EMS System Development Plan.

are not included. According to an official with the Bureau of Emergency Medical Services, "the plan is finished and complete."[12] After adoption by the department, the regional EMS councils were supposed to develop individual plans with the input of local EMS providers and agencies. According to a cover letter provided with the plan, PEHSC is responsible for monitoring the plan for compliance and will review it annually as part of its work program, although there is nothing in the plan itself that indicates this.

Table 5

Components of the Pennsylvania State EMS System Development Plan

Component	Number of Indicators Associated With a Component[a]
1. Leadership, Organization, Regulation & Policy Subsystem	12
2. Resource Management Subsystems – Financial	3
3. Resource Management Subsystems – Human Resources	8
4. Resource Management Subsystems – Transportation	3
5. Resource Management Subsystems – Facility and Specialty Care Regionalization	7
6. Public Access And Communications Subsystems	4
7. Public Information, Education and Prevention Subsystem	6
8. Clinical Care, Integration of Care, and Medical Direction Subsystem	8
9. Information, Evaluation, and Research	10
10. Large Scale Event Preparedness and Response Subsystem	6
Total	67

[a] There are 67 different indicators associated with the 10 components of the plan. According to the June 2010 plan P. 2), an indicator "gauge" gives the reader a graphic representation of the current composite rating for each indicator. Based on the rating, as well as reviewing all of the data received, a format was developed to indicate a direction for EMS in the future as a model EMS system for Pennsylvania. The results are written as action items for review and implementation.

Source: *Pennsylvania's Emergency Medical Services System Plan*, PA EMS, Department of Health, June 2010.

Requirements of Current Plan

When Act 37 was written, language related to the statewide planning process varied from previous statutory language in important ways. The following points highlight these differences.

1. Section 8111(2)(i) and (ii) of Act 2009-37 requires that plans developed by regional councils become an official part of the Statewide EMS system plan and are to address the same seven plan requirements for their specific areas as required by the statute for the statewide plan. Act 1985-45 only required

[12] LB&FC meeting notes, January 9, 2013.

regional councils to prepare plans but did not specifically stipulate that they officially become part of the Statewide Plan.

2. Both Act 1985-45 and Act 2009-37 require that the department revise the plan. Act 45 required such revisions to occur annually. Act 37 does not have a requirement for annual revision of the plan. Both acts have a provision calling for the annual publication of comprehensive and specific reports of activity and plan implementation.
3. Act 37 added language that requires "persons regulated by the department under this chapter and dispatchers of EMS agencies shall provide data, without charge, as reasonably requested by the department and regional EMS councils, to aid them in developing and revising Statewide and regional EMS system plans."[13]
4. Act 37 added language directing the department to use the Statewide plan for contract and grant making purposes (to the regional councils) as set forth in §8112(a) of the Act. The previous statute did not have this requirement.

PEHSC March 2013 Review

Based on difficulties we expressed about cross walking the published plan with the statutory requirements, the department tasked PEHSC with producing a deliverable that dovetails the two documents. In March 2013, PEHSC released a report called the "Reformatted State EMS Development Plan," further examining the 14, Years 1 through 3, high priority indicators that were chosen by the taskforce from the original 67 contained in the 2010 Statewide Plan, and attempting to identify the specifics of the seven minimum statutorily required elements discussed previously. This March 2013 review also contained specific tasks for the BEMS/DOH and the regional councils related to the 14 highest priority indicators, both of which were missing from the adopted 2010 plan. Exhibit 3 lists the 14 high priority, years 1-3, indicators that the department and the regional councils are to begin implementing on July 1, 2013. The 2013 report notes that, "completion of work on these indicators provides a pathway for work on Year 3-5 and Year 5-10 indicators."[14]

[13] Act 2009-37, §8111(c)(2).
[14] *Pennsylvania's Emergency Medical Services System Plan 2013: Year 1-3 Priorities,* March 2013, p. 3.

Exhibit 3

Year 1 – 3 Priority Indicators

Assessment Indicators That Are Considered Most Important to Implement

1G. Use of goals that are time specific, quantifiable and measurable.
2A. Budgets are developed for DOH/BEMS and other subsystem infrastructure.
2B. Established method for collecting EMS system financial data.
2C. EMS system, DOH/BEMS funding.
3A. Performance standard established for turnover rate of pre-hospital providers.
5C. DOH/BEMS brings together stakeholders to improve specialty care subsystems.
6D. Coordinated communication system with multidirectional communication.
7E. Develop and adopt community outreach self-determination program.
9F. Generation of EMSIS reports by the EMS system.
9E. Expert review of the system performance data by state EMS advisory board.
9H. Pre-hospital, statewide, mandatory performance improvement system.
9J. Enforce participation in EMSIS and statewide performance improvement.
10A. Statewide MCI assessment.
10C. Statewide EMS MCI plans are clearly defined and integrated.

Source: *Pennsylvania's Emergency Medical Services System Plan 2013: Year 1-3 Priorities,* March 2013, pp. 4-34.

Analysis of Statewide Plan

The Statewide Emergency Medical Services Plan as originally drafted and approved in June 2010 does not appear to meet the requirements of Act 2009-37 that address what is to be included in the plan (see page 18). It was comprehensive in its examination of EMS in Pennsylvania, but failed to contain enough specificity to comply with the statutory requirements or be action oriented. The revisions/fleshing out that was done with the March 2013 effort by PEHSC moves the plan closer to being both relevant and obtainable as there now is a roadmap of what actions need to be taken by DOH/BEMS and the regional councils to ensure that emergency services available to the citizens of the Commonwealth are of high quality. However, it is still lacking in several key areas necessary for implementation. First it fails to identify the estimated costs to implement the indicators, including the years 1-3 priority indicators. No dollar figures are identified for any of the 10 components or for the 67 indicators that are associated with a component, and no financial analysis is undertaken of the overall cost of implementation. The plan simply identifies for which activities estimated costs are anticipated. Because specific cost data is not included, the overall cost to DOH and regional councils to implement the components of the Statewide Plan cannot be identified or planned.

The March 2013 report addressed the lack of cost data for each of the high priority indicators as follows:

> "The determination of cost(s) to the system associated with this indicator is a daunting task for several reasons. (1) Lack of available data to the task force. (2) Cost estimates could only be used and considering

> the size of the Commonwealth and its diversity, they may not be useful. (3) Costs would only reflect current rates; the plan spans over a 10 year period."[15]

The report goes on to note that, for these reasons, the task force that worked on the plan only attempted to identify funding sources for each indicator. The report goes on to recommend that an independent consultant be hired to determine actual costs. Therefore, the amount of funding that will need to be directed to implement the Statewide Plan from the EMSOF, and how that might affect funding available for other areas of EMS, cannot be determined.

Another weakness of the 2010 published plan is that it does not address the specific responsibilities of agencies which are charged with its implementation. And although the March 2013 reformatted plan does include state and regional tasks required to implement the 14 highest priority indicators, there are no specific timelines for their implementation, and there are no specific responsible/accountable parties identified. Both the old and the new EMS statutes require the department to annually publish comprehensive and specific reports of state plan activity and implementation, however the department could not provide us with any such reports.

The statute calls for the regional councils to develop individual plans for their regions that "include the same types of information that is required for the Statewide plan."[16] A review of the Statewide Plan did not indicate how regional plans were to be incorporated into the Statewide Plan. At the time of our review, the regional councils' system plans for any year had not been added to the state plan, even though the plan was presented over three years ago. Presumably, they are being created to be incorporated into the upcoming 2013-14 EMSOF funding contracts (we have been told that the regional plans become their official workplans each year). This is especially crucial as implementation of many of the Year 1 through Year 3 priorities is to begin on July 1, 2013.

Finally, §8112(e)(1) added new language to the state plan development portion of the law that directs the department to utilize the plan in decision making, especially as related to EMSOF allocations. They did not use the state plan as guidance in the allocation of funding in 2011-12, and we have had no indication from the BEMS that they are using it to aid in funding decision making for the upcoming FY 2013-14 contracts. As a result, key decisions regarding EMS system development and the expenditure of state EMSOF monies continue to be made without benefit of a coordinated statewide strategy or plan. In fact, as of the writing of this report, the BEMS had not adopted or even commented on the March 2013 submittal to them from PEHSC (from whom we obtained a copy).

---

[15] *Pennsylvania's Emergency Medical Services System Plan 2013, Year 1-3 Priorities.*
[16] Act 2009-37, §8111(2)(ii).

Award of EMSOF-Funded Grants/Contracts

Under the EMS Act, 35 P.S. §8112(a), the department may allocate, via grant or contract, EMSOF monies to entities to serve as regional EMS councils responsible for the initiation, expansion, maintenance, and improvement of the regional EMS systems that are in accordance with the statewide EMS system plan. The current EMSOF contracting process is shown in Exhibit 4 on page 26. If a contract is entered into for EMSOF grant funds, the entity must carry out the duties assigned by the department under §8109(c) (relating to the regional emergency medical services councils). Grants funds may be used for only the following purposes:

(1) Providing programs of public education, information, health promotion and prevention regarding EMS.
(2) Purchasing ambulances, other EMS vehicles, medical equipment and rescue equipment.
(3) Applying to costs associated with conducting training and testing programs for EMS providers.
(4) Applying to costs associated with inspections and investigations conducted to assist the department to carry out its regulatory authority under this chapter.
(5) Purchasing communications equipment and services, including alerting equipment, provided that the purchases are in accordance with the Statewide EMS system plan.
(6) Assisting with the merger of EMS agencies or assisting an EMS agency to acquire another EMS agency, when the department determines circumstances exist such that the transaction and financial assistance are needed to serve the public interest.
(7) Applying to costs associated with the maintenance and operation of regional EMS councils. Those costs may include, but shall not be limited to, salaries, wages and benefits of staff, travel, equipment and supplies, leasing of office space and other costs incidental to the conduct of business which are deemed by the department to be necessary and appropriate for carrying out the purposes of this chapter.
(8) Applying to costs associated with collection and analysis of data necessary to evaluate the effectiveness of EMS systems in providing EMS and to administer quality improvement programs.
(9) Applying to costs associated with assisting EMS agencies to recruit and retain EMS providers.

The law goes on to state that EMSOF grant funds provided to the regional councils may not be used for the following purposes:

(1) Acquisition, construction or rehabilitation of facilities or buildings, except renovation as may be necessary for the implementation or modification of EMS communication systems.

(2) Purchasing hospital equipment, other than communications equipment for medical command and receiving facilities, unless the equipment is used or intended to be used in an equipment exchange program with EMS agencies.
(3) Maintenance of ambulances, other EMS vehicles and equipment.
(4) Applying to costs deemed by the department as inappropriate for carrying out the purposes of this chapter.
(5) Applying to costs which are normally borne by patients, except for extraordinary costs as determined by the department.

We found that there are several contract and grant prerequisites put in place by Act 2009-37 in §8112(f). The department shall not contract with or provide a grant to an entity for that entity to serve as a regional EMS council unless:

(1) The entity has submitted a contract or grant application to the department in a form and format prescribed by the department that is consistent with the Statewide and regional EMS system plans.
(2) The application addresses planning, maintenance and improvement of the regional EMS system.
(3) The entity demonstrates to the department's satisfaction the qualifications and commitment to plan, maintain and improve a regional EMS system and that the entity has the required organizational structure and provisions for representation of appropriate entities.

Similar to the previous law, the department is to consider the amount of funds available to the contractor or grantee from non-state contributions and federal grant or contract programs pertaining to EMS. Non-State contributions are defined as the outlay of cash and in-kind services to the contractor or grantee or toward the operation of a regional EMS system by private, public or government third parties, including the federal government.[17] The department has not, to our knowledge, ever utilized this factor in allocating EMSOF funds to the regional councils.

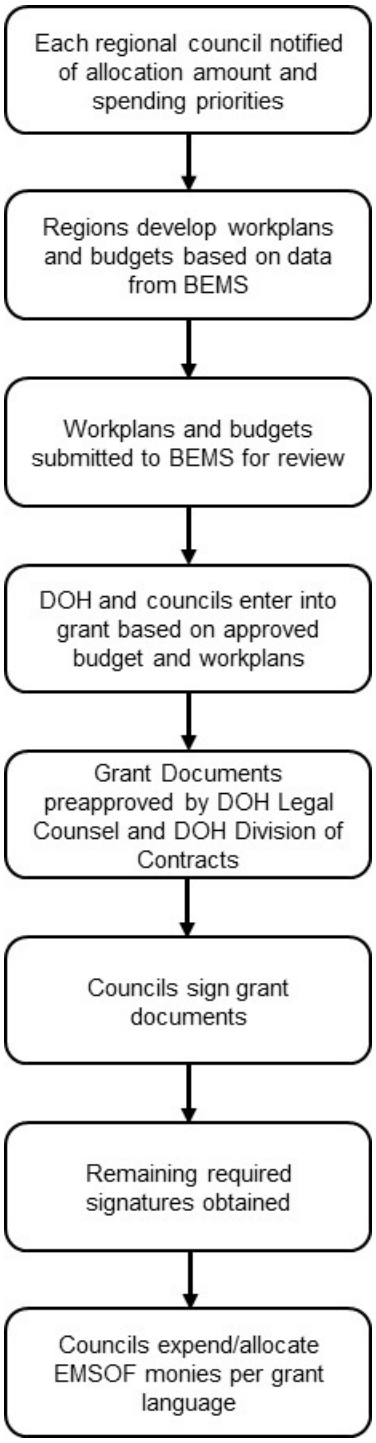
A new provision put in place by Act 37 (§8112(l)) gives the department the ability to enter into sole source contracts or grants upon expiration of a contract or grant with an entity to carry out the duties of a regional EMS council without undertaking a competitive bidding process. The new language also states that previous entity may continue to serve as a regional EMS council if they have demonstrated to the department's satisfaction that it has the ability and commitment to plan, maintain, and improve the regional EMS system consistent with the terms of the prior contract or grant.

Contradictory language in current program regulations which state that a regional EMS council or other contractor does not have the right to have a contract

[17] Act 37-2009, §8112(i).

Exhibit 4

The EMSOF Contracting Process



Source: Developed by LB&FC staff from an examination of EMSOF records and discussions with staff of the Department of Health.

renewed will need to be amended to reflect the changes in the statute. And, although the department maintains that authority to not simply renew existing contracts, contracts with the existing regional EMS councils appear to have been routinely renewed to the same entities on an annual basis since the beginning of the program. Beginning with FY 1997-98, the department began issuing three-year contracts with each regional council and PEHSC. The major basis (selection criteria) utilized by the department for these contract awards is a budget summary/ workplan submitted by the regional councils and PEHSC which subsequently becomes an attachment to the contract.

Under §8112(j), **t**he department may also enter into contracts and grants with organizations other than regional EMS councils in order to assist the department in complying with the provisions of this section and chapter and to make payments in advance or by way of reimbursement and in installments and on conditions as the department determines will most effectively carry out the provisions of this chapter. The recipient of a contract or grant shall make reports to the department as may be required by the department.

Allocation of the EMSOF Appropriation

Statutory and Regulatory Provisions

The Emergency Medical Services Act states that 75 percent of available EMSOF monies are to be disbursed by the department for only the following purposes:

(1) To eligible EMS agencies for applicable purposes stated under section 8112(c) (relating to contracts and grants), with at least 10% of these funds to be allocated to provide additional financial assistance for those EMS systems serving rural areas.
(2) To the board for the performance of duties imposed upon it under this chapter.
(3) To regional EMS councils for the development, maintenance and improvement of EMS systems, including ambulance and communications equipment, and for training, education and EMS agency licensure purposes.
(4) To other contractors and grantees as authorized under section 8112(j).

Program regulations governing allocation of EMSOF funds are found at 28 Pa. Code §§1001.21-1001.27. The regulations include a detailed listing of purposes for which a contractor may receive funding and the following ten specific factors the department is to consider in determining who shall receive EMSOF funding and in what amount. These funding factors include:

– Total amount of funds available.

- Conformity of the proposed application to the *State EMS Plan.*
- Financial need of the applicant.
- Source of other funds available to the applicant for the purpose set forth in the application, including non-state contributions, federal grants, or federal contracts pertaining to EMS. Non-state contributions include cash and in-kind services provided to the contractor or toward the operation of an EMS system by private, public, or government entities, including the federal government.
- Economic base of the geographic area served by the applicant.
- Population of the geographic area served by the applicant.
- Special rural needs of the geographic area served by the applicant.
- Potential duplication of services.
- Priorities of the department.
- Other factors set forth by the department in published guidelines or policies.

State Allocation Practices

Since FY 1989-90, the DOH has allocated EMSOF monies through a combination of an allocation formula (regional councils) and contract negotiations (PEHSC and special project contractors). Prior to that time, available EMS funds were divided equally among the regions after Emergency Medical Services Office (EMSO) operations and other program functions were funded. Since 1989, the department has used a population-based formula method to allocate monies to the state's regional councils. Beginning in FY 1991-92, a factor for regional council square mileage was added to this formula.

We examined and analyzed the DOH's allocation of EMSOF monies using FY 2011-12 as the sample year. This section discusses the formula, the allocation process, and the allocation of FY 2011-12 EMSOF monies to the Pennsylvania Emergency Health Services Council and the regional EMS councils.

The Allocation Formula. The formula currently being used by the BEMS to allocate EMSOF funds to the regional councils is the same as that developed during the late 1980s. A formula is used only for allocating EMSOF monies to the regions; allocations to the State Advisory Council are not formula-based. With adjustments that have occurred since then to account for rural population and square mileage, the formula used for the FY 2011-12 allocations can be expressed as shown on Exhibit 5.

Exhibit 5

Formula Used by the Department of Health to Allocate EMSOF Monies to the Regions for FY 2011-12

The Formula: Regional EMS Allocation = A + B + C

Where:

A = Regional population divided by 2000 state population of 12,281,054 times 50 percent of available EMSOF monies;

B = Regional rural population divided by state rural population of 2,819,968 times 30 percent of available EMSOF monies; and

C = Number of square miles in region divided by the state area of 44,817 square miles times 20 percent of available EMSOF monies.

Source: Developed by LB&FC staff from information obtained from the Emergency Medical Services Office, PA DOH.

Tables 6 and 7 show the results of the application of these factors of total population, rural population, and square mileage to the regional councils and subsequent EMSOF grant amounts. It is important to note that during the time of our previous study, the population of the state that was determined to be rural in nature was 3,691,079 while the formula used for 2011-12 had a rural population total of only 2,819,968, a decrease of 24 percent over a period of 14 years.

Table 8 on page 37 shows that on a per capita basis, EMSOF funding varies significantly, with largely rural regional councils receiving $2.22 per capita; mixed urban/rural councils, $1.11 per capita; and urban councils, $63 per capita, statewide.

The Allocation Process. The allocation process currently in use is illustrated in Exhibit 6 on page 32. As expressed on this flow chart, we found the process works as follows:

1. The General Assembly annually appropriates monies from the EMSOF to the DOH. Twenty-five percent of this appropriation is allocated to the Catastrophic Medical and Rehabilitation Fund, a restricted revenue account, for victims of trauma. The remaining 75 percent is made available to the BEMS for the initiation, expansion, maintenance, and improvement of emergency medical services in Pennsylvania.

2. Once the bureau determines the amount of EMSOF monies available for disbursement, an allocation is made to the PA Emergency Health Services Council. The PEHSC Advisory Council submits a budget request to the bureau in which it states its workplan and budget. Using these as guides, a contract is negotiated with spending allocations for PEHSC for the upcoming three years.

Table 6

Formula Factors by Regional Council
Population, Rural Population, and Square Miles of Each Regional Council

Regional Council	Total Population Number[a]	Total Population Percent of Total	Rural Population Number[a]	Rural Population Percent of Total	Square Mileage Number	Square Mileage Percent of Total
Bradford Susquehanna	104,999	0.9	79,733	2.8	1,974	4.4
Bucks County	597,635	4.9	59,070	2.1	607	1.4
Chester County	433,501	3.5	82,433	2.9	756	1.7
Delaware County	550,864	4.5	6,031	0.2	184	0.4
Eastern PA EMS	1,300,619	10.6	325,974	11.6	3,347	7.5
EHS Federation	1,702,415	13.9	506,270	18.0	5,136	11.5
EMMCO East	234,416	1.9	142,025	5.0	5,091	11.4
EMMCO West	639,641	5.2	264,853	9.4	5,076	11.3
EMS Institute	2,656,007	21.6	572,443	20.3	7,045	15.7
Lycoming, Tioga & Sullivan	167,973	1.4	84,640	3.0	2,819	6.3
Montgomery County	750,097	6.1	26,201	0.9	483	1.1
Northeastern PA	654,649	5.3	207,687	7.4	3,023	6.7
Philadelphia	1,517,550	12.4	0	0.0	135	0.3
Seven Mountains	242,979	2.0	113,193	4.0	2,802	6.3
Southern Alleghenies	471,596	3.8	230,606	8.2	4,615	10.3
Susquehanna	256,113	2.1	118,809	4.2	1,724	3.8
Total	12,281,054		2,819,968		44,817	

[a]Population totals are from the year 2000 as those figures were used by the Department of Health in calculating the FY 2011-12 EMSOF contracts with individual regional councils.

Source: Developed by LB&FC staff from EMSOF allocation information obtained from the BEMS, PA DOH.

3. Following the PEHSC allocation, the bureau may allocate a portion of the EMSOF appropriation for special projects, if any. These projects generally have statewide interest and impact and are often pilot projects that are tested in one region before being implemented statewide. The bureau has not set aside any EMSOF funds lately for special projects, but, when it did, it was typically $300,000 to $500,000 of the EMSOF appropriation each fiscal year.

4. Next, the bureau allocates funds to the various regional EMS councils. To determine the amount available for allocation to the regions, the BEMS subtracts the PEHSC allocation and the special projects allocation from the EMSOF appropriation amount. The difference is the amount that is available to be disbursed to the regional councils utilizing the allocation formula described earlier. Fifty percent of the available amount is allocated to each region based on its population and 30 percent is allocated based on the rural population of the region; the remaining 20 percent is

allocated based on the region's square mileage. The sum of these three calculated amounts is the region's total allocation.

5. Regional EMS councils may receive additional EMSOF monies later in the fiscal year if they initiate a special project that has been approved by the Bureau.

During FY 2011-12, the bureau disbursed a total of $10,973,000 from the Emergency Medical Services Operating Fund. This is up from $8,686,367 total disbursed at the time of our last audit in 1998. After subtracting from the appropriation the amount needed by PEHSC determined in its negotiated workplan ($491,000), the bureau allocated the remaining $10.482 million based on each region's total population, rural population, and square mileage. The Office made these calculations using the allocation formula illustrated on Exhibit 5.

$10,482,008 x 50 percent for population = $ 5,241,004
$10,482,008 x 30 percent for rural population = $3,144,602
$10,482,008 x 20 percent for square mileage = $2,096,402

The fiscal results of this allocation, by regional council, is found below, in Table 7.

Table 7

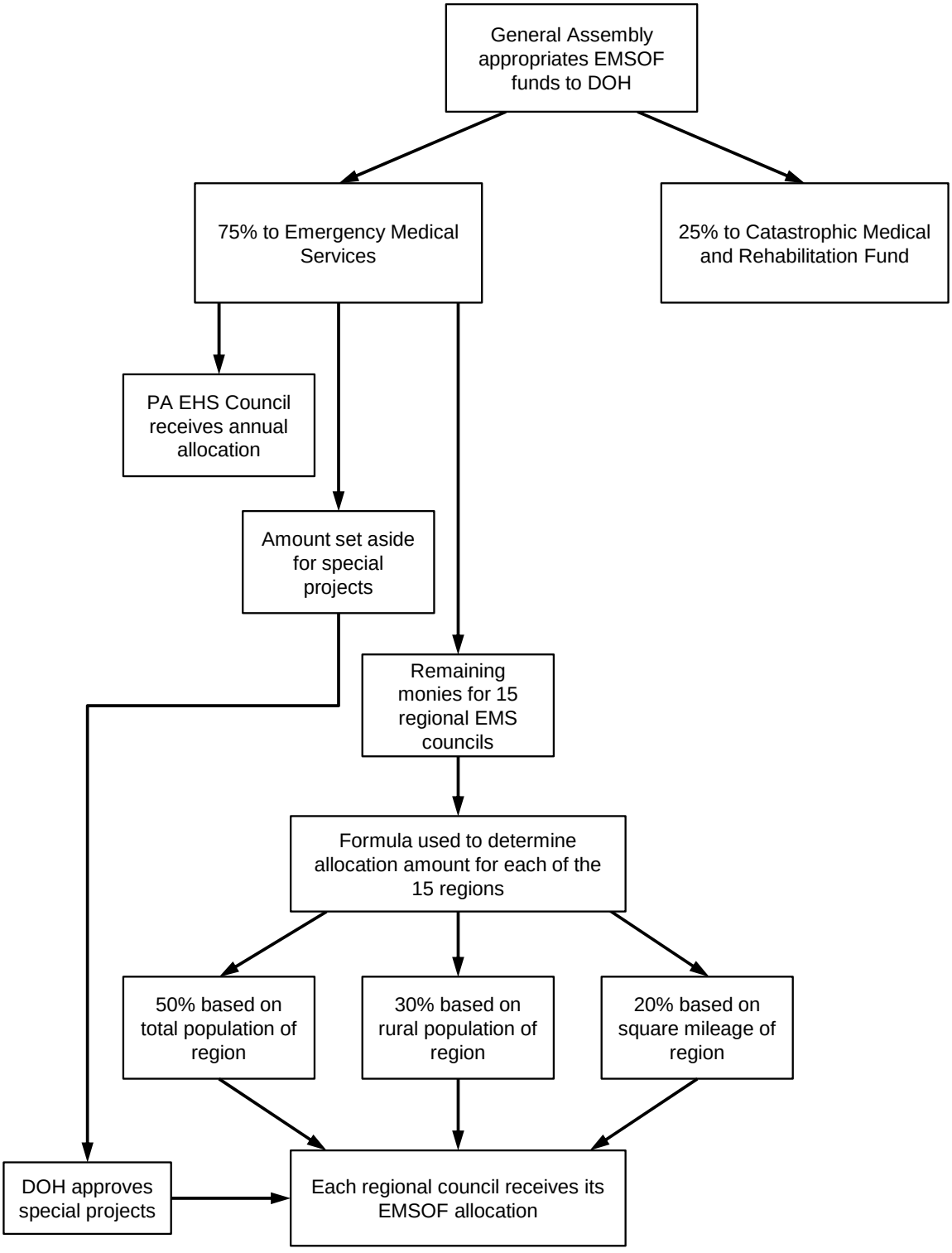
Calculation of 2011-12 EMSOF Allocations to Regional EMS Councils Based on Formula Factors

Regional Council	Total Allocation	Based on Amount of 2011-12 Allocation: Total Population	Rural Population	Square Mileage
Bradford Susquehanna	$ 239,897	$ 44,809	$ 88,049	$ 92,338
Bucks County	337,827	255,044	66,037	28,394
Chester County	296,040	184,999	91,193	35,363
Delaware County	249,723	235,084	6,289	8,607
Eastern PA EMS	1,020,917	555,046	364,774	156,562
EHS Federation	1,447,220	726,515	566,028	240,246
EMMCO East	556,686	100,038	157,230	238,141
EMMCO West	816,933	272,970	295,593	237,440
EMS Institute	2,030,827	1,133,465	638,354	329,544
Lycoming, Tioga & Sullivan	328,724	71,683	94,338	131,864
Montgomery County	369,387	320,108	28,301	22,593
Northeastern PA	753,775	279,375	232,701	141,407
Philadelphia	649,892	647,622	0	6,315
Seven Mountains	380,219	103,693	125,784	131,069
Southern Alleghenies	688,839	201,256	257,857	215,876
Susquehanna	315,102	109,298	132,073	80,643
Regional Council Total	$10,482,008	$5,241,004	$3,144,602	$2,096,402

Source: Developed by LB&FC staff with information obtained from the BEMS, Pa DOH.

Exhibit 6

The Process Used by the Department of Health to Allocate EMSOF Monies



Source: Developed by LB&FC staff from EMSOF program records and discussions with staff of the Emergency Medical Services Office, PA Department of Health.

Following notification of the approximate amounts of the EMSOF appropriation that will go to each of the regional EMS councils, the regional councils develop annual work plans and specific budgets, (based on the funding priorities established by the bureau and published in the *Pennsylvania Bulletin*; see pages 38 and 39) for review and approval by the bureau. The councils may negotiate the activities listed in the workplan, as long as they are within the allocated budget amount and priorities established. Once the workplans and specific spending amounts are finalized/approved, the DOH enters into a grant agreement with each regional council.

According to the grant agreement language, councils are required to submit quarterly progress reports of expenditures and activities. Councils are also required to submit additional back-up documentation of amounts and activities to reconcile them if they do not match with those anticipated in the workplan. Based on these reports, during the third quarter of each fiscal year the department negotiates with the regional councils on the reallocation of any contracted, but unspent, EMSOF amounts.

The following are observations and conclusions concerning the allocation process based on our examination of the Department's allocation of FY 2011-12 EMSOF funding:

1. The department's allocation formula does not take into account all of the EMS funding factors listed in the EMS regulations.

EMS regulations at 28 Pa. Code §1001.23 stipulate that the Health Department consider 10 factors when determining who shall receive EMSOF funding and in what amount. As shown on Exhibit 7, we found that the formula, as currently applied, considers only four of these 10 factors.

Exhibit 7

A Comparison of the Department's EMSOF Allocation Formula to Funding Factors Established in Regulation

Funding Factor[a]	Current Allocation Formula Accounts for This Factor
1. Total amount of funds available	Yes
2. Conformity of the proposed application to the Statewide EMS Development Plan	No
3. Financial need of the applicant	No
4. Funds available to the applicant for the purpose set forth in the application, including non-state contributions, Federal grants, or Federal contracts pertaining to EMS. Non-state contributions include cash and in-kind services provided to the contractor or toward the operation of an EMS system by private, public, or government entities, including the Federal government	No
5. Economic base of the geographic area served by the applicant	No
6. Population of the geographic area served by the applicant	Yes
7. Special rural needs of the geographic area served by the applicant	Yes
8. Potential duplication of services.	No
9. Priorities of the department	No
10. Other factors set forth by the department in published guidelines or policies	Yes[b]

[a] EMS regulations, 28 Pa. Code §1001.23, require that the DOH consider the factors listed in this column in determining who shall receive EMSOF funding and in what amount.
[b] Square mileage.

Source: Developed by LB&FC staff from EMS program regulations and examination of the DOH allocation formula.

The current formula focuses heavily on only three of the ten factors, population, rural population, and square mileage. Beginning in FY 1991-92, the department identified an "other factor," square mileage, for use in the formula. According to the department, square mileage was added as a factor to the allocation formula because larger geographic areas are generally more rural in nature and have more limited local funding capabilities. Staff of the EMS Office stated that, in some years, special projects that are funded with EMSOF monies focus on rural needs of the councils (e.g., communications projects). In those years, the EMS Office considers the factor "special rural needs of the geographic area served by the applicant" as being included.

Most notably absent from the current allocation process are the factors of "financial need of the applicant" and the activities that a council needs to undertake to help bring their region (and providers) into compliance with the state system plan. Regardless of a regional council's financial condition or their level of attainment of system planning requirements, a portion of the EMS appropriation is allocated to each regional council each year. Those councils that have a large source of secondary income (e.g., county government revenues or a revenue producing funded call center) receive funding consideration the same as those councils that have a small or no base of secondary income. And councils receive their allocations regardless of their level of attainment with statewide planning requirements.

The LB&FC has previously recommended that the DOH modify the allocation formula to incorporate additional factors which are identified in the DOH's EMS regulations as factors "to be considered in determining who shall receive funding and in what amount." In addition, Act 2009-37, in §8112, requires that the department use the adopted state EMS system plan for contract and grant purposes. As of this report's writing, the department had not added or changed any factors used in its allocation formula.

2. The EMSOF allocation formula (weightings) and process is not established in EMS program regulations and has not otherwise been formally published.

Previously released LB&FC EMS performance audit reports (1987, 1991, and 1998) recommended that the department establish a formal allocation methodology in regulation and publish the methodology in the *Pennsylvania Bulletin.* We also recommended that the published statement of the allocation methodology include documentation of the allocation formula, the subsequent allocation negotiation process, and the basis of special supplemental project awards.

As of May 2013, the department's specific allocation formula and the basis for distribution of any special supplemental funding and any federal funding had not been promulgated in regulation form, published in the *Pennsylvania Bulletin,* or otherwise documented in formal written program guidelines or manuals. Instead, the EMS Office has outlined the formula in chart form. This chart does not, however, explain the overall allocation process. Information on how the formula was derived and the overall allocation process, including federal funds, continue to be available only through discussion with the EMS Office director and staff.

3. FY 2011-12 Allocation Amounts Were Consistent With the Allocation Formula

Previously released LB&FC audits found inconsistencies in actual contract awards vs. amounts calculated using the allocation formula. No documentation was available on the basis and outcome of the negotiation process that was used instead to determine contract award amounts.

As part of the current audit, the LB&FC staff again applied the allocation formula to the amount of money available for disbursement to the regional councils. Unlike 1991, the application of the allocation formula for FY 2011-12 resulted in the calculated allocations matching the contract amounts that were awarded to each regional council. The FY 2011-12 allocations are shown on Table 7.

4. The BEMS Imposes a Matching Fund Requirement as a Condition for Receiving EMSOF Funds at the Provider Level.

Although not contained in the statute, current program regulations, found at 35 Pa Code, §1001.22(d), allow the department to, by contract or notice in the *Pennsylvania Bulletin*, require a contractor or other applicant for funding to provide matching funds in specified percentages for funds distributed by the department or a regional EMS council as a condition for receiving EMSOF monies. These requirements are published every year in the *Pennsylvania Bulletin* under "Provider Equipment" and in the agreements with the regional councils with the language, "certain funds under this contract are contingent upon the contractor documenting local matching funds in ratios that are specified in this contract."

The budget summaries of the FY 2009-10 through FY 2011-12 contracts required matching funds for prehospital provider equipment (PPE) in the following ratios: (1) for urban areas—50 percent state money/50 percent matching funds and (2) for rural areas—60 percent state money/40 percent matching funds. These requirements appear not to be imposed on PPE funds that are retained by regional councils.

5. Due to the current formula that allocates 30 percent of the available EMSOF funds to the regions based on rural population, rural councils receive significantly more funding on a per capita basis than mixed urban/rural and urban councils.

As shown on Table 8, the average per capita state funding for regional councils classified as rural was $2.22 in FY 2011-12. The average per capita allocation figure for mixed urban/rural councils was $1.11, while the average per capita allocation figure for urban councils was $0.63. Statewide, the EMSOF allocation per capita was $0.85.

This funding differential for rural areas is based on the premise that EMS systems development is often lacking in the more rural areas of the state, due in large part to the absence of a strong local funding base and sources of secondary income. As stated above, rural PPE's have to provide less of a match amount to obtain EMSOF money for purchases, as well.

The Department's efforts to provide additional assistance are consistent with the intent of Act 37. However the impact to non-rural areas is greater because the rural areas in Pennsylvania continue to shrink, but the 10 percent additional percentage allocation to rural areas remains the same. In 1998, the formula used by the department had a rural population of 3,691,079 while that used in FY 2011-12 allocations was 2,819,968, a decrease of 24 percent.

There is a mixed reaction among councils of this statutory directive. Urban councils tend to believe the current allocation is unfair and allows "double dipping" for the rural regions. They would like to see funding allocations made based on need or call volume. In contrast, rural council representatives tend to feel that the

current formula's additional allocation based on rural population is necessary, and note that the rural councils will need more money in the near future since the local funding base is weak for most rural systems.

Table 8

Per Capita EMS Funding Allocations, by Regional Council
(Classified as Rural, Urban, and Mixed Urban/Rural)
FY 2011-12

Rural : Regional Councils With 50% + Rural Pop	% Rural	FY 2011-12 Allocation	FY 2011-12 Population[a]	Amount Per Capita
Bradford Susquehanna	76	$239,897	104,999	$2.28
EMMCO East	61	556,686	234,416	2.37
Lycoming, Tioga, Sullivan	50	328,724	167,973	1.95
Total 50% + Rural		$1,125,307	507,388	$2.22
Mixed Urban/Rural: Regional Councils With 26% - 49% Rural Population				
Southern Alleghenies	49	$ 688,839	471,596	$1.46
Seven Mountains	46	380,219	242,979	1.56
Susquehanna	46	315,102	256,113	1.23
EMMCO West	41	816,933	639,641	1.28
Northeastern	32	753,775	654,649	1.15
Federation	30	1,447,220	1,702,415	.85
Total 26% - 49%		$4,402,088	3,967,393	$1.11
Urban: Regional Councils With 0% - 25% Rural Population				
Eastern	25	$1,020,917	1,300,619	$0.78
EMSI	22	2,030,827	2,656,007	0.76
Chester	19	296,040	433,501	0.68
Bucks	10	337,827	597,635	0.56
Delaware	10	249,723	550,864	0.45
Montgomery	4	369,387	750,097	0.49
Philadelphia	0	649,892	1,517,550	0.43
Total 0% - 25% Rural		$4,954,613	7,806,273	$0.63
State Total		$10,482,008	12,281,054	$0.85

[a] The population used by the Bureau for the FY 2011-12 EMSOF allocation utilized U.S. census figures for 2000.

Source: Developed by LB&FC staff from information obtained from the PA Department of Health, BEMS.

6. EMSOF allocations to the Pennsylvania Health Services Council are disbursed through a budget request and subsequent unwritten negotiation process.

The amount of the EMSOF allocation is determined through a negotiation process. The process for and discussions held during these negotiations are unwritten and occur between the BEMS Bureau Director and the PEHSC Director and Chairman following the receipt of the Council's budget request. We were not able to

obtain PEHSC's original budget request but only that they received an allocation of approximately $491,000 in EMSOF grant money in FY 2011-12. While a verbal explanation on how monies are allocated to PEHSC was provided, the process is not well-documented. The department has not implemented the LB&FC's 1991 recommendation that written documentation be maintained for all EMSOF allocations.

7. Many of the state EMS Office's fiscal records are not automated making it difficult to obtain basic management information.

During the LB&FC's previous performance audits of the EMSOF, we noted that the EMS fiscal records maintained by the DOH were poorly maintained. While we found an improvement over the situation found during previous audits, the current situation within the bureau still has deficiencies. In particular, the bureau still maintains a manual filing system with a folder for each regional council. In order to obtain summary information on EMSOF spending, documents must be retrieved from the folders and the data manually calculated. Examples of summary information that must be pulled from the individual folders and calculated manually include: total expenditures by recipient, total EMSOF expenditures (budgeted and actual) by purpose, and total EMSOF expenditures by contract spending category. We also found several instances where documents for regional councils were misfiled.

The Office Manager position responsible for developing the system and maintaining EMSOF fiscal records left the position in May 2013, and those duties have been assumed by another employee.

Establishment of EMSOF Spending Priorities

Regulations, at 28 Pa. Code §1001.23(b), provide that the DOH will establish priorities for the expenditure of EMSOF monies at the regional and local levels. These are to be annually published in a notice in the *Pennsylvania Bulletin.*

At the time of our prior audits, the Director of the Division of Emergency Medical Services was setting the funding priorities and informing the regional councils of these priorities through memoranda. These priorities were not established with formal input from the regional councils, the State Advisory Council, or providers and were not being published in the *Pennsylvania Bulletin* as is required by regulation.

Since that time, the department has modified the way in which it establishes spending priorities and now annually publishes the priorities in the *Pennsylvania Bulletin.* According to the department, input regarding these priorities is obtained through a "funding priority committee" made up of regional EMS council directors and staff of the Bureau.

We examined the funding priorities established in the *Pennsylvania Bulletin* for the regional councils for each fiscal year in the most recent three-year contracts (FY 2009-10 through FY 2011-12). For each year, these priorities reflect an emphasis on:

- prehospital provider equipment both essential and specialized (specifically respiratory and bariatric equipment),
- risk management,
- recruitment and retention of prehospital personnel,
- quality assurance,
- merger consolidation investigations/studies,
- replacement of older ambulances, and
- emergency preparedness.

In the *Pennsylvania Bulletin,* the DOH issues specific equipment listings from which EMS providers must choose when making equipment purchases.

While the department has taken steps to obtain input on its spending priority decisions, many at the regional and local level still believe that mandating how EMSOF monies are to be spent now amounts to "unnecessary micromanagement" of the program, especially in a system that has reached or is nearing "maturity." When Act 45 was first passed, the state's EMS system was at a very basic level. In 1978, fewer than 10 percent of the state's ambulance services were certified under a voluntary certification program, and it was reasonable to establish the purchase of specific prehospital provider equipment as a top priority. Today, licensure of ambulances in the Commonwealth stands at 100 percent.

As discussed in the previous section on statewide EMS planning, we also found that the establishment of EMSOF spending priorities is not directly tied to the statewide system EMS development plan as is required in Act 2009-37.

Contract Administration and Monitorship

Act 37 and program regulations authorize the department to enter into grant agreements or contracts with regional EMS councils and other appropriate entities to assist in initiating, expanding, and improving the statewide EMS system. In addition to specifying the amount of their annual EMSOF allocation and the activities and purposes for which they may expend EMSOF monies, these contracts contain numerous provisions to be administered and monitored by the department. For example, the contracts contain provisions pertaining to budgeting, allocations and payments, annual work programs, travel expense policies, financial reporting, audit requirements, and other standard terms and conditions. Appendix B of this report contains a copy of Appendices A (Work Statement), B (Payment Provisions), and D (Program Specific Provisions) of the standard regional council contract. Appendix D

of the standard contract is the specific regional council's budget. These core documents of the grants have been revamped throughout the years and updated on a regular basis by the department and approved by other agencies, including DGS and the Comptroller's Office.[18]

Ongoing management and monitorship are essential to the effective administration of contracts. As stated in Management Directive M215.1 amended "Contracting for Services":

> The obligations accepted by the contractor are stated in the contract; however, that does not guarantee that the contractor will perform exactly as the agency expects it to. Monitoring and control are essential to ensure that the contractor uses and manages its resources in a manner that will provide the agency exactly what it has contracted for in terms of quality, timeliness, and economy of cost.

To examine these and other related issues, we flow-charted and reviewed the current DOH contract management process. The result can be found in Exhibit 8. The LB&FC's previous audits of EMSOF administration found that the department was not adequately monitoring and enforcing a number of provisions in contracts with the regional EMS councils. These audits also found that the regional councils were frequently not complying with these requirements and that the department was not withholding payments to councils that failed to comply with contract provisions.

We found that since our last audit, the DOH has taken a number of actions to improve the contractual relationship between the regional councils and the Department of Health. Some of this progress has come about through changes in contract boilerplate language designed to encourage greater compliance. Improvements have also been realized in part due to a number of changes which the DOH implemented. These include:

- assigning specific contract management responsibilities to a designated staff position in the Bureau;
- arranging for periodic program compliance reviews scheduled with and conducted by the Department of Health's Comptroller;
- implementing multi-year contracts;[19] and
- initiating a system of recurring payments to the regions.[20]

---

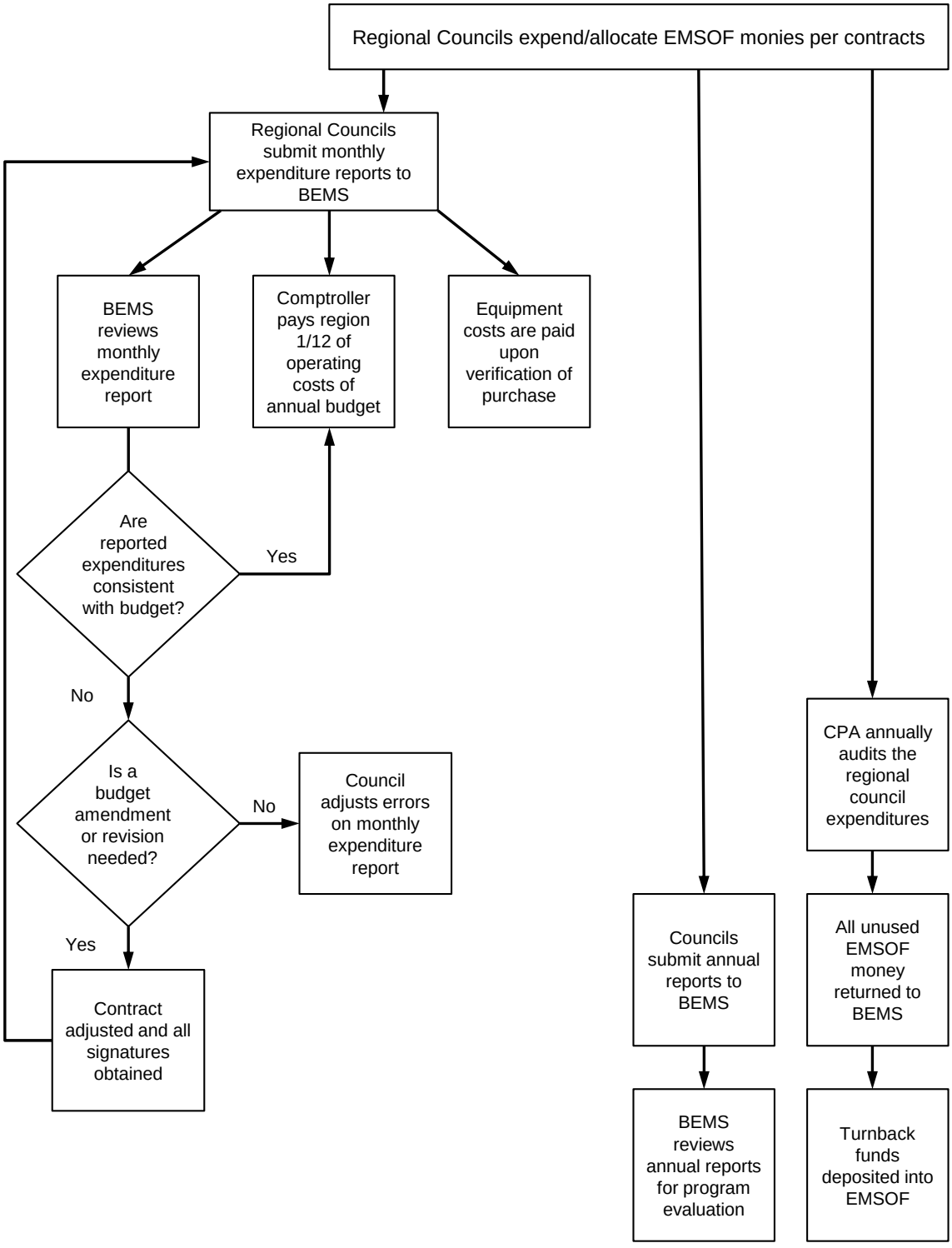
[18] PA DOH written response to LB&FC information request, March 12, 2013.

[19] In FY 2012-13 the department went back to issuing one-year grant agreements, due to the possibility of consolidation/merger of various regional councils.

[20] Under this system, the Comptroller's Office pays the councils one-twelfth of their budget for administrative and operating costs each month, subject to the approval of the EMS Office.

Exhibit 8

EMSOF Contract Management Process



Source: Developed by LB&FC staff from examination of Department of Health records and observation of program operations.

The department also reported to us that bureau staff communicates with the councils on a regular basis reminding them of upcoming deadlines and reporting requirement due dates. BEMS has administrative staff track all reporting requirements and submissions. The bureau also works closely with the department's auditing, budget, and contract analyst staff throughout the fiscal year.

We utilized the following list of follow-up items from our previous report completed in 1998 to determine the current status of DOH monitorship activities in the areas cited previously as being deficient. Our file review of documents for FY 2011-12 found no instances of substantial noncompliance with the following:

- Submission of comprehensive regional EMS plans (workplans).
- Submission of an annual financial and compliance audit, if required.
- Timely filing of amended budgets and work programs.
- Timely submission of monthly cost reports.

Review of FY 2011-12 Regional Council and PEHSC Audits

The contract between the Department of Health (DOH) and regional councils and PEHSC for EMSOF incorporates an annual audit requirement as part of the grant agreement/contract's required documents. The particular audit requirements that are applicable are determined by the source(s) of the contract's funding.[21]

The grant agreements require the contractor to have an audit made in accordance with established requirements identified in the Appendix "when the contractor expends less than $500,000 of total Federal awards received from all sources during its fiscal year, and the contractor expends $500,000 or more of state funds received under this contract during the state fiscal year."[22] In FY 2011-12, eight councils met this requirement for having to perform an audit (Eastern, EHSF, EMMCO East, EMMCO West, EMSI, Northeastern, Philadelphia, and Southern Alleghenies) and did submit the required audits. Eight councils (Bucks, Bradford-Susquehanna,[23] Chester, Delaware, Lycoming, Montgomery, Seven Mountains, and Susquehanna) and PESHC received less than $500,000 in EMSOF and less than $500,000 in federal funding in FY 2011-12. These councils and PESHC were therefore not required to have an audit performed of their EMSOF contract. However, three of these councils (Bradford-Susquehanna, Seven Mountains, and Susquehanna) and PEHSC did submit an audit to DOH.

[21] Audit requirements Section of the contract that is signed by individual regional councils and the Department of Health, p.1.
[22] Audit requirements Section of the contract, Part IV, p.4.
[23] Bradford-Susquehanna Council was combined with Northeastern Council in November 2012.

Submission of Audits

Audits are required to be completed and submitted within 120 days of the end of the state fiscal year. Of the eight councils required to file an audit, we found that five of the eight audits were submitted within 120 days of the end of the fiscal year and two were submitted late (35 and 50 days after the 120 day required submittal date). We could not determine when one audit was submitted because the department did not date stamp when the audit was received.

What Must Be Reported in Audits

When audits are required, they must be a financial audit that is in accordance with generally accepted government auditing standards.[24] According to the contract:

There are nine minimum audit reporting requirements that are to be addressed in the audit.

- A comparison of budgeted to actual expenditures/services.
- Notes to the financial schedules.
- Identify each contract by its department contract number.
- Adequacy of internal controls examined.
- Compliance with laws, regulations and other provisions of the contract.
- Schedule of findings and questionable costs (if applicable).
- Corrective action plans (if applicable).
- Status of prior audit findings and recommendations.
- Letter to management (if applicable) disclosing non-reportable conditions.

Our review of the audits for the eight councils required to submit an audit showed that that each had complied with the required audit reporting requirements. Auditors only made recommendations for change for two councils (EMMCO East and Southern Alleghenies). For EMMCO East, the auditors made recommendations that they believe would strengthen the internal controls and operating efficiencies of the organization. In response, the council sent a letter acknowledging the auditors work and agreeing that the council was responsible for maintaining effective internal controls over financial reporting and preventing and detecting fraud. However, the council in its response does not directly address the recommendations and whether it will implement them.

[24]Auditing costs are reimbursable by the department if such costs are specifically budgeted in the contract's budget as audit expenses.

The auditors recommended that Southern Alleghenies hire additional staff to ensure that more than one staff person has authority over financial transactions. In response, the council indicated that hiring additional staff was not feasible and that they would continue the expenditure practice of requiring dual signature checks. The remaining six audits contained no findings of material noncompliance or internal control weaknesses, which is determined by testing compliance with certain provisions of laws, regulations, contracts, and grants as well as the internal controls in place regarding financial reporting.

The LB&FC also reviewed the audits submitted by the three councils and PESHC which, according to the auditing requirements, were not required to file an audit because their state and federal grants were both under $500,000 in FY 2011-12. No findings or recommendations were made by the auditors for these three councils or PEHSC.

Comparison of Audits with Budgets Submitted to the Department of Health by Eight Regional Councils Required to Provide Audits

In the spring of each year, councils submit to DOH estimated budgets for the upcoming fiscal year reporting on how they intend to spend their EMSOF grant funds.[25] These later become attached to the grant agreements as Appendix C, Budget Summary. There are eight possible categories in the budget summary in which state and federal funds can be spent. These categories are:

-Personnel Services	-Equipment
-Consultant Services	-Supplies
-Subcontract Services	-Travel
-Patient Services[26]	-Other Costs

The LB&FC reviewed the FY 2011-12 audits submitted by the eight councils required to submit audits to see how closely their EMSOF expenditures matched their budget summaries of anticipated expenditures submitted for FY 2011-12. Although the budgets summaries submitted by the councils did not include anticipated federal funding, the audits submitted to DOH include both state and federal dollars as revenues and expenditures without differentiating between these categories of dollars.[27] In many instances, secondary income and expenditures made with secondary revenue also was combined with these other funds. In addition, each council contracts independently with a private Certified Public Accounting firm to complete its audits. Because there is no program-related specific direction from the

[25] Although each council and PEHSC also received a federal grant, those dollar figures, with the exception of PEHSC, were not reported by the councils on their budget estimates.
[26] None of the regional councils included any funding under Patient Services.
[27] The amount of federal funds each regional council received from the department varied from a low of $14,200 to a high of $455,512 in FY 2011-12.

department, the firms each follow their own auditing format, with the result that some audits provide significantly more financial details than others.

In order to determine if state provided EMSOF funds were spent according to the categories provided in the grants, we first had to determine in which budget category the federal funds were expended and back them out of the total expenditures. Five of the eight audits (EHSF, EMMCO East, EMMCO West, Philadelphia, and Southern Alleghenies) provided sufficient information that allowed us to somewhat identify the expenditure category in which each federal allocation was utilized. However, due to the combining of funding streams utilized in all of the audits and the variance of categories used by the auditors compared to the regional council's grant agreements, a direct comparison of estimated or anticipated EMSOF funded expenditures against actual expenditures of EMSOF grant funds, by category, was not possible. This issue was compounded by the fact that the department through its year-end reconciliation process allows the councils to shift unspent EMSOF money from one category to other categories. If the department does not approve a particular request (which we were told typically does not happen) the regional councils must return allocated, but unspent, grant funds to the department for return to the fund.

Because it is the single largest category of expenditures made by the regional councils with their EMSOF allocations, we specifically looked at personnel expenditures reported on the audits for the eight councils required to submit them. We compared these figures against actual EMSOF salary and benefit expenditures as reported by the regional councils to BEMS for FY 2011-12 and found $51,058 less was spent according to the auditors than what was reported to us as actuals by the regional councils. The amount of personnel expenditures reported on the audits for the eight regional councils including that spent on federally funded regional planning coordinators was collectively $25,048 lower than the total actual amount of personnel expenditures reported by the councils to the Bureau of EMS. Given the differences in how the financial information in the audits was presented, we did not consider these differences to be material.

Comparison of Audits and Contract Budgets With IRS 990 Tax Filings

We next attempted to do a comparison of revenues and expenditures for each regional council and PEHSC as reported in their budget summaries and their audits to their IRS 990 filings required of 501(c)(3) organizations. No 990 tax filings were available for review for Chester, Delaware, Lycoming, Montgomery, and Philadelphia regional councils probably because they are affiliated directly with county government. Because the tax filings are not required to be submitted to the DOH, we attempted to obtain them online. Bucks County filed Form 990-EZ in 2011 and very limited expenditure data was included on the return. In two councils (Bradford-Susquehanna and Northeastern) and PESHC, the latest 990 tax return

available for review was for FY 2010-11. Because we were evaluating against FY 2011-12 audited expenditures we were unable to do a direct comparison. Federal 990 tax returns for FY 2011-12 were obtained for eight regional councils; Eastern, EHSF, EMMCO East, EMMCO West, EMSI, Seven Mountains, Southern Alleghenies, and Susquehanna councils.

Comparing the Federal 990s to other information we had showed that the most frequently occurring inconsistencies were related to program revenue and compensation of the council's executive directors. For example, the FY 2011-12 990 tax return for Eastern PA EMS Council shows total revenue of $2,139,840, of which $1,375,515 was depicted as government grants. The 990 return, however, includes $578,752 in program service revenue and $176,925 in miscellaneous revenue that was not reported to the department as secondary income by the council. The tax return also shows that the executive director received direct compensation of $146,986 and other compensation of $18,276 in FY 2011-12. Corresponding financial data provided by the department indicated that the total gross salary for the executive director in FY 2011-12 was $98,659, and the cost of benefits provided was $14,312, all paid with EMSOF grant money. The difference in compensation between the tax return and the financial data provided by the department, which were depicted as actual, was $52,291. The department provided no explanation as to why the discrepancy in the level of the executive director's compensation exists when we brought it to their attention.[28] Apart from the executive director's compensation very little was directly comparable between the tax return and financial audit except for travel expenses. The tax return also showed $36,733 in total travel expenses, while the financial audit showed only $20,925 in travel expenses, a difference of $15,808.

Secondary Income in Audits

The LB&FC obtained from the Department of Health the amount of secondary income each regional council reported receiving in FY 2011-12. Thirteen councils reported to the department receiving secondary income totaling $4,902,029. Of the 12 audits that were available for our review (11 of which were regional councils and one was PEHSC), 9 reported to the department that they received secondary income in FY 2011-12. Nine of the audits (Federation, EMMCO East, EMMCO West, EMSI, Northeastern, Seven Mountains, Southern Alleghenies, Susquehanna, and PEHSC) showed that secondary income was included in the audited figures. Three of the audits (Bradford Susquehanna, Eastern, and Philadelphia) contained no information on revenue, therefore secondary income could not be examined. Both Federation and EMSI reported no secondary income to the department, yet

[28] The definition of total compensation as defined in IRS instructions is very comprehensive and includes items such as deferred compensation and reimbursed travel expenses that may explain at least some of these discrepancies.

their audits showed secondary income ($2,058 and $34,251, respectively) was received and reported as revenue.

For nine of the audits, we could compare between secondary income reported to the department and secondary income as reported on the audited financial statements. In doing so, we found $107,258 more was reported by councils to the department than was reported by the auditors. And although the department provided us with a secondary income figure for Eastern of $14,400, they did not include the MedCom revenue to the council of $97,000[29] as secondary income, even though it was reported to them as secondary income by Eastern. Please see Table 14 and Table 23, respectively, for a listing of secondary income as reported by the regional councils and PEHSC.

Evaluation and Quality Assurance Activities

National EMS standards establish system evaluation and quality assurance as essential components of an EMS system. According to the standards, the state's EMS lead agency has primary responsibility in this area. Both the EMS Act and program regulations assign the DOH program evaluation and quality assurance activities.

Statutory and Regulatory Requirements

State law and program regulations contain numerous references to lead agency responsibilities pertaining to evaluation and quality assurance. Act 2009-37, specifically at §8104(13), requires the Secretary of the DOH to provide for the "periodic, comprehensive review and evaluation of the extent and quality of the emergency health care services provided in the system's service area." Another section of the act specifies that DOH has the authority to "maintain a quality assurance program for the purpose of monitoring the delivery of emergency medical services."

Act 37 also requires the Department to prepare and update a statewide EMS plan. This plan is to contain an assessment of the effectiveness of existing services and a method for evaluating the stated objectives of the plan. Most of the minimum required statutory components of the plan have system evaluation as a component, such as: assessing effectiveness of the EMS system, developing performance measures for the delivery of EMS services, developing methods and a schedule for achieving the stated performance measures, and having methods in place for monitoring and evaluating the achievement of the stated performance measures.

[29] Figure includes $85,000 of "in-kind" services as per Eastern PA EMS Regional Council submittal to DOH.

EMS program regulations reiterate that the department is lead agency for both program evaluation and quality assurance responsibilities. Regulation sections pertaining to the regional councils, 28 Pa. Code §1001.121(c), state that:

> The Department will evaluate the performance and effectiveness of each EMS regional council on a periodic basis to assure that each council is appropriately meeting the needs of its region in planning, developing, maintaining, expanding, improving and upgrading the EMS system in its region.

Program regulations also require that the state lead agency, in conjunction with the State Advisory Council, identify the necessary components for a statewide quality assurance program for the Commonwealth's EMS system.

DOH Program Evaluation Efforts

The NHTSA's *EMS Agenda for the Future* refers to systems evaluation as the essential process of assessing the quality and effectiveness of EMS, so that strategies for continuous improvement can be designed and implemented. We found that systematic focused evaluation activities at the state level have been, and continue to be, minimal.

Several previous LB&FC audits of the EMSOF found that the department was not conducting required evaluations of the performance and effectiveness of regional EMS councils, and our file review gave us little evidence that these activities are occurring today. Without these assessments there may be substantial amounts of EMSOF monies that are being expended with no formal evaluation of the performance and effectiveness of the organizations to which the monies are being provided. Our previous report recommended that the department should:

> ... develop a standard, regional EMS council evaluation/review instrument which can be administered on a sample of the regional councils on a rotating basis. This instrument should incorporate goals and objectives of the planned comprehensive statewide EMS plan and allow for evaluation of regional performance against these goals and objectives. Completion of these evaluations should include field visits and independent verification of data at the regional level by Health Department staff.

Assessments of Pennsylvania's EMS system by the NHTSA concluded that:

- The state EMS office must develop and implement a systematic plan for evaluation of regional council program effectiveness. This should include on-site reviews.
- The state EMS office must systematically assess the effectiveness of state dollars in affecting patient outcomes.

Health Department officials had previously stated that lack of adequate staffing prevented such evaluation efforts. We found that, as of January 2013, although a new state EMS plan has been adopted in 2010, the DOH was still not performing "performance and effectiveness reviews" of the type suggested in law, regulation, and contract language. The review of periodic progress reports submitted by the regional councils against workplans which was introduced first in 1991 continues, however, and has evolved into a more formal reporting process.

DOH Quality Assurance Activities

Previous LB&FC reports on the EMS system in Pennsylvania cited problems with the implementation by the department of an operationalized statewide, regional council-based, quality assurance program. According to the state EMS development plan, such plans are to provide "a systematic means to continuously improve the operational, clinical, and administrative aspect of EMS systems in their respective regions" and are seen as a top priority for the program. Quality assurance guidelines and a statewide quality assurance program were not in place in Pennsylvania's EMS system as of early 1998.

We found, however, that since that time the department has taken several steps to create a system that has instituted quality assurance processes at both the state and regional level. The formal grant agreement language that regional councils must comply with now includes the following:[30]

> F. In reference to Regional Programs, the Grantee shall:
>
> 1. Maintain a Regional EMS Quality Improvement Process to monitor the delivery of EMS, specific to emergency medical services provided by EMS personnel on an on-going basis;
> 2. Conduct unannounced quality improvement audits on the regional EMS system, including Advance Life Support Medical Directors and Medical Command Facilities when determined by the Department;
> 3. Investigate all complaints received from the public concerning the quality of care rendered by EMS personnel and forward recommendations and findings to the Department within 60 calendar days of receiving the complaint;
> 4. Facilitate the Regional Quality Improvement Committee, which shall recommend to the Grantee ways to improve the delivery of EMS within the region.
>   a. The Regional Quality Improvement Committee shall meet once every 90 calendar days, at locations to be determined by the Committee.

[30] Regional Council Grant Agreement, Appendix A: Work Statement, p. 2.

b. Grantee shall provide reports and recommendations of the Committee to the Department within 30 calendar days after the Committee meeting.

G. In reference to Complaints, the Grantee shall:
When assigned by the Department, investigate complaints related to the delivery of EMS within the region, including complaints reported against providers, organizations, agencies, hospitals and trauma centers. The Grantee shall, after receiving a Department assigned investigation, forward recommendations, based on the outcome of the complaint investigation, to the Department within 60 calendar days, unless the Department approves an extension.

This language is modeled from the quality assurance guidelines adopted by BEMS, effective July 1995. This document, developed with the assistance of PEHSC and entitled *Pennsylvania's Quality Improvement System Guidelines,* was intended to outline the structure of the quality assurance system at the state, regional, and local levels but had not been instituted at the regional level at the time of our last review.

The guidelines also require that the state BEMS office have a Medical Director on staff to oversee the quality and timeliness of clinical care delivered by the Commonwealth's EMS system. This position has been created and filled since the time of our last review. In addition, the bureau has focused all of their quality assurance activities in a specific program manager position, the EMS Quality and Data program manager who helps ensure that the activities are being undertaken as required including investigations, complaint handling, and liaison to the individual regional quality improvement committees.

We specifically asked the department how they ensured that basic inspection licensure, training, and certification functions are being completed by regional councils. They told us that the tracking system for ambulance licensing is an online program that requires bureau actions before a license can be issued. When a vehicle is inspected, an individual check sheet is generated and must be sent to the bureau before that individual vehicle receives a decal and can be used. Remaining components have to be completed during each phase of ambulance licensing once all of the requirements have been met. Bureau staff review the application and then take the action needed to license the vehicle.

The bureau also told us that the regular EMS council's training activities registry is computerized, and the staff need to take action to certify an individual who has been identified as an outlier for any reason, such as not meeting ongoing training requirements. The quick response service recognition program also has individual check sheets that must be provided before a QRS (Quick Response Service) can be recognized.

IV. Administration and Use of EMSOF Funding by the Regional EMS Councils

The Regional EMS Councils

Origin and Statutory Authority

Pennsylvania's current regional EMS structure had its origins in regional and county emergency health services (EHS) councils which began working with the Department of Health (DOH) as early as 1970 to plan and develop a statewide EMS system. Legislation enacted in 1976 established the legal basis for the Commonwealth's EMS system and provided for the development of comprehensive "systems" of EMS throughout the state. This early legislation authorized the department to develop such systems through a network of regional councils.

This original statute has been amended several times, the most recent of which was Act 2009-37 (which replaced Act 1985-45), but always continuing the use of regional emergency medical services councils to assist the DOH in carrying out the provisions of the EMS Act. The act defines a regional EMS council as:

> A nonprofit incorporated entity or appropriate equivalent that is assigned by the Department of Health to plan, develop, maintain, expand, and improve emergency medical services systems within a specific geographical area of this Commonwealth and to coordinate those systems into a regional emergency medical system.

By law, the EMS councils are to adhere to policy direction established by the department. EMS program regulations further provide that the DOH will designate an EMS council for each geographic area of the state. The department's designations are to be based on:

- Existing usual patient care flow patterns.
- The capability to provide definitive care services to the majority of general, emergent, and critical patients.
- Financial resources to sustain the EMS system operations.
- The capability to establish community-wide and regional care programs.

Duties and Responsibilities

As provided in Act 2009-37, the regional councils are to assist the department in achieving a unified statewide EMS system. Each council is responsible for organizing, maintaining, implementing, expanding, and improving the EMS system within its specified part of the state. The following are among the specific duties

and responsibilities which are to be performed by the councils, if directed by the department:

(1) Assist the department in achieving the Statewide and regional EMS system components and goals described under section 8104 (relating to emergency medical services system programs).

(2) Assist the department in the collection and maintenance of standardized data and information as provided in section 8106 (relating to emergency medical services patient care reports).

(3) Prepare, annually review and revise, as needed, a regional EMS system plan for the EMS region the department has designated and for which the department has contracted or provided a grant to it to serve.

(4) Carry out, to the extent feasible, the Statewide and regional EMS system plans.

(5) Assure the reasonable availability of training and continuing education programs for EMS providers.

(6) Provide necessary and reasonable staff services and appropriate and convenient office facilities that can serve as the EMS region's location for the planning, maintenance and coordinative and evaluative functions of the council.

(7) Establish a mechanism to provide for input from facilities and EMS agencies in the EMS region in decisions that include, but are not limited to, membership on its governing body.

(8) Establish, subject to department approval, regional EMS triage, treatment and transportation protocols consistent with Statewide protocols adopted by the department. A regional EMS council may also establish, subject to department approval, additional triage, treatment and transportation protocols. No regional protocol shall be subject to the rulemaking process.

(9) Advise public safety answering points and municipal and county governments as to the EMS resources available for dispatching and recommend dispatch criteria that may be developed by the department or the council as approved by the department.

(10) Assist the department in achieving a unified Statewide EMS system.

(11) Designate a regional EMS medical director and establish a medical advisory committee and a quality improvement committee.

(12) Develop a conflict of interest policy, subject to department approval, and require its board or advisory council members, officials and employees to agree to the policy in writing.

(13) Perform other duties assigned by the department to assist the department in carrying out the requirements of this chapter.

Many of these duties were added to the regional councils in Act 37 and were not in effect during the time of our last audit.

Council Structure, Organization, and Service Areas

As of FY 2011-12, the following 16 county or multi-county regional EMS councils were under contract to the DOH: Bradford Susquehanna EMS Council,; Bucks County; Chester County; Delaware County; Eastern Pennsylvania; EHS Federation; EMS Institute; EMMCO East; EMMCO West; EMS of Northeastern PA; Lycoming, Tioga, and Sullivan; Montgomery County; Philadelphia; Seven Mountains; Southern Alleghenies; and Susquehanna. (Bradford Susquehanna was merged with EMS of Northeastern PA in November 2012.)

While five counties in the southeastern portion of the state are single-county units, most are multi-county organizations. Emergency Medical Services Institute regional council in southwestern Pennsylvania encompasses the most counties, ten. Exhibit 9 identifies the counties which comprise each regional council.

Description of Council Types in Pennsylvania

The Emergency Medical Services Act, at 35 P.S. §8109(b), recognizes three organizational types which can function as EMS councils to assist the DOH in carrying out statutory EMS provisions in their respective geographic areas:

(1) A unit of general local government, with an advisory council, meeting requirements for representation.

(2) A representative public entity administering a compact or other area-wide arrangement or consortium.

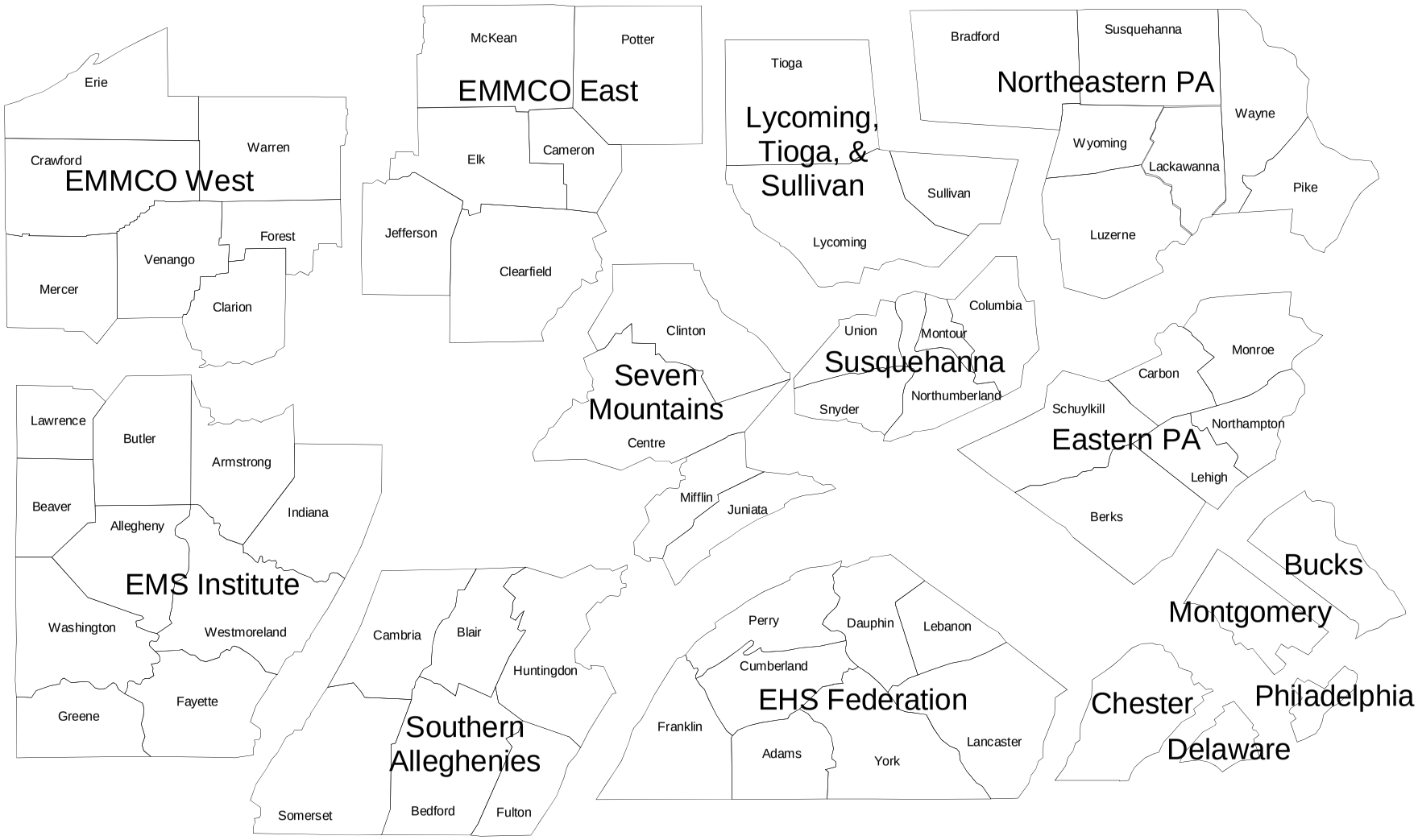
(3) Any other public or private nonprofit entity which meets requirements for representation.

The organizational structure of a regional EMS council is to representative of the public, health professions, and major private and public voluntary agencies organizations and institutions concerned with providing EMS in the region.

Unit of Local Government. Of the regional EMS councils currently under contract to the DOH, six are of the first type, a unit of general local government. Five of the regional councils are single-county regions. These include the southeastern counties of Bucks, Chester, Delaware, Montgomery, and Philadelphia. The sixth county-based regional system is a unique variation of this type in which the governing EMS council of one county (Lycoming) also serves in that capacity for two other counties (Tioga and Sullivan) through a contractual arrangement.

Exhibit 9

Regional EMS Councils



Source: Developed by LB&FC staff with information provided by BEMS, January, 2013.

With the exception of Philadelphia, the governing bodies for these councils are the county commissioners. The governing board of the Philadelphia EMS council consists of seven city government officials: the Mayor, the Managing Director, the Fire Commissioner, the Police Commissioner, the Health Commissioner, the Medical Director, and the Regional EMS Director. We found that each of the county-based regional EMS councils utilize, as required in statute, EMS advisory councils representing diverse EMS-related organizations and associations.

Nonprofit Organization. The remaining nine councils are incorporated private nonprofit entities governed by representative boards, which serve multicounty regions (Type 3). None of the councils are a representative public entity administering a compact or consortium (Type 2).

As shown in Table 9, the regional councils have service areas which range in population size from a low of 104,999 (Bradford Susquehanna) to a high of 2.7 million (EMS Institute); and in square mileage from 135 square miles (Philadelphia) to 7,045 square miles (EMS Institute).

Table 9

Regional EMS Council Service Areas
(As of June 30, 2012)

Region	Number of Counties	Total Population[a]	% Urban	% Rural	Square Miles
Bradford Susquehanna[b]	2	104,999	24%	76%	1,974
Bucks County	1	597,635	90	10	607
Chester County	1	433,501	81	19	756
Delaware County	1	550,864	99	1	184
Eastern PA EMS	6	1,300,619	75	25	3,347
EHS Federation	8	1,702,415	70	30	5,136
EMMCO East	6	234,416	39	61	5,091
EMMCO West	7	639,641	59	41	5,076
EMS Institute	10	2,656,007	78	22	7,045
Lycoming, Tioga & Sullivan	3	167,973	50	50	2,819
Montgomery County	1	750,097	97	3	483
Northeastern PA	5	654,649	68	32	3,023
Philadelphia	1	1,517,560	100	0	135
Seven Mountains	4	242,979	53	47	2,802
Southern Alleghenies	6	471,596	51	49	4,615
Susquehanna	5	256,113	54	46	1,724
Total	67	12,281,054	77%	23%	44,817

[a] Population totals are from the year 2000 as those figures were used by the Department of Health in calculating the FY 2011-12 EMSOF contracts with individual regional councils.
[b] Bradford Susquehanna Regional Council was merged with Northeastern PA Regional Council in November 2012.

Source: Developed by LB&FC staff from data provided by the Department of Health.

Emergency Responses and Regional EMS Resources

During FY 1996-97, when we last reviewed this program, Pennsylvania ambulance services responded to 1.2 million ambulance calls. As shown on Table 10, the number of responses has risen dramatically (over 83 percent) since then, with a total of approximately 2.2 million reported by providers during FY 2011-12. The number of responses in each regional council territory ranged from a low of 15,210 in Delaware County to a high of 655,066 in the EMS Institute region. The DOH estimates that 50 percent of the licensed ambulance services in Pennsylvania are providing 98 percent of the trips. The remaining 50 percent of the licensed services are providing 2 percent of the total trips made on an annual basis. As discussed on page 11 approximately 1.7 million (78 percent) of these trips were billable.

Table 10

Number of Emergency Trips Made by Ambulance Services in Pennsylvania, by Regional Council
(FY 2011-12)

Regional Council	Calls	Percent of Total
Bucks County	65,319	2.98%
Chester County	30,070	1.37
Delaware County	16,210	0.74
Eastern PA EMS	192,620	8.79
EHS Federation	295,163	13.47
EMMCO East	38,693	1.77
EMMCO West	111,463	5.08
EMS Institute	655,066	29.88
Lycoming, Tioga & Sullivan	31,600	1.44
Montgomery County	93,409	4.26
Northeastern PA[a]	160,909	7.34
Philadelphia[b]	270,000	12.32
Seven Mountains	33,903	1.55
Southern Alleghenies	148,579	6.78
Susquehanna	37,633	1.72
MISSING[2]	11,381	0.52
Total	2,192,018	100.00%

[a] The total for Northeastern includes runs made by the Bradford Susquehanna Regional Council, which merged with Northeastern PA EMS in November 2012.
[b] These trips were added to the count manually due to technological system incompatibilities.

Source: Developed by LB&FC staff from information provided by the PA Department of Health.

As of December 30, 2012, a total of 4,690 licensed ambulances (prehospital) were available to respond to calls for EMS, to provide prehospital medical treatment, and to transport patients to appropriate medical facilities. EMS response vehicles can be licensed by the Commonwealth in the following categories; (a) basic life support—BLS, (b) advanced life support—ALS, (c) advanced life support air ambulance services—ALS Air, and (d) advanced life support without transport capability—ALS Squad. The breakdown of these vehicles by type and by regional council is provided in Table 11.

Table 11

PA Licensed Ambulances by Type and Regional Council
(CY 2012)

Regional Council	BLS[a]	ALS[b]	ALS Squad[c]	AIR[d]	Total Ambulances[e]
Bucks	218	86	7	10	321
Chester	93	28	31	11	163
Delaware	133	55	35	12	235
Eastern	221	206	22	2	451
EHS Federation	393	107	97	3	600
EMMCO East	62	73	18	19	172
EMMCO West	79	102	19	18	218
EMS Institute	100	537	64	4	705
Lycoming, Tioga & Sullivan	66	18	13	7	104
Montgomery	215	118	6	13	352
Northeastern PA	258	199	26	5	488
Philadelphia	379	91	2	14	486
Seven Mountains	53	20	10	8	91
Southern Alleghenies	67	112	18	9	206
Susquehanna	47	29	7	15	98
Total	2,384	1,781	375	150	4,690

[a] Refers to stand-alone basic life support ambulances only.
[b] Includes ambulances which are licensed as part of an advanced life support service but which may also be licensed as a BLS service or an ALS Squad ambulance.
[c] Refers to an advanced life support service which is without transport capability.
[d] Refers to an advanced life support ambulance with air capability.
[e] Represents the total number of ambulances, some of which may be providing transport services in multiple categories.

Source: Developed by LB&FC staff from information obtained from the Department of Health, Bureau of Emergency Medical Services.

In Pennsylvania, individual companies may be licensed as one service even though they operate different levels of service (e.g., BLS as well as ALS) or operate out of multiple locations. For example, in Philadelphia, EMS is provided through-

out the City by the Philadelphia Fire Department (PFD). The PFD operates 37 stations, including a mixture of BLS and ALS, all under one license. Similar, but less extreme, cases exist throughout the Commonwealth. Table 12 shows the total number of EMS licensed service agencies by type and by regional council. In calendar year 2012, this figure was 2,200. If multiple service levels of licenses are removed, the total number of standalone services (i.e., one license equals one service) that exist in Pennsylvania as of CY 2012 is 1,073 (please see Table 4 for a breakdown by region). This compares to a total of 1,128 that we reported as of June 30, 1997, a decrease of 55, or approximately 5 percent, in the number of standalone licensed services over 15 years.

Table 12

Emergency Medical Services Agencies by License Types by Region
(CY 2012)

Region	Basic Life Support[a]	Advanced Life Support[b]	Quick Response Services[c]	AIR[d]	Total Services
Bucks	81	27	43	0	151
Chester	31	12	12	1	56
Delaware	54	18	15	0	87
Eastern	102	41	85	1	229
EHS Federation	146	45	120	1	312
EMMCO East	39	13	29	1	82
EMMCO West	70	20	36	2	128
EMS Institute	140	130	70	3	343
Lycoming, Tioga & Sullivan	45	7	38	0	90
Montgomery	86	34	13	1	134
Northeastern PA	137	32	34	4	207
Philadelphia	82	14	4	2	102
Seven Mountains	35	9	16	0	60
Southern Alleghenies	58	37	53	0	148
Susquehanna	35	20	15	1	71
Total	1,141	459	583	17	2,200[e]

[a] Refers to stand-alone basic life support services only
[b] Includes services which are licensed as advanced life support services but which may also be licensed as a BLS service or as an ALS squad service.
[c] Refers to an entity that provides EMS to patients pending the arrival of an ambulance service.
[d] Refers to an advanced life support service with air ambulance capability.
[e] Double counting occurs because some agencies chose to have individual licenses for various levels of service.

Source: Developed by LB&FC staff from data provided by the Department of Health, Bureau of Emergency Medical Services.

While licensed ambulance services receive the most regulatory attention, other services, known as Quick Response Services (QRS), have received increased

oversight in recent years. A Quick Response Service is recognized by the Department of Health if it meets certain requirements and is strategically located to fill a response time gap (e.g., if EMS cannot be provided within 10 minutes of the time a call for assistance is received). The definition can also be expanded to include a service which would meet a regional EMS council's needs, such as a marine response unit or industrial response team. Persons who serve as QRS personnel are certified through the Department of Health as a Quick Responder or First Responder if they have been trained and certified to the appropriate care level.

The total number of trained and DOH-certified prehospital personnel available to respond to calls for EMS as of calendar year 2012 was 55,437. This is up from 54,665 during last audit. This figure includes 38,435 EMTs, 10,146 EMT-Paramedics, 4,840 First Responders, and 1,628 prehospital RNs (see Table 13 for a breakdown by regional council). The number of First Responders has decreased the most (53 percent) since our last audit, while EMT paramedics and prehospital RNs saw significant increases at 51 percent and 176 percent respectively. In 2012, there were 388 certified prehospital MDs while in 1998 there were none. As depicted in Table 3, statewide, there are about 303 EMTs, 80 EMT-Paramedics and 38 First Responders per 100,000 population.

Table 13

Number of EMR's, EMT's, Paramedics, PHRN's and Physicians
(CY 2012)

Regional Council	Emergency Medical Responders	Emergency Medical Technicians	Paramedics	Pre-Hospital Registered Nurse	Physicians
Bradford Susquehanna ...	89	617	149	44	1
Bucks County	109	1,761	358	47	9
Chester County.....	83	1,306	308	86	4
Delaware County.....	38	1,756	384	67	6
Eastern PA	764	3,781	861	185	26
EHS Federation.....	396	5,562	1,133	219	50
EMMCO East.....	172	998	214	50	4
EMMCO West.....	208	2,584	604	115	16
EMS Institute	1,373	7,259	3,347	455	139
Lycoming, Tioga Sullivan .	289	1,048	211	28	2
Montgomery County	107	1,317	362	64	19
Northeastern PA.....	197	2,441	568	61	5
Philadelphia.....	17	4,372	853	71	12
Seven Mountains.....	166	945	163	12	4
Southern Alleghenies	640	1,761	478	90	8
Susquehanna	192	927	153	34	83
Total.....	4,840	38,435	10,146	1,628	388

Source: Developed by LB&FC staff from data provided by the Department of Health.

Regional Council Funding

Table 14 is a summary of income available to the regional councils during FY 2011-12 as reported to us by the BEMS. As the table shows, the regional councils had total revenues of $17,671,429 in FY 2011-12. EMSOF provided grants accounted for approximately $10.5 million (up from $8.0 million in FY 1996-97), or about 59 percent of total revenues available to the councils for the EMS system, including for prehospital provider disbursements in FY 2011-12. Approximately $2.3 million in revenue was from federal funds allocated by the BEMS as contract amendments. For a detailed breakdown of federal funds provided by the department to each regional council from FFY 2006-07 through FFY 2011-12, please see Table 15.

As Table 14 shows, the extent to which the regional councils rely on EMSOF funding varies significantly, from less than 15 percent of total revenues in some regions (Chester County) to over 75 percent of all revenues in seven of the regions. As of FY 2011-12, no regional councils are 100 percent dependent on EMSOF to fund their operations.

Income from secondary sources supplements EMSOF funding for most of the regional councils in existence in FY 2011-12. About $4.9.million (down from $6.0 million in FY 1996-97) was derived from secondary sources in this fiscal year. We found that regional councils receive secondary income from a variety of sources, including county governments, hospitals and community colleges, conferences, textbook sales, training tuition and related charges, and miscellaneous sales (e.g., sale of a vehicle, EMS patches). In some cases, this income takes the form of in-kind services. For example, some councils receive in-kind assistance from their county governments in the form of office and facility space, utilities, postage, and other operating, and administrative services.

Regional Council's Expenditure of EMSOF Allocations

A total of $10,482,008 in EMSOF funding was allocated to the regional EMS councils in FY 2011-12. This is a 26 percent increase from FY 1996-97, when $8,333,480 of EMSOF funds were granted. The department allocated these funds among the councils using the allocation formula methodology outlined in Chapter III of this report.

Table 14

Amount and Source of Income Available to the Regional EMS Councils
(FY 2011-12)

Regional Council	EMSOF	Federal Funds	Non Federal Governments	Training/ Tuition/ Books	Community Colleges	Other	Subtotal Secondary Income	Total Revenue	EMSOF as % of Total Revenue
Bradford Susquehanna[a]	$ 239,897.00	$ 44,200.00						$ 284,097.00	84.4[a]
Bucks County	337,827.00	42,700.00	$ 400,000.00	$ 52,000.00	$ 45,000.00		$ 497,000.00	877,527.00	38.5
Chester County	296,040.00	26,500.00	2,299,446.13	-	-	$ 42,574.91	2,342,021.04	2,664,561.04	11.1
Delaware County	249,723.00	112,700.00	-	22,320.45	-	42,000.00	64,320.45	426,743.45	58.5
Eastern PA EMS	1,020,917.00	340,197.00	14,400.00	-	-	-	14,400.00	1,375,514.00	74.2
EHS Federation	1,447,220.00	455,512.00	-	-	-	-	-	1,902,732.00	76.1[b]
EMMCO East	556,686.00	14,200.00	-	27,083.00	-	3,849.44	30,932.44	601,818.44	92.5
EMMCO West	816,933.00	191,452.00	-	-	-	58,317.00	58,317.00	1,066,702.00	76.6
EMS Institute	2,030,827.00	325,200.00	-	-	-	-	-	2,356,027.00	86.2[b]
Lycoming, Tioga & Sullivan	328,724.00	44,200.00	55,120.00	300.00	-	-	55,420.00	428,344.00	76.7
Montgomery County	369,387.00	54,200.00	475,897.00	118,000.00	95,000.00	62,600.00	751,497.00	1,175,084.00	31.4
Northeastern PA	753,775.00	283,700.00	8,400.00	51,365.00	-	12,736.00	72,501.00	1,109,976.00	67.9
Philadelphia	649,892.00	52,700.00	524,951.89	-	-	-	524,951.89	1,227,543.89	52.9
Seven Mountains	380,219.00	153,700.00	153,700.00	7,018.00	-	18,231.00	178,949.00	712,868.00	53.3
Southern Alleghenies	688,839.00	118,530.00	163,530.00	65,667.00	-	37,335.00	266,532.00	1,073,901.00	64.1
Susquehanna	315,102.00	27,700.00	1,868.00	24,785.00	-	18,535.00	45,188.00	387,990.00	81.2
Total	$10,482,008.00	$2,287,391.00	$4,097,313.02	$368,538.45	$140,000.00	$296,178.35	$4,902,029.82	$17,671,428.82	59.3

[a] Bradford Susquehanna Regional Council was combined with Northeastern PA Regional Council in November 2012. Information on the amount of secondary income received by Bradford Susquehanna Regional Council was not available.
[b] EHS Federation and EMS Institute reported no secondary income for FY 2011-12.

Source: Developed by LB&FC staff from data provided by the Bureau of Emergency Medical Services.

Table 15

EMS Federal Funding to Regional Councils

(FFY 2006-07 Through FFY 2011-12)

Regional Council	FFY 06-07	FFY 07-08	FFY 08-09	FFY 09-10	FFY 10-11	FFY 11-12	Total
Bradford Susquehanna	$ 126,019	$ 119,022	$ 93,969	$ 85,070	$ 51,289	$ 44,200	$ 519,569
Bucks County	91,528	95,000	70,000	221,350	60,974	42,700	581,552
Chester County	94,167	85,000	85,000	151,648[a]	52,566[a]	26,500	494,881
Delaware County	82,431	55,000	55,000	195,953	52,216	112,700	553,300
Eastern PA EMS	473,011	191,944	166,838	622,254	263,553[a]	340,197[c]	2,057,797
EHS Federation	295,906	187,194	240,007	738,250	335,888[a]	455,512	2,252,757
EMMCO East	117,941	91,166	66,007	107,969	41,569[a]	14,200	438,852
EMMCO West	161,553	133,710	108,523	316,111	143,317	191,452	1,054,666
EMS Institute	203,313	235,358	1,865,235[b]	1,206,711	587,048[b]	325,200	4,422,865
Lycoming, Tioga & Sullivan	91,760	65,583	65,503	105,598	54,020	44,200	426,664
Montgomery County	91,922	92,500	92,500	260,836	71,833	54,200	663,791
Northeastern PA	130,488	284,544	134,438	520,130	172,489	283,700	1,525,789
Philadelphia	89,954	140,000	140,000	466,365	77,549	52,700	966,568
Seven Mountains	137,710	137,144	112,038	211,486	146,417	153,700	898,495
Southern Alleghenies	156,832	193,027	192,894	375,918	183,321[a]	118,530[c]	1,220,522
Susquehanna	115,465	79,305	54,172	117,732	50,451[a]	27,700	444,825
Total	$2,460,000	$2,185,497	$3,542,124	$5,703,381	$2,344,500	$2,287,391	$18,522,893

[a] A total of $228,500 in Federal Hospital Preparedness Program funding was provided to seven regional councils for miscellaneous regional planning tasks, including $75,000 for Eastern EMS Med Com Center.

[b] Total includes $1,615,000 in Federal Office of Rural Health Policy funding for Medical Surge Equipment that EMSI received from the department.

[c] A total of $164,330 in Federal Hospital Preparedness Program funding was provided to two regional councils for miscellaneous regional planning tasks. Southern Alleghenies received $64,330 for medical surge equipment and Eastern EMS received $100,000 for its Med Com Center.

Source: Prepared by LB&FC staff using Bureau of EMS Matrix of SAF Amendments sheet FY 2006-07 to FY 2011-12

This section of the report provides an accounting of the purposes for which the regional councils expended their FY 2011-12 allocations. Exhibit 10 provides a listing of eligible expenditure activities according to both the current program statute and the current program regulations. The categories of eligible expenditures have changed in the statute since the time of our last audit in 1998, most notably the removal of certain equipment for hospital emergency departments from eligible expenditures (even though this language is still contained in program regulations) and the expansion of eligible activities to include costs associated with mergers/acquisitions of EMS agencies and costs to assist EMS agencies with recruitment and retention of providers. Program regulations have remained the same, however.

Exhibit 10

Purposes for Which EMSOF Monies Can Be Expended

(As Stated in Law and Program Regulations)

Statutory Authorization: 35 P.S. §8112(a)

1 EMS public education, information, health promotion and prevention.
2. Ambulance and other EMS vehicles and medical and rescue equipment purchases.
3. Training and testing for EMS providers.
4. Ambulance service inspections and licensures, including investigations.
5. Communications equipment and services, including alerting equipment.
6. Activities related to the merger/acquisition of EMS agencies.
7. Applying to costs associated with the maintenance and operation of regional EMS councils.
8. Data collection and analysis and system evaluation.
9. Costs associated to assist EMS agencies to recruit and retain EMS providers.

Program Regulations: 28 Pa. Code §1001.22.

1. Ambulance purchases, medical equipment, and rescue equipment.
2. Communications equipment.
3. Certain equipment for hospital emergency departments.[a]
4. Public education programs (including first aid and CPR courses).
5. Training programs for prehospital personnel.
6. Ambulance licensure inspections.
7. Maintenance and operation of regional councils (including salaries, benefits, travel, and equipment and supplies).
8. Collecting and analyzing data to evaluate the effectiveness of the EMS system.
9. Emergency allocations (costs associated with state or federally declared emergencies).
10. Implementation of voluntary certification programs, including voluntary rescue service certification programs.
11. Other costs deemed appropriate by the Department of Health.

[a]When such equipment is used or intended to be used in equipment exchange programs with ambulance services.

Source: 35 P.S. §8112(a) and 28 Pa. Code §1001.22.

Table 16 provides an accounting of how EMSOF monies were spent by region and by purpose within seven major spending categories. This information was compiled utilizing budget information found in FY 2011-12 regional council contracts with the Commonwealth as well as actual expenditure data for salaries and benefits obtained from the regional councils.

It is worth noting that Act 2009-37 removed the language requiring that 75 percent of the EMSOF funds available for emergency medical services systems shall be allocated for the direct support of those systems. This issue of what constituted "direct support" was a source of contention and uncertainty since the beginning of the program in 1985 due to differing interpretations of the legislative intent of the phrase (e.g., individual provider equipment needs, regional EMS system needs) and the department's unwillingness to clearly define it.

As Table 17 shows, approximately 55 percent of total EMSOF expenditures made by the regional councils in FY 2011-12 were for the salaries and benefit costs of regional EMS council staff. This compares to 42.6 percent spent in FY 1996-97. The second largest cost item in FY 2011-12 was approximately $2.3 million spent in the category of other costs (office rent, leases, supplies, etc.). Next was approximately $1.5 million in funds spent for prehospital provider equipment, which was approximately 9 percent lower than what was spent in this category in FY 1996-97. Training expenditures were the next highest at $588,784, or 5.8 percent of the total. In FY 1996-97, 11.7 percent of the total spent was for training. A complete comparison of FY 1996-97 to FY 2011-12 of all expenditures made, by category, for all regional councils combined is found below.

Salary and Benefit Expenditures. Spending from the EMSOF for salaries in FY 2011-12 was $4.2 million, compared to $2.7 million spent in FY 1996-97. We found that while the majority of the councils pay all salary costs with EMSOF monies, others such as the Chester, Bucks, and Philadelphia EMS councils, pay some salaries from other funds, most notably, county government monies. Please see Table 19 for a comparison of councils relative dependence on EMSOF for salary and benefit costs.

The regional councils used another $1,385,437 in EMSOF funds in FY 2011-12 to cover all or a portion of their fringe benefit costs. This is more than double what was spent on benefits at the time of our last study ($690,774). At three regional councils, Delaware; Lycoming, Tioga and Sullivan; and Montgomery, fringe benefits were paid entirely from non-EMSOF monies. In four cases, Eastern, EHS Federation, EMMCO East, and Susquehanna, all fringe benefits were paid with EMSOF monies. In the remaining councils, fringe benefit costs were covered with a combination of EMSOF monies and other funds.

In FY 1996-97, fringe benefit rates, based on total salary costs, ranged from a low of 18.5 percent at Lycoming, Tioga and Sullivan to a high of 42 percent at Philadelphia, with the average benefit rate amounting to 31.5 percent. In FY 2011-12 fringe benefit rates ranged from a low of 27 at EMSI to a high of 58 percent in Delaware County. The average fringe benefit rate for all councils in FY 2011-12 was 42.2 percent, an increase of approximately 34 percent over the 17 years since our last study. The fringe benefit rates are determined by each regional council and can

Table 16

Expenditures of Emergency Medical Services Operating Fund Monies, as Budgeted, by Regional Council and Purpose

(FY 2011-12)

Regional Council	Salaries[a]	PPE[b]	Training[c]	Fringe Benefits*	Travel	Consultant Services	Other Costs[d]	Total
Bradford Susquehanna	$ 90,601	$ 24,686	$ 9,031	$ 13,511	$ 3,884	$ 0	$ 73,451	$ 215,164
Bucks County	132,006	50,000	28,291	41,030	8,500	16,800	61,200	337,827
Chester County	99,494	79,873	79,922	23,831	0	0	10,300	293,420
Delaware County	176,421	0	42,900	0[d]	900	0	10,735	230,956
Eastern PA	446,080	10,000	31,500	181,880	27,900	0	289,647	987,007
EHS Federation	391,484	391,327	120,000	209,817	4,030	26,150	303,696	1,446,504
EMMCO East	195,270	101,205	17,000	83,509	18,700	0	144,424	560,108
EMMCO West	344,264	71,358	18,427	155,796	13,592	1,875	196,965	802,277
EMS Institute	657,759	370,000	95,000	171,564	23,800	35,000	568,340	1,921,463
Lycoming, Tioga & Sullivan	165,245	93,948	10,750	0[e]	7,875	0	45,600	323,418
Montgomery County	288,125	81,262	0	0[e]	0	0	0	369,387
Northeastern PA	351,677	5,000	71,805	137,499	7,355	0	134,898	708,234
Philadelphia[f]	285,168	152,564	29,108	128,217	1,675	0	74,282	671,014
Seven Mountains	170,476	16,851	14,800	67,112	11,442	0	70,926	351,607
Southern Alleghenies	298,009	25,108	13,250	128,313	12,850	0	177,250	654,780
Susquehanna	118,995	5,900	7,000	43,358	6,425	0	84,381	266,059
Total	$4,211,074	$1,479,082	$588,784	$1,385,437	$148,928	$79,825	$2,246,095	$10,139,225

[a] Salaries and benefits reported on this table are actuals, as opposed to the remainder of the categories which are budgeted amounts. Therefore, amounts expended will not equal EMSOF contracted amounts.
[b] Prehospital Provider Equipment (PPE) funding provided to providers by regional councils from EMSOF.
[c] Expenditures made for training function above and beyond to salaries and benefit costs for training-related staff.
[d] Includes subcontract services, equipment, supplies, printing, vehicle maintenance and other administrative costs.
[e] Fringe benefits are paid by county.
[f] EMSOF paid salary and benefits for Philadelphia are for FY 2012-13.

Source: Developed by LB&FC staff from financial data provided by the Bureau of Emergency Medical Services.

Table 17

Amount and Percent of EMSOF Monies Spent By Regional Councils by Category
(FY 1996-97 Compared to FY 2011-12)

	1996-97		2011-12	
	Amt	% of Total	Amt.	% of Total
Salaries and Benefits[a]	$3,395,297	42.6	$5,596,511	55.2
Training	933,131	11.7	588,784	5.8
Prehospital Provider Equipt[b]	1,873,654	23.5	1,479,082	14.6
Travel	122,905	1.5	148,928	1.5
Consultant Services[c]			79,825	0.8
Other Misc Costs	1,637,259	20.6	2,246,095	22.1
Total	$7,962,246	100.0	$10,139,225	100.0

[a] Total salaries and benefits are actuals for FY 2011-12, except for Philadelphia where FY 2012-13 data was used.
[b] These figures include EMSOF monies for PPE that were either retained by councils for their own use or disbursed to local prehospital providers.
[b] Includes subcontract services, rent, leases, equipment, supplies, printing, vehicle maintenance, and other administrative costs.
[c] This category of expenditures was combined into "Other Costs" in FY 1996-97.

Source: Developed by LB&FC staff from actual salary and benefit data for each regional council and from expenditures estimated by each regional council for training, prehospital provider equipment, travel, consultant services and other miscellaneous costs as part of the contract process.

include Social Security, Workmen's Compensation, Medicare, Unemployment Taxes, Health, Dental, Vision, Pension, and Life Insurance. Please see the section titled "salary and benefit review" beginning on page 71 for comparison of salaries and benefits available to employees at each regional council.

Other Costs. The second largest cost item in FY 2011-12 was approximately $2.3 million spent in the category of other costs (office rent, leases, supplies, etc.). This compares to approximately $1.6 million ($1,519,643 plus $117,616 in consultant services) spent in this category in FY 1996-97. If a like comparison is done of these two spending categories, 20.6 percent of the total EMSOF money spent in FY 1996-97 was spent on other costs and 23.9 percent was spent in FY 2011-12.

Prehospital Provider Equipment. "Prehospital provider equipment" (PPE) is a designated budget category on budget and expenditure formats used by the BEMS in administering EMSOF monies. This budget/expenditure classification generally refers to monies which are disbursed by the regional councils to prehospital providers (primarily ambulance services) within their regions. These disbursements have traditionally been for equipment purchases.

In FY 1996-97, 23.5 percent of the EMSOF monies, or $1,873,654, were reported as PPE expenditures. About one-third of this amount, $630,453, was retained for use by certain regional councils. The balance of $1,243,201 was disbursed to local EMS providers. In FY 2011-12, $1,479,082 (14.6 percent of expenditures) was spent from EMSOF by regional councils on PPE related items, $1,116,593 (75.5 percent) was disbursed to local EMS providers, and $362,489 (24.5 percent) was retained for use by certain regional councils. The majority of this money was used for equipment purchases. Delaware County did not spend any of their FY 2011-12 EMSOF allocation on PPE items.

Training. Training expenditures using EMSOF funds amounted to $933,131 in FY 1996-97, or 11.9 percent of total spending. In FY 2011-12, EMSOF funds spent for training purposes was $588,784, a decrease of nearly 37 percent. This figure does not include salary and benefit expenditures for council staff involved in training activities. While the nature of training costs vary by region, typical training costs include the purchase and maintenance of training equipment, instructor fees, class tuition fees, testing facility rentals, and testing supplies.

Training expenditures from EMSOF funds in FY 2011-12 ranged from a low of zero dollars in Montgomery County to a high of $120,000 at EHS Federation, with an average of $36,799. In FY 1996-97, the high was $304,675 at EMS Institute, with an average training cost of $58,321. We are not aware of whether regional councils used other sources of funding available to them in FY 2011-12 for additional training expenditures.

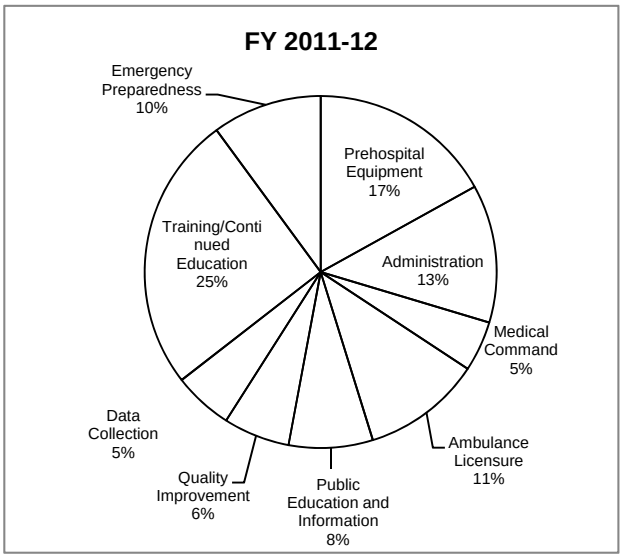
Travel Costs. Regional council travel expenditures include costs for vehicle leasing; vehicle maintenance and operations; mileage for non-leased vehicles; and lodging, subsistence, and tolls. Vehicle lease rates varied for each region, whereas mileage costs were 51 cents a mile for all councils (compared to 30 cents a mile in FY 1996-97). Contracts require that the councils use EMSOF monies for travel in accordance with Commonwealth travel guidelines.

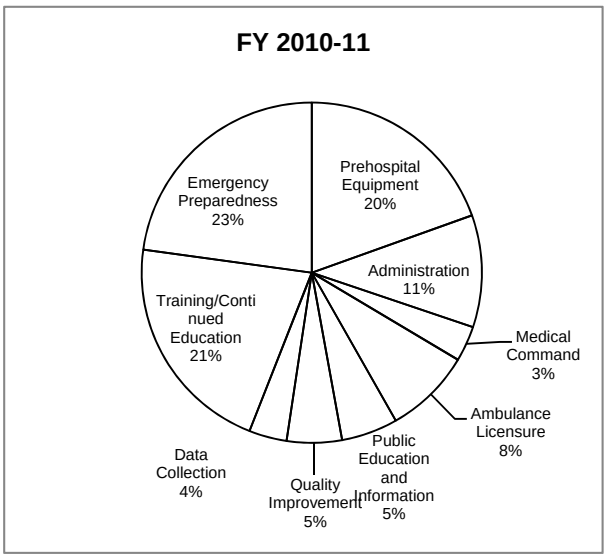
Regional council spending for travel totaled $148,928 in FY 2011-12, with a high of $27,900 at Eastern PA EMS and a low of zero dollars in both Montgomery and Chester Counties. The average spent in FY 2011-12 per council was $9,308. In FY 1996-97, total travel expenditures were $122,905, or $7,681 per council.

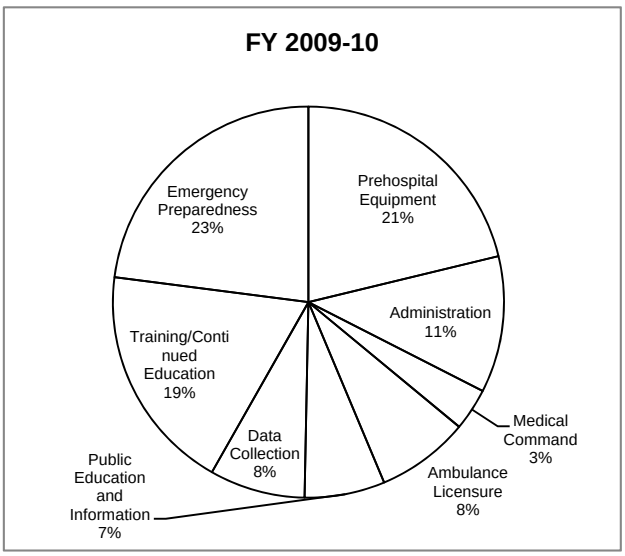
As noted in Chapter III of this report regarding audit requirements, we compared the regional council's spending of EMSOF monies against authorized spending purposes as set forth in law and regulation. We found that expenditures made by the councils are consistent with the authorized spending purposes shown on Exhibit 10. Exhibit 11 shows the percent spent, by category, of EMSOF money by the regional councils from FY 2008-09 to FY 2011-12 followed by an explanation of the spending categories provided by the department.

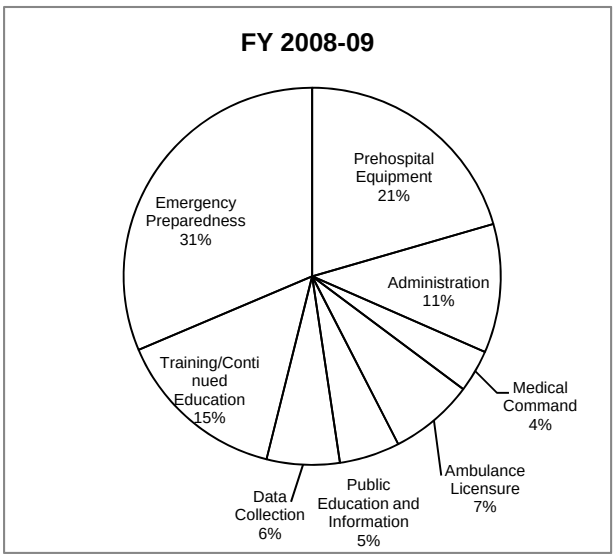
Exhibit 11

Regional Council Expenditure Trends
FY 2008-09 Through FY 2011-12









Source: Created by LB&FC staff using data provided by the BEMS, Pennsylvania DOH.

Spending Category Definitions Used by BEMS

Administration - Salary and fringe, office space, office supplies, payroll processing, accounting, travel.

Medical command - Salary and fringe, medical director, staff for hospital inspection, meeting events, travel.

Ambulance licensing - Salary and fringe, travel, maintenance of data collection, processing license applications, processing QRS recognition certificates.

Public education - Public information and education activities including printing and travel.

Quality assurance - Salary and fringe for quality assurance activities, data analysis.

Data collection - NEMSIS: compatible software, salary and fringe, report generation, data transfer support of quality assurance activities, transfer of data to national technical assistance center.

Emergency preparedness - Support of strike teams, planning and conducting drills and tabletops, salary for regional planning coordinators, hospital preparedness, trailers, tow vehicles, SMS planning.

Prehospital equipment - Direct provider support: equipment and special projects.

Regional Council Staffing

As Table 18 depicts, full-time regional council staff sizes range from three to 12, with an average complement of 6.5 full-time employees per council. This is up from an average of six staff per council in 1998. There are a total of 21 part-time staff statewide. While staff size varies from council to council, there is some commonality of staffing structures.

Typical positions include an executive director, a training coordinator, a quality assurance director, a licensing coordinator, and various support staff, such as a secretary and administrative assistants. With the exception of Philadelphia and LTS, staff at the regional council are nonunionized. The following are brief descriptions of these positions:

Director - responsible for oversight of the staff and EMS system operations for the county or multi-county area.

Deputy Director - has primary responsibility for preparing and managing the budget and contract with Department of Health (state fiscal year) and for the county budget (calendar year); also has responsibilities related to other phases of the EMSOF Program.

Table 18

Regional EMS Council Staff Sizes
(As of June 30, 2012)

Region	Number of Staff Full-Time	Part-Time
Bradford Susquehanna	3	3
Bucks County	6	1
Chester County	5	2
Delaware County	5	1
Eastern PA EMS	8[a]	3
EHS Federation	9[a]	4[b]
EMMCO East	4	0
EMMCO West	9[a]	0
EMS Institute	12[a]	0
Lycoming, Tioga & Sullivan	6	1
Montgomery County	6	1
Northeastern PA	9[a]	0
Philadelphia	7	0
Seven Mountains	5[a]	0
Southern Alleghenies	8[a]	4
Susquehanna	3	1
Total	105	21

[a] One of the full-time staff positions is funded by a federal Hospital Preparedness Program grant and utilized for emergency preparedness purposes.
[b] Four of the 13 total positions were EHS Federation evaluators, EHS Federation patient actors, National Registry Evaluators, and National Registry Patient Actors paid with EMSOF funds.

Source: Developed by LB&FC staff from staffing information obtained from the Pennsylvania Department of Health and the regional EMS council offices.

Prehospital Systems Coordinator - responsible for all aspects of the Ambulance Licensure Program and for the Medical Command Facility Accreditation program.

Training Coordinator - responsible for all aspects of the EMS training program; the individual in this position supervises various courses provided through EMS training institutes in the region and assists the State Training Coordinator on various projects.

Data Coordinator - responsible for collection and dissemination of data.

Technical Program Specialist - responsible for development and manipulation of office software programs.

Field Representative - primarily responsible for assisting with on-site inspection in the ambulance licensure and medical command facility accreditation programs.

Secretary/Administrative Assistant - responsible for providing clerical and typing services to office personnel especially related to training and licensing recordkeeping.

Emergency Preparedness Specialists - Six of the regional councils (Eastern, EMMCOW, EMSI, Federation, Northeastern, and Seven Mountains) have employees that function in this capacity. The positions are funded with federal grant funds.

Salary and Benefit Review

House Resolution 315 directed the LB&FC to undertake a comprehensive listing of all compensation packages of all employees of the regional emergency medical services councils and the Pennsylvania Emergency Health Services Council (PEHSC). Additional information, including revenue and expenditure data for PEHSC is found after this analysis.

Working in conjunction with the Bureau of Emergency Medical Services, we contacted each regional council and PEHSC and requested information on the total compensation package, including benefits, that each board member and employee receives as part of their employment package. We gathered information on positions; salary levels; healthcare coverage for employees and their dependents (including vision, dental, and pharmacological); amount, if any, the employee must contribute to participate in those plans; and copays and deductibles required to be met as a part of these benefits. In addition, we examined the number of paid holidays, vacation, sick, and personal leave earned annually and the nature of payments received for unused leave upon separation or retirement. Finally, we examined the amount of life insurance provided and the type of pension plan available to employees including employee and employer contributions and the amount of time required to vest in the plan. We looked at whether employees are able to purchase additional life insurance and contribute additional funds to the retirement plan.

Table 19 provides a comparison of the relative dependence that each regional council and PEHSC have on the EMSOF for their salary and benefit costs. It also depicts benefit costs as a percent of total salary and benefit costs as a percent of total compensation costs (both salary and benefits). Table 20 provides three years' worth of EMSOF expenditure data for salaries and benefits at each regional council.

The average percent of total regional council and PEHSC salary and benefits paid for with EMSOF allocations is 79 percent and 77 percent respectively, showing

Table 19

Comparison of Gross Salaries and Benefits and EMSOF Amount Spent on Salaries and Benefits for Each Regional Council and PEHSC

(FY 2011-12)

Regional Council	Amount of Gross Salaries	EMSOF Amount Spent on Salaries	Percent of Total Salary Paid With EMSOF	Gross Amount Spent on Benefits	EMSOF Amount Spent on Benefits	Percent of Total Benefits Paid With EMSOF	Total Benefits as a Percent of Total Salary	Benefit Costs as a Percent of Total Compensation Costs
Bucks County	$ 311,442	$ 132,006	43%	$ 174,594	$ 41,030	24%	56%	36%
Chester County	299,713	99,494	34	91,237	23,831	27	31	23
Delaware County	261,630	176,421	68	151,500	0	0	58	37
Eastern PA EMS	510,261	446,080	88	186,218	181,880	98	37	27
EHS Federation	443,922	391,484	89	231,049	209,817	91	52	34
EMMCO East	195,270	195,270	100	83,509	83,509	100	43	30
EMMCO West	385,545	344,264	90	181,251	155,796	86	47	32
EMS Institute	728,092	657,759	91	195,051	171,564	88	27	31
Lycoming, Tioga & Sullivan	237,926	165,245	70	103,207	0	0	44	30
Montgomery County	312,307	288,125	93	106,447	0	0	34	26
Northeastern PA	393,378	351,677	90	174,344	137,499	79	45	31
Philadelphia[a]	440,212	285,168	65	186,846	128,217	69	43	30
Seven Mountains	205,436	170,476	83	84,084	67,112	80	41	29
Southern Alleghenies	412,136	298,009	73	156,603	128,313	82	38	28
Susquehanna	118,995	118,995	100	43,358	43,358	100	37	27
PEHSC	308,032	256,632	84	73,382	57,962	79	24	19
Total	$5,564,297	$4,377,105		$2,222,680	$1,429,888			
Average	$347,769	$273,569	79%	$138,918	$109,991	77%	41%	29%

[a] Data provided for Philadelphia is for FY 2012-13.

Source: Salary and benefit information provided by the Department of Health.

Table 20

Actual Salaries and Benefits Paid by Each Regional Council for Three Fiscal Years Utilizing EMSOF Monies

(FYs 2009-10, 2010-11 & 2011-12)

	FY 2009-10		FY 2010-11		FY 2011-12	
Regional Council	Salary	Benefits	Salary	Benefits	Salary	Benefits
Bradford Susquehanna	$ 87,689	$ 14,180	$ 77,477	$ 10,814	$ 90,601	$ 13,511
Bucks County	129,945	38,671	129,946	39,833	132,006	41,030
Chester County	127,770	121,553	88,701	24,029	99,494	23,831
Delaware County	216,577	0[a]	173,295	0[a]	176,421	0[a]
Eastern PA	413,062	140,458	397,450	145,616	446,080	181,880
EHS Federation	331,408	180,523	367,318	200,285	391,484	209,817
EMMCO East	177,091	72,011	185,952	76,048	195,270	83,509
EMMCO West	310,443	165,489	324,633	147,773	344,264	155,796
EMS Institute	579,197	152,324	644,030	181,024	657,759	171,564
Lycoming, Tioga & Sullivan	161,634	0[a]	164,815	0[a]	165,245	0[a]
Montgomery County	270,834	0[a]	279,756	0[a]	288,125	0[a]
Northeastern PA	326,831	126,272	335,573	132,272	351,677	137,499
Philadelphia[b]	269,898	99,862	277,994	102,858	285,168	128,217
Seven Mountains	163,737	64,436	170,013	65,352	170,476	67,112
Southern Alleghenies	281,288	105,606	320,776	112,326	298,009	128,313
Susquehanna	143,365	52,105	147,116	47,329	118,995	43,358
Total	$3,990,769	$1,333,490	$4,084,845	$1,285,559	$4,211,074	$1,385,437

[a] Benefits paid by the county.
[b] Salary and fringe benefits for Philadelphia are for FY 2012-13.

Source: Developed by LB&FC staff from information provided by the Department of Health.

a relative high dependence on EMSOF monies for these basic functions. Benefits as a percent of total salary across all councils and PEHSC averages 41 percent. Delaware was the highest at 58 percent, and PEHSC was the lowest AT 24 percent. Three councils were over 50 percent. Benefits as a percent of total compensation costs across all councils and PEHSC averaged 29 percent in FY 2011-12, with a low of 10 percent at PEHSC and a high of 37 percent at Delaware. This is in line with a recent publication that stated that as of December, 2012 nearly one third (31 percent) of costs in all industries to employers for workers total compensation went to pay for benefits.[1] Of that 31 percent, the largest share (8.5 percent) was directed to health care costs. The report went on to state that, when broken out, the cost to state and local governments for paying total benefit costs was, on average, 35 percent of total compensation provided to employees.[2] A more in depth discussion of council and PEHSC benefit expenditures follows on page 75 of this report.

[1] *Number of the Week: Employers' Benefits Costs,* The Wall Street Journal, March 23, 2013.
[2] *Number of the Week: Employers' Benefits Costs,* The Wall Street Journal, March 23, 2013.

EMSOF Funds Used for Salaries

We compared salary levels for typical positions utilized at all regional councils and PEHSC. Table 21 shows the results of this comparison. We note that the Emergency Medical Services Bureau Director reported that council board members receive no compensation for their participation in the regional councils, including per diems and travel expenses.

Table 21

Gross Salaries by Regional Council for Selected Positions
(FY 2011-12)

Regional Council	Amount of Gross Salaries	EMSOF Amount Spent on Salaries	% of Total Salary Paid With EMSOF	Executive Directors	Training/ Education	Licensing	Clerical
Bucks County	$ 311,442	$ 132,006	43%	$ 63,351	$ 50,221	$ 50,221	$ 80,249[a]
Chester County	299,713	99,494	34	76,294	41,500	101,746[a]	0[b]
Delaware County	261,630	176,421	68	80,209	90,477[a]	61,492	24,451
Eastern PA EMS	510,261	446,080	88	98,659	55,999	47,112	65,918[c]
EHS Federation	443,922	391,484	89	85,059	35,081	34,632	21,722[a]
EMMCO East	195,270	195,270	100	60,944	51,542	45,386	37,398
EMMCO West	385,545	344,264	90	69,999	38,865	48,281	67,161[a]
EMS Institute	728,092	657,759	91	92,643	229,528[d]	175,698[c]	0[b]
Lycoming, Tioga & Sullivan	237,926	165,245	70	60,751	70,842[a]	35,102	30,173
Montgomery County	312,307	288,125	93	85,195	98,795[a]	44,138	32,176
Northeastern PA	393,378	351,677	90	75,900	48,372	37,520	68,760[a]
Philadelphia	440,212	285,168	65	96,037	59,007	65,910	39,488
Seven Mountains	205,436	170,476	83	51,868	38,624	38,624	41,360
Southern Alleghenies	412,136	298,009	73	77,924	124,588[c]	52,635	36,266[a]
Susquehanna	118,995	118,995	100	50,003	8,908[e]	35,290	24,794
PEHSC	308,032	256,632	84	84,819	None	None	67,669[a]
Total	$5,564,297	$4,377,105		$1,209,655	$1,042,349	$873,787	$637,585
Average	$347,769	$273,569	79%	$75,607[f]	$47,380[f]	$48,544[f]	$30,361[f]

[a] Total salary of two staff.
[b] Council reported that they did not have clerical staff in FY 2011-12.
[c] Total salary of three staff.
[d] Total salary for four staff.
[e] Part-time position.
[f] The total was divided by the total number of staff identified by each council and PEHSC that they considered executive directors, training/education staff, licensing staff, and clerical staff.

Source: Salary information provided by the Department of Health. To determine positions for each category calls were made to selected councils asking them to identify their training/education, licensing, and clerical staff. For other councils a determination was made by looking at the job titles that were provided to the LB&FC.

All regional councils and PEHSC rely on EMSOF to pay for a portion or all of employee salary costs. The average percent of employee's salaries paid with

EMSOF for the councils and PEHSC was 79 percent. The lowest percent of total salaries paid with EMSOF was in Chester County (34 percent), while the highest percent of total salaries paid with EMSOF was in EMMCO East and Susquehanna (100 percent). Nine regional councils and PEHSC used EMSOF to pay for 83 percent or more of salaries for employees. Four councils relied on EMSOF to pay between 65 and 73 percent of salaries for employees. Two councils relied on EMSOF to pay between 34 percent and 43 percent of salaries for employees.

As shown, the average salary for executive directors at the regional councils is $75,607 per year, with a high of $98,659 at Eastern and a low of $50,003 at Susquehanna. Employees region-wide that are utilized in training coordinator/specialist positions average $47,380 per year, with a high of $77,924 at Southern Alleghenies (Executive Director) and a low of $8,908 at Susquehanna (part-time). Per council, the average spent on training positions is $69,490. Several of the councils, however, have more than one person that is employed for this purpose with a total of 22 staff across all regions.

Licensing/inspection functions are handled typically by licensing coordinators, operational specialists, or field representatives. Their average salary per position is $48,544 per year, with a high of $65,910 in Philadelphia and a low of $34,632 at Federation. An average of $58,253 is spent per council on these positions, since some of the councils have more than one employee doing licensing/inspection work for a total of 18 positions statewide. Finally, there are a total of 21 staff at 13 regional councils and PEHSC performing clerical/administrative work. Staff at Chester and EMSI do their own clerical work. The high salary is $41,360 at Seven Mountains and the low is $14,064 at Eastern (part-time). Average salary for the 21 total positions is $30,361 per year, while an average of $45,542 is being spent for this purpose by each council that has clerical staff.

EMSOF Funding Used for Benefits

We asked the regional councils and PEHSC to provide us with a breakdown of their FY 2011-12 specific benefits paid for with their EMSOF allocation. Typical categories of benefits' expenditures reported to us were healthcare, retirement, life insurance, workers compensation, and contributions made under the Federal Insurance Contribution Act (FICA). Table 22 shows the comparison between these various specific categories by regional council and PEHSC. As noted previously, three regional councils do not use any EMSOF funds to pay for benefits. In contrast, two regional councils used EMSOF funds to pay all their benefits. Ten regional councils and PEHSC used a blend of EMSOF and other funds to pay for their employees' benefits. The reliance placed on EMSOF for these councils that use other funds as well as EMSOF is depicted on Table 19. The average reliance is 77 percent (excluding those that are zero) and it is noted that those councils with the lowest reliance are those affiliated with counties. Nine councils and PEHSC used EMSOF funds for 79 percent or more of their benefit costs in FY 2011-12.

Table 22

Breakdown by Type of Benefits Paid by Regional Councils and PEHSC With EMSOF Funds

(FY 2011-12)

Council[a]	EMSOF Amount Spent on Benefits	Percent of Benefits Dependent on EMSOF	Health, Including Dental/Vision and Pharm.[b]	Retirement	Life Insurance	Vacation	FICA[c]	Unemp/ Workers Comp.
Bucks	$ 41,030	24%	65%	19%	<1%		15%	1%
Chester	23,831	27	34	40	1		25	
Delaware	0	0						
Eastern	181,880	98	81	12	6			
EHSF[d]	209,817	91	65	11	6	2%[e]	15	1
EMMCO East	83,509	100	65	11	5		19	
EMMCO West	155,796	86	63[f]	11	2	23[g]		
EMSI	171,564	88	70	27	3			
Lycoming, Tioga & Sullivan	0	0						
Montgomery	0	0						
Northeastern	137,499	79	54	22	<1		21	2
Philadelphia	128,217[h]	69	64[f]	18	<1		11	7
Seven Mountains	67,112	80	61	14	3		19	3
Southern Alleghenies	128,313	82	57[i]	18	6		16[j]	4
Susquehanna	43,358	100	70	17	4		9	
PEHSC	57,962	79	74	12	14			
Average		77%[k]	63%[k]	18%[k]	4%[k]	13%[k]	17%[k]	3%[k]

[a] Delaware, Lycoming and Montgomery councils did not have any benefits paid out of EMSOF and therefore are not included in this table.
[b] Disability is included as part of health benefits.
[c] For some councils this may include other payroll taxes that were not broken out.
[d] Does not include benefit that the council pays for staff uniforms.
[e] Encumbered by council for annual leave payout.
[f] Includes Wellness payment made to employees for health related items such as gym membership.
[g] EMMCO West holds a duplicate amount of money to pay for PTO leave throughout the year even though these payments are covered by the EMSOF amount used for salaries. This money is then reallocated to other uses at the end of the fiscal year such as PPE expenditures.
[h] Philadelphia's EMSOF amount for benefits is for FY 2012-13. Also, Philadelphia budgets less than 1 percent to provide basic legal services for employees.
[i] Includes the percent the council pays as cash in lieu of health insurance to employees covered by health insurance under another plan.
[j] Includes a small amount of unemployment.
[k] Averages exclude those regional councils who do not use EMSOF to pay benefit costs or who did not report benefits paid with EMSOF for selected categories (vacation, FICA, and unemployment/workers compensation).

Source: Developed by LB&FC staff from data provided by EMS Regional Councils.

As expected, the single largest category of benefits' expenditures were health care costs. Of the EMSOF funds used by 12 councils and PEHSC to provide benefits for employees in FY 2011-12, an average of 63 percent was spent on health care costs, including dental, vision, and prescription. Pennsylvania's *2012 State Government Workforce Statistics Report* shows that in FY 2010-11 health benefit costs were 43 percent of total benefit costs based on agency contributions to the state employees' health care program.[3] On average, regional councils and PEHSC spent a much higher percent of the EMSOF funding utilized benefits for health care costs.

All councils but one (Chester at 34 percent) spent more of their benefit costs on health care than the percent that health care represented in total benefit, costs for Commonwealth employees. Eastern was the highest at over 80 percent and two additional councils (EMSI and Susquehanna) and PEHSC were at or above 70 percent of their benefit costs that went towards health care. Items we included in this category of expenditures included insurance premiums for basic, dental, and vision coverage; prescription coverage; wellness programs; disability coverage; Medicare payments (if broken out separately by the council); and payments to reimburse employees the difference in costs if they were able to obtain health care coverage through a spouse's plan.

Retirement was the second largest benefit category for which councils reported spending EMSOF funds. On average, the councils and PEHSC directed 18 percent of EMSOF funding spent on benefits toward retirement. This is higher than what the Commonwealth paid toward retirement. In 2010-11, approximately 10 percent of total benefits paid by the Commonwealth were directed toward employee retirement costs.[4] The amount reported spent by councils on retirement ranged from a low of 11 percent reported by three regional councils (EHSF, EMMCO East, and EMMCO West) to a high of 40 percent reported by Chester County. However, Chester County utilized less than $24,000 in EMSOF funds to pay for benefits, choosing to pay the major cost of benefits with other funds.

Councils used a relativity small amount of EMSOF funds to pay for life insurance. PEHSC was the one exception in that it reported that 14 percent of EMSOF funding used for benefits was spent on life insurance costs for employees. Three councils (Eastern, EHSF, and Southern Alleghenies) reported that they spent 6 percent of their EMSOF funds for life insurance costs. Four councils reported that they spent 1 percent or less of EMSOF funding used for benefits for life insurance benefits (Bucks, Chester, Northeastern, and Philadelphia). The average percent paid for life insurance by all organizations utilizing EMSOF funds for benefits was 4 percent.

[3] *2012 State Government Workforce Statistics Report,* PA Office of Administration, p. 8.
[4] *2012 State Government Workforce Statistics Report,* PA Office of Administration, p. 8.

Regional councils and PEHSC were not consistent in the categories they reported for benefits paid with EMSOF. For example, only nine regional councils reported on the amount of Federal Insurance Contributions Act (Social Security and Medicare) that were paid using EMSOF benefits, and only six reported that they used EMSOF funds to pay for unemployment and/or workers compensation.

The variation in how councils spend the EMSOF monies does not allow the department to make meaningful cross-cutting comparison for all councils. As an example, two regional councils (EHSF and EMMCO West) reported that they encumbered a portion of their EMSOF benefit funds to pay for vacation or Personal Time Off (PTO) related salaries. EHSF used it for payouts to employees who might separate from employment. EMMCO West however, holds a duplicate pot of money to pay for PTO leave throughout the year, even though these payments are also covered by the EMSOF amount used for salaries. This money is then reallocated to other uses at the end of the fiscal year.

Comparison of Councils' Benefits Packages

Exhibits 12, 13, and 14 show the results of the comparison of benefits provided for all regional councils, PEHSC, and typical employees of the Commonwealth at agencies under the Governor's jurisdiction. The exhibits are followed by an analysis of their content. Descriptions of the specifics for each EMS regional council,[5] PEHSC, and the Commonwealth can be found in Appendix A.

Holidays, Vacation Days, and Carryover

Exhibit 12 shows that all councils and PEHSC allow paid holiday days. Delaware allows the most at 15. EMSI allows the least at eight. Seven councils allow more than the Commonwealth (11) provides in holidays: Bucks, Chester, Delaware, Eastern, EMMCO West, Montgomery, Susquehanna, and Local 22 in Philadelphia.

Four councils give personal or pooled time off (PTO) instead of separate vacation and sick days: EMMCO West, EMSI, LTS, and Southern Alleghenies. Three provide a range of PTO days depending on how long a person has worked. Ranges of PTO days that can be earned are fairly similar, except EMMCO West awards 18 PTO days at the beginning of employment while LTS and Southern Alleghenies award only 10 and 9, respectively. EMMCO West also gives the most PTO days to long-term employees (33), while LTS and Southern Alleghenies allow a maximum of 29 and 27 PTO days respectively. One (EMSI) provides 18 days of PTO from when an employee starts and does not increase that amount regardless of length of employment. Employees as EMSI, however, do not have to put official leave in for leave taken in less than four-hour increments. They must, however, make up this time off as time worked.

[5] Detailed benefit information is not included in Appendix A for Bradford Susquehanna due to their merger with Northeastern in November 2012.

Exhibit 12

Annual Paid Leave and Carryover Awarded to Staff in Each Regional Council and the Pennsylvania Emergency Health Services Council

Regional Council	Holidays	Vacation Days	Carryover Per Year[a]	Sick Days	Carryover Per Year[b]	Personal Days
Bucks	13	5 – 25	20	12	12	1[j]
Chester	14	12 - 24	15	6 - 12	12	3
Delaware	15	10 - 25	5[c]	12	30	0[d]
Eastern	13	15 - 21	30	12	90	0
EHS Federation	11	12 - 24	24	12	30	5
EMMCO East	11	10 - 15	0	12	0	4
EMMCO West	12	18 - 33	10[e]	[e]		[e]
EMS Institute	8	18	5[f]	[f]		[f]
Lycoming, Tioga,& Sullivan	11	10 - 29	10[g]	[g]		[g]
Montgomery	12	5 - 25	15	12	12	5
Northeastern PA	11	10 - 15	15	12	12	1
Philadelphia Local 22	12	10 - 25	592	20	All	4
Philadelphia Council 33	10	10 -25	70	20	200	4
Philadelphia Council 47	10	10 - 25	70	20	200	4
Seven Mountains	11	6 - 24	24	12	120	3
Southern Alleghenies	10	9 - 27	40[h]	[h]		[h]
Susquehanna	11.5	10 - 21	21	10	0	0
PEHSC	9	15 - 20	45	12	120	0
Employees Under the Governor[i]	11	7 - 26	45	13	300	1 - 4

[a] For the majority of councils the number of vacation days awarded depends on the number of years an employee has worked for the council. The number of carryover days is the maximum number of days which can be carried over to the following calendar or fiscal year. In some cases the number depicted is cumulative in nature, not yearly allowances.

[b] For the majority of councils the number of sick days awarded is the same regardless of the number of years an employee has worked for the council. For most, the number of carryover sick days listed is cumulative; i.e., the cumulative maximum number of days which can be carried over to the following calendar or fiscal year.

[c] Vacation days carried over must be used by February 1st of the following year.

[d] If an employee has perfect attendance they will receive two personal days the following year.

[e] EMMCO West combines vacation, sick and personal days as Personal Time Off (PTO). In addition, employees receive 12 reserve sick days for unanticipated long-term health issues.

[f] EMS Institute combines vacation, sick and personal days as PTO.

[g] Lycoming, Tioga & Sullivan council combines vacation, sick and personal days as pooled time off. In addition, from, 2-5 long term sick days awarded each year, depending on years of service.

[h] Southern Alleghenies combines vacation, sick and personal days as PTO.

[i] For Commonwealth employees hired after July 1, 2011 fewer vacation and sick days are earned each year.

[j] Employees receive one personal day a year that is dependent on them having sick leave available. If they have sick leave available they can convert one sick day to a personal day. If they have no sick days they cannot get a personal day.

Source: Developed by LB&FC staff from information obtained from review of benefit packages and follow-up telephone calls.

Exhibit 13

Health Including Dental, Vision, and Prescription Benefits Available to Staff in Each Regional Council and PEHSC

		Health Benefits			Dental Benefits		Vision Benefits		Presc. Benefits	
Regional Council	Type	Cont.	Copay	Ded.[a]	Employee	Family	Employee	Family	Employee	Family
Bucks[b]	HMO	1%[c]	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Chester[b]	BCBS	$23-$135[e]	Yes	No	$4	$9.50	$2.50	$6.00	Rolled in	Rolled in
Delaware[b]	HMO[f]	1-2.5%	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Eastern	PPO	$7-$19	Yes	No	$4	$13	Rolled in	Rolled in	Rolled in	Rolled in
EHS Federation	PPO	No	Yes	Yes	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
EMMCO East	PPO	No	Yes	No	Rolled in	No[g]	Rolled in	Rolled in	Rolled in	Rolled in
EMMCO West	PPO	$7-$46[h]	Yes	Yes	Rolled in	No	Rolled in	Rolled in	Rolled in	Rolled in
EMS Institute	PPO	No	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Lycoming, Tioga & Sullivan[b]	HMO[i]	$36-$94	Yes	Yes	Rolled in	$28-$88	$5	$13	Rolled in	Rolled in
Montgomery[b]	HMOj	$27-$92	Yes	No	Rolled in	$5 per dep.	Rolled in	Rolled in	Rolled in	Rolled in
Northeastern PA	PPO	No	Yes	Yes	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Philadelphia[b] Local 22	HMO	[k]No	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Philadelphia[b] Council 33	HMO	$66- $164	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Philadelphia[b] Council 47	HMO[l]	$66- $164	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Seven Mountains	HSA	No	Yes	Yes[m]	Rolled in	Rolled in	No	No	Rolled in	Rolled in
Southern Alleghenies	PPO	$0-$103[n]	Yes	Yes[o]	Rolled in	Rolled in	No	No	Rolled in	Rolled in
Susquehanna	PPO	$48-$115	Yes	Yes	Rolled in	$34.34	Rolled in	No	Rolled in	Rolled in
PEHSC	PPO	No	Yes	Yes[m]	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in
Commonwealth Employees[p]	PPO[p]	1.5- 3%	Yes	No	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in	Rolled in

[a] All but 2 regional councils and PEHSC offer short and long term disability at no additional charge to employees. LTS allows employees to buy both STD and LTD at group rates and Northeastern only provides LTD for employees. [b] Employees at these councils are considered county employees and therefore receive county benefits. [c] Where a % is shown, it means employees pay the identified percent of their annual salary for health care coverage. [d] Rolled in means that the cost for coverage is part of the health care benefit plan. [e] Where there is a dollar range, the smaller amount represents what employees must contribute monthly for the cost of the premium just for themselves, while the higher range represents what employees must contribute for the cost of the premium if they purchase coverage for their dependent(s). In Chester County this amount is also influenced by an employee's salary range. Amounts given are premiums paid by employees per month. [f] The majority of employees are in the Keystone HMO but there is a second health care plan available to employees (Amerihealth HMO) as well. [g] Employees may pay to provide dental coverage for their families. None did so at the time we asked. [h] Council requires employees to contribute a percent of the premium depending on how long they have worked for the council. Employees with up to three years of employment must contribute 10% of the premium cost for coverage for themselves and their family. If employed three to six years employees must contribute 5% of premium cost. If employed more than six years employees contribute 1.5 percent of premium cost. [I] Most of the employees are in the HMO, however there is also a Blue Cross Blue Shield plan that employees can choose for health care coverage. [j] Two other health plans also available for employees, a PPO and BCBS. Most employees are in the HMO. [k] Employees may chose a BCBS plan if they desire, but all employees are in the HMO. Employees have the option of a BCBS plan or two different HMO plans. All employees in an HMO plan. [m] Employees pay deductible but are reimbursed. [n] Council pays health care cost for employee only. If the employee wants family coverage the employee must pay 10% of the difference between single and family premium cost. If an employee's spouse is able to get family coverage through their job the region will reimburse the full cost of the difference between individual and family coverage cost to the employee. [o] Deductible only applies for out of network health care visits/stays. [p] There is also a HMO plan. For the HMO and the PPO, employees pay 3% of base salary which is reduced to 1.5% if the employee elects to participate in our disease/wellness program. If hired after August 1, 2003, employees pay an additional cost to enroll in the PPO due to the additional cost of the plan.

Source: Developed by LB&FC staff from information obtained from each regional council, PEHSC and the Commonwealth through review of benefit packages and follow-up telephone calls. If a Council offers more than one plan we chose to provide data on the plan that the majority of employees chose to participate in.

Exhibit 14

Life, Retirement, Maximum Accumulated Paid Vacation, and Paid Sick Days and Reimbursement of Educational Expenses by Regional Councils and PEHSC

	Life Insurance		Retirement				Separation Benefits		Separation Benefits		
Regional Council	Amt.	Cont.[a]	Type	Cont.[b]	Match	Vesting	Vac. Days	Reimb.	Sick Days	Reimb.	Educational Expenses
Bucks	Salary	No	Cty	9%	Formula[c]	5 yrs.	20	100%	All	50%[d]	No
Chester	Salary	No	Cty	5%	Formula[c]	5 yrs..	15	100%	12	25%	No
Delaware	Salary	S1.43	Cty	7%	Formula[c]	90 days	5	100%	30	No	No
Eastern	Salary X 3	No	403B	No	5%	6 mos.	30	100%	90	No	Yes
EHS Federation	$50,000	No	401K	No	6%	6 mos.	48	100%	30	No	Yes
EMMCO East	$75,000	No	SEP	No	6%	6 mos.	0	0%	0	No	Yes
EMMCO West	$75,000	No	SEP	No	5%	2 mos.	10[f]	100%	PTO Days	PTO Days	No
EMS Institute	$75,000	No	SEP	No	7%	1 yr.	5[f]	100%	PTO Days	PTO Days	No
Lycoming, Tioga, and Sullivan	$10,000	No	Cty	8%	Formula[c]	5 yrs.	10[f]	100%	10 (long-term)	25%	No
Montgomery	Salary	No	Cty	5%	Formula[c]	5 yrs.	15	100%	All	100%[g]	Yes
Northeastern PA	$10,000	No	SEP	No	8%	30 days	2 yrs.	100%	90	No	No
Philadelphia Local 22	$25,000	No	Cty	8.40%	Formula	10 yrs.	592	100%	Unlimited	60%	No
Philadelphia Council 33	$20,000	No	Cty	7.20%	Formula	10 yrs.	70	100%	200	40%	No
Philadelphia Council 47	$30,000	No	Cty	7.20%	Formula	10 yrs.	70	100%	200	40%	No
Seven Mountains	Salary X 2	No	403B	No	3%-7%	Immed.	24	100%	60	50%	No
Southern Alleghenies	Salary	No	403B	No	2%-75	6 mos.	40[e]	100%	PTO Days	PTO Days	No
Susquehanna	Salary X 2	No	SEP	No	5%	6 mos.	15	100%	0	No	No
PEHSC	Salary X 3	No	SIMP IRA	3%	3%[i]	1 yr.	1½ yrs	100%	120	No	No
Employees Under the Governor	$40,000	No	Def	6.25%	Formula	10 yrs.	45	100%	300	30 to 50%	No

[a] All councils and PEHSC offer accidental death and dismemberment coverage as part of their life insurance benefit package at no additional cost to employees. Only one council, Delaware, requires employees to participate in the cost of life insurance premiums. Three of the councils allow employees to purchase additional life insurance coverage at group rates at their own expense. These three are Chester, LTS and Southern Alleghenies. The Commonwealth also allows employees to purchase additional life insurance at group rates, up to 5 times their salary to a maximum of $500,000.

[b] Percentages indicate mandatory employee contributions. "No" means there is no mandatory contribution required for council to contribute. All but one of the councils, Philadelphia, allow employees to contribute more than the minimum, if required, towards their retirement plans. These additional amounts above the minimum required are not matched in any way by the councils and are not reflected in the pension calculation made at time of retirement. In some cases they are federally taxed. Only one council, Seven Mountains, will match additional contributions, specifically, up to a maximum of 7% of an employee's salary.

[c] Pension amounts provided to employees based on member's mandatory contributions, interest earned and an amount based on class of service times "final salary" times years of services in class. Amount of County contribution needed to ensure fund solvency determined by actuarial formula each year.

[d] Employees separating after 8 years of service receive full pay for one-half of accumulated sick hours with a maximum payment equal to 20 percent of their annual rate of pay.

[e] Any vacation carried over the next year must be taken before February 1st or it will be forfeit.

[f] Award pooled leave days or PTO instead of vacation, sick and personal days.

[g] When employees retire they will be paid 100 percent for 60 sick days and the rest at 25 percent.

[h] Amount of retirement contributions paid for each employee by the council depends on how long an employee has worked for the council. For the first year of employment the council will contribute 2 percent of gross salary, for one to two years of employment the council will contribute 4 percent of gross salary, for two years and more of employment the council will contribute 7 percent of gross salary.

[I] Employees choose the amount of pay taken out of their salary for retirement. PEHSC will match up to 3 percent.

Source: Developed by LB&FC staff from information obtained from each regional council through review of benefit packages and follow-up telephone calls to each region. Councils and PEHSC were asked whether employees were required to contribute toward their retirement and whether the contribution was matched by the employer.

The remaining 11 councils, PEHSC, and the Commonwealth award separate vacation and sick days. For all 11, an employee earns more vacation days a year the longer they work. Two councils (Bucks and Montgomery) only award five vacation days when an employee is hired. Seven Mountains and the Commonwealth are the next lowest at six and seven days awarded at the beginning of employment. All the others allow new employees between 10 and 12 vacation days at the beginning of employment. PEHSC awards 15 vacation days at the start of employment. The majority of those that award non-PTO time award between 21 and 26 for long-term employees. The exceptions to this are EMMCO East and Northeastern at a maximum of 15 days.

PTO carryover for the four councils awarding PTO is low for three (EMMCO West, EMSI, LTS) (5-10) but is higher for Southern Alleghenies (40). Vacation carryover for the remaining councils, PEHSC, and the Commonwealth, ranges from zero in EMMCO East to a high of a maximum of 592 days at Local 22 in Philadelphia. The other two unions in Philadelphia (Councils 33 and 47) allow a maximum of 70 days to be carried forward. Both PEHSC and Commonwealth Executive Branch agencies allow 45 days to be carried forward each year that accrues cumulatively.

Sick Leave and Carryover

As noted above, four councils award PTO instead of separate sick days. Philadelphia awards 20 sick days per year for all council employees, which is the high for all councils. The remaining councils not awarding PTO award between 10 to 12 days of sick leave annually except Chester, which has a range of 6-12 per year, depending on length of employment. The Commonwealth awards 13 sick days annually. None reported allowing the taking of anticipated sick leave as it is earned in monthly increments.

The range of sick leave allowed to be carried over varies widely from council to council. Both EMMCO East and Southern Alleghenies allow zero sick leave carryover, while Local 22 in Philadelphia allows all unused sick days to be carried over. The other two Philadelphia unions (33 and 47) allow 200 sick days to be carried forward annually, while PEHSC and Seven Mountains allow 120 and Commonwealth Executive Branch agencies 300. For the remaining councils not awarding PTO, four allow 12 days to be carried forward, two allow 30 days, and one allows 90 days.

Personal Days

None of the councils awarding pooled leave award additional personal days off. Montgomery and EHS Federation award the most personal days off (five) annually. Employees of EMMCO East are awarded four days per year, as are those in

Philadelphia. Commonwealth employees earn between one and four personal days off depending on years of service.

Health Benefits

As shown in Exhibit 13, all councils offer a health care plan in which employees can choose to participate. All but two of these councils, LTS and Northeastern, offer short- and long-term disability at no additional charge to employees as a part of their health care plan package. LTS allows employees to purchase both short- and long-term disability at group rates, while Northeastern only provides long term disability. Four councils (Chester, Delaware, Lycoming, and Montgomery) give employees a choice of health care plans from which to choose. In Philadelphia, employees represented by two unions (Local 22 and Council 47) also have a choice of health care plans to choose from, as do employees under the Governor's jurisdiction. As stated previously, if options are given, the information provided on Exhibit 13 is for the plan that the majority of employees in that council have chosen.

Five councils (EHSF, EMMCO East, EMSI, Northeastern, and Seven Mountains) and PEHSC provide health care coverage for employees and their dependents at no charge to the employee. Eight councils require employees to contribute to the cost of the health care plan (Bucks, Chester, Delaware, Eastern, EMMCO West, Lycoming, Montgomery, and Susquehanna). Two of these councils, Bucks and Delaware, require that employees pay an identified percent of their salary for health care. In the remaining six councils (Chester, Eastern, EMMCO West, Lycoming, Montgomery, and Susquehanna), employees pay a percentage of the premium cost for health care coverage which varies based on the coverage chosen and if dependents are added. Commonwealth employees are also required to contribute a portion (between 1.5 percent and 3 percent) of their salary to the cost of their health care. One council (Southern Alleghenies) only requires employee's to pay for health care coverage for their spouse or families. If they choose single coverage for themselves, the council picks up the cost. In Philadelphia, employees in Local 22 are not required to provide any payment towards health care coverage, while employees in Councils 33 and 47 are required to pay for coverage based on a percent of the premium cost for the coverage chosen.

When required, the amount of contributions that employees pay monthly for their percent of the health care premium varies significantly. For example, employees in the Eastern regional council only pay $7 per month for single coverage and $19 per month for family coverage, while Susquehanna requires employees to pay $48 for single coverage and $115 monthly for family coverage. The cost in Chester ranges from $23 to $135. Employees in two unions in Philadelphia (Councils 33 and 47) pay the highest amounts in premium participation—$66 per month for single coverage and $164 per month for family coverage.

Seven councils (EHSF, EMMCO West, Lycoming, Northeastern, Seven Mountains, Southern Alleghenies, and Susquehanna) and PEHSC have deductibles that must be met as part of the health care plan. However, one of the councils (Seven Mountains) and PEHSC reimburse employees for the deductible. Seven Mountains does not reimburse deductibles if family participation is chosen. Employees in Southern Alleghenies only have to pay the deductible if they go to an out-of-network provider. The amount of the deductibles range significantly. Four councils (Lycoming, Northeastern, Southern Alleghenies, and Susquehanna) health care plan deductibles are $250 per person. EMMCO West's health care deductible is $750 per person, while the deductible in Lycoming, Northeastern, and Susquehanna is $250 per person. Only EHSF has a deductible of $500 for individual or $1,000 per family. Commonwealth employees have no deductibles.

For the most part, councils, PEHSC, and Commonwealth employees have co-pays that employees must pay for visits to their primary care physician (PCP), specialists, the emergency room, and for prescription drugs. The average PCP co-pay cost was $15 for the councils and PEHSC. Local 22 in Philadelphia, however, has no co-pays for visits to a PCP or specialist. Employees in all but three of the councils (EMMCO West, Susquehanna, and Local 22 in Philadelphia) pay between $10 and $20 for visits to a PCP. This is also true for Commonwealth employees. Co-pays for visits to specialists averaged $25, with eight councils and PEHSC between $20 and $30. The low is $0 at Local 22 in Philadelphia and the high is $40 at EHSF, EMMCO East, Susquehanna, and the other two unions in Philadelphia (Councils 33 and 47). Commonwealth employees have a $25 co-pay for specialist visits.

The average co-pay cost for all councils and PEHSC for emergency room visits was $64. The highest co-pays were $200 for councils 33 and 47 in Philadelphia and Bucks and Seven Mountains at $100. Eight councils and PEHSC had ER co-pays between $35 and $50. The lowest co-pays were in Eastern, EHSF, Montgomery, and Local 22 in Philadelphia ($35). Commonwealth employees have a $50 co-pay.

Co-pays for generic prescription drugs averaged $11 for all councils and PEHSC. Chester is the highest at $30, while Northeastern and Local 22 in Philadelphia were $0 and $1, respectively. Commonwealth employees co-pay is $10 for brand name medications. Brand name prescription co-pays (where there was a range within a council for formulary vs. nonformulary, we used the average) were higher, averaging $31 for all councils and PEHSC. PEHSC had the highest average brand name co-pay at $43, while Local 22 in Philadelphia was the lowest at $10. Delaware and Susquehanna had a fairly low co-pay of $15. Commonwealth employees pay an average of $27 co-pay for brand name prescriptions.

Dental Benefits

Seven councils (Bucks, Delaware, EHSF, EMSI, Northeastern, Seven Mountains, and Southern Alleghenies), PEHSC, and the Commonwealth pay for dental coverage for employees and their families at no charge. Two councils (Chester and Eastern) require contributions from employees. Five councils (EMMCO East, EMMCO West, LTS, Montgomery, and Susquehanna) provide coverage for employees free of charge but not for dependents. In four of these councils, EMMCO East, LTS, Montgomery, and Susquehanna, employees may purchase dental coverage for family. EMMCO West does not provide employees the option of purchasing dental coverage for dependents.

Vision Benefits

Nine councils (Bucks, Delaware, Eastern, EHSF, EMMCO East, EMSI, Montgomery, Northeastern, and Philadelphia), PEHSC, and the Commonwealth pay for vision for employees and their family at no charge to the employee. Two councils (Chester and Lycoming) require contributions from employees if they want coverage for themselves and family. Two councils (EMMCO West and Susquehanna) pay for employees but dependent coverage is not offered. Two councils (Seven Mountains and Southern Alleghenies) do not offer vision coverage for employees or their dependents.

Life Insurance

Five councils use the amount of the employee's salary as their life insurance benefit amount. One council (Eastern) and PEHSC use three times their salary as the benefit and two (Seven Mountains and Susquehanna) use two times the salary as life insurance benefit. The remaining councils provide an average of $41,000 in life insurance coverage for employees, with a low of $10,000 worth of coverage in LTS and Northeastern. Only three councils allow employees to purchase additional life insurance coverage (Chester, LTS, and Southern Alleghenies) at their own expense. Only Delaware requires employees to contribute toward the cost of life insurance. All councils and PEHSC offer accidental death and dismemberment as part of their life insurance package at no cost to employees.

Employees under the Governor's jurisdiction hired after January 1, 2011, receive $40,000 of life insurance coverage at no cost, but they may purchase additional coverage up to five times their salary with a maximum of $500,000.

Retirement Plans

As shown in Exhibit 14, there are a variety of retirement plans in place at the councils; all limit participation to full-time employees (more than 1,000 hours per

year). Separation benefits also vary from council to council. Employees of the county-affiliated councils participate in their respective county-defined benefit plan. All the county councils require mandatory contributions to the pension fund by employees taken as payroll deductions, ranging from lows of 5 percent in Chester and Montgomery Counties to a high of 9 percent in Bucks County. Defined pension plan benefits are based on an employee's contributions and interest earned on those contributions. Pension payouts are based on class of service times "final salary" times years of service in class. The counties apply a formula at the end of each year to determine what the county should contribute to their retirement fund to ensure they can meet their guaranteed payouts. Employees under the Governor have a defined pension plan similar to the county-affiliated regional councils.

In contrast, none of the non-county councils have mandatory employee contributions toward their pension. They are all a form of an IRA plan, the majority of which are Simplified Employee Pension or SEP-IRA plans. PEHSC, however, requires a contribution of 3 percent. One council (Southern Alleghenies) contributes more to an employee's pension the longer they work for the council. Only one council (Seven Mountains) will match additional contributions by an employee to their pension of up to 7 percent, although all of them except Philadelphia allow employees to contribute more than the minimum. Match amounts by non-county affiliated councils and PEHSC average 5.3 percent and range from 3 percent at PEHSC to 8 percent at Northeastern.

Vesting

The average amount of time that employees of the regional councils and PEHSC must work before they become fully vested to receive employer paid retirement benefits is 2.17 years. The majority of regional councils allow employees to vest between 30 days and 6 months, including those councils which do not mandate employee contributions. Only Bucks, Chester, EMSI, LTS, Montgomery, Philadelphia, and PEHSC are higher. One council, Seven Mountains, allows employees to vest in the pension program immediately. This is in contrast to the Commonwealth where employees must now wait 10 years to vest in the retirement program. Philadelphia, also at 10 years, is the highest regional council in this category.

Separation Benefits—Vacation

Almost all regional councils and PEHSC pay employees for unused vacation leave upon separation from employment, with various caps of maximum days paid. The exception is EMMCO East, which provides no payment for unused vacation leave except that which is earned in the last year of employment. The average number of days paid is 132 days, but this average is skewed by Local 22 in Philadelphia, which pays for all vacation earned and not used at 100 percent up to 592 days (approximately 1.62 years) and PEHSC which pays 100 percent of unused vacation

leave of up to one-and-a-half years as a benefit upon separation. The other two unions in Philadelphia (33 and 47) pay for 100 percent of a maximum of 70 days. At the low end, Delaware will only pay for a maximum of five unused days. Employees under the Governor's jurisdiction receive 100 percent reimbursement of unused vacation pay upon separation to a maximum of 45 days.

Separation Benefits—Sick

Six councils and PEHSC do not pay for accrued, unused sick leave when an employee leaves. Most other councils pay only a portion of unused sick leave, ranging from highs of 60 percent and 50 percent of all accumulated unused sick leave in Philadelphia Local 22 and Bucks County, respectively, to 25 percent of 12 days and 5 percent of 10 days in Chester and LTS, respectively. In Montgomery, the first 60 days of sick leave are paid at 100 percent, any remaining sick leave is paid at 25 percent. Employees under the Governor's jurisdiction receive 30 percent to 50 percent of sick leave as a paid benefit based on length of employment.

Educational Expenses

Four councils will pay a portion of education expenses.

V. Administration and Use of EMSOF Funding by the State Advisory Board - PA Emergency Health Services Council (PEHSC)

Origin, Mission, and Composition

The Pennsylvania Emergency Health Services Council (PEHSC) was organized in 1974 to serve as a statewide advisory body to the DOH on emergency medical services issues. In conjunction with the DOH, the Council was active in EMS planning and other activities prior to the passage of the Commonwealth's EMS Act, Act 1985-45. Act 45 recognized the Council's Board of Directors as the official EMS advisory body to the DOH. This role was reauthorized in Act 2009-37. According to the statute (§8108 (b)), the duties of the Board shall be to:

(1) Elect officers.

(2) Advise the department concerning manpower and training, communications, EMS agencies, content of regulations, standards and policies promulgated by the department under this chapter and other subjects deemed appropriate by the department.

(3) Serve as the forum for discussion on the content of the Statewide EMS system plan, or any proposed revisions thereto, and advise the department as to the content of the plan.

The Pennsylvania Emergency Health Services Council is a nonprofit corporation composed of volunteer, professional, and paraprofessional organizations involved in EMS. PEHSC by-laws stipulate that the council be geographically representative of the provider organizations which represent emergency medical technicians, EMT-paramedics, registered nurses, firefighters, emergency medical services councils, physicians, hospital administrators, and other health care providers concerned with EMS. At the time of the audit, the Council consisted of more than 91 organizations representing all facets of EMS in Pennsylvania. Each organization, each of which have voting privileges, appoints a representative and one alternate to serve on the Council, and each year the Council elects a Board of Directors, comprised of representatives of at least 30 of the organizations represented by the Council. PEHSC also has an affiliate council comprised of 144 organizations or individuals who are considered to be members of the Committee without voting privileges.

The primary purpose, or mission, of the State Advisory Council is to:

- promote the coordinated development and evaluation of EMS in the Commonwealth;

- aid and advise member organizations and the Commonwealth through the development and planning of programs for EMS;
- promote the welfare of the citizens of the Commonwealth; and
- serve as an advisory body to the Secretary of Health and all other appropriate agencies within the Commonwealth.

Organizational Structure and Staffing

The Council is headed by a Board of Directors. The Board elects the Council officers, which include president, vice president, secretary, and treasurer. The officers, two at-large board members, and the immediate past president comprise the Council's Executive Committee.

As shown on Exhibit 15, the Council structure also includes various standing committees and task forces which are designated to deal with specific facets of the EMS system:

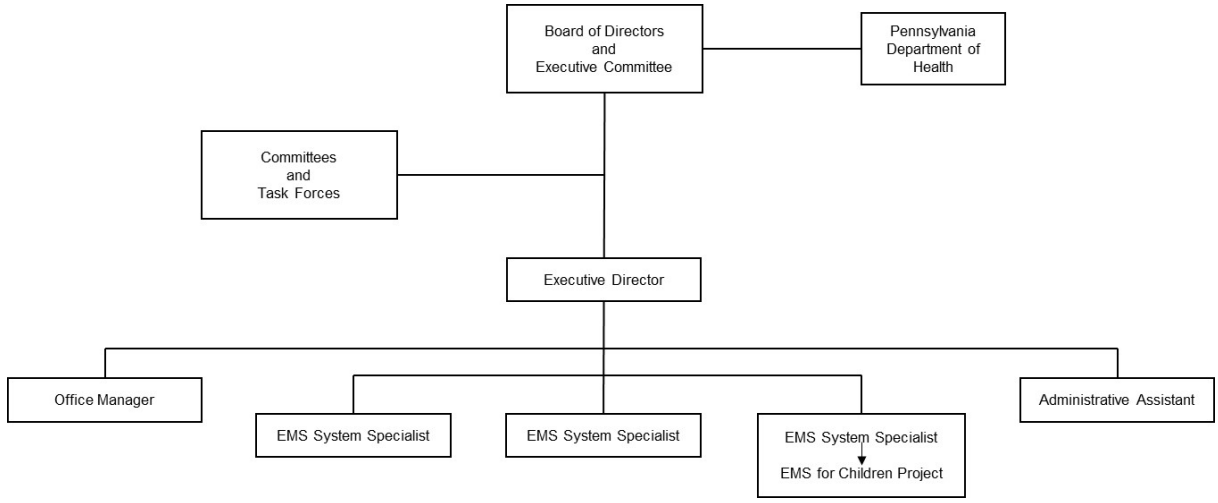
- Executive Committee
- Medical Advisory Committee
- EMS for Children Advisory Committee
- Air Medical Task Force
- Critical Care Transport Task Force
- Rescue Task Force
- Rules and Regulations-Act 37 Task Force
- State EMS Development Plan Task Force
- EMS Information Task Force

According to the PEHSC, over 300 EMS providers and administrators from across Pennsylvania volunteer to serve on the various PEHSC committees. The committees draft recommendations and program proposals for consideration by the Council's Board of Directors.

As of February 2013, the PEHSC had a staff complement of six positions, all of which are filled. The PEHSC staff is responsible for coordinating and administering the work of the Council and its committees and for providing advice and assistance to the DOH and technical expertise to Pennsylvania's EMS community. The Council's executive office is located in Mechanicsburg, Pennsylvania.

Exhibit 15

Pennsylvania Emergency Health Services Council Organization Chart



Source: Developed by LB&FC staff with information provided by Pennsylvania Emergency Health Services Council staff.

Statewide Council Funding

In FY 2011-12, the PEHSC had total revenues from all sources of $686,660. This is approximately 7 percent lower than the total available revenue in FY 1996-97 ($737,125). As shown on Table 22 EMSOF monies have accounted for an increasing percentage of PEHSC's operating revenue. In FY 2011-12, EMSOF accounted for 72 percent of their revenue; in FY 1996-97 it was only 49 percent of the total funding available to PEHSC. Table 23 provides revenue from all data sources for PEHSC from FY 1997-98, the year of our last report, through FY 2011-12.

Other major funding sources for PEHSC in FY 2011-12 included $90,000 in federal funding (the EMS for Children Program), $100,000 in conference income, and approximately $5,000 in interest income. Incidental revenues come from donations and revenue from video sales. Non-EMSOF revenue in FY 2011-12 is $189,636 (49 percent) lower than income from similar sources in FY 1996-97, which was $384,238.[6] The majority of the decrease has been reductions in annual conference revenues and the amount of the federal grant award. The PEHSC does not charge any fees or dues to its member organizations. As noted above, the PEHSC receives much of its funding from EMSOF through a contract with the DOH. Legislation, Act 1994-82, specifically included funding to the State Advisory Council as one of the purposes for which EMSOF funds can be used.

[6] This figure includes $16,522 in income received from a rescue conference that is no longer held.

Table 23

Pennsylvania Emergency Health Services Council

Revenue by Source

For FY 1997-98 and FY 2007-08 Through FY 2012-13

Revenue Source	Amount FYE 1997	Percent of Total	Amount FYE 2007	Percent of Total	Amount FYE 2008	Percent of Total	Amount FYE 2009	Percent of Total	Amount FYE 2010	Percent of Total	Amount FYE 2011	Percent of Total	Amount FYE 2012	Percent of Total
EMSOF	$352,887	49.14%	$424,360	63.55%	$437,091	60.55%	$450,204	67.27%	$463,710	68.37%	$477,621	64.64%	$491,949	71.64%
Federal Grant - EMSC	204,470	28.47	111,624	16.72	90,000	12.47	68,376[a]	10.22	90,000	13.27	90,000	12.18	90,000	13.11
Annual Conference	158,587	22.08	100,806	15.10	136,554	18.92	146,112	21.83	120,778	17.81	166,945	22.59	100,109	14.58
AHA Grant					50,000	6.93								
Recruitment & Retention - PA DOH Funds			25,000	3.74										
Interest Income[b]	2,196	0.31	5,966	0.89	8,207	1.14	4,531	0.68	3,758	0.55	4,350	0.59	4,602	0.67
Total Revenue	$718,140	100.00%	$667,756	100.00%	$721,852	100.00%	$669,223	100.00%	$678,246	100.00%	$738,916	100.00%	$686,660	100.00%

[a] EMSC funds reduced by federal and state fiscal year gap.
[b] Includes interest income from corporate investments.

Source: Developed by LB&FC staff from PEHSC fiscal records.

Unlike the regional councils, which obtain their allocations based on a formula, the PEHSC submits an annual budget request to the DOH's Emergency Medical Services Office for review and approval. The budget amount is subsequently negotiated between the PEHSC director and the BEMS Bureau Director. This negotiation process is unwritten. (See Chapter III of this report for additional information.)

Total PEHSC Expenditures and Expenditure of EMSOF Monies

Audited PEHSC expenditures from all sources totaled $664,172 in FY 2011-12. This is an increase of approximately 1 percent from FY 1996-97 (our last review) when $656,584 was spent. Of this amount, 67 percent ($443,275) was paid with EMSOF funding. This compares to the 54 percent that was paid with EMSOF grant funds in 1996-97. Table 24 shows total PEHSC expenditures (both audited and contracted amounts) by broad purpose and source and EMSOF expenditures as a percentage of total expenditures for FY 2011-12.

Although in most fiscal years EMSOF monies account for the majority of PEHSC's funding, the dependency of PEHSC on EMSOF funds to cover expenditures has grown.

Table 24

Total Expenditures by the Pennsylvania Emergency Health Services Council
(FY 2011-12)

Purpose	Audit Total[a]	Contract Budgeted Total	EMSOF[b]	Federal Grant[b]	Other Sources	% of Exps. Dependent on EMSOF
Salaries	$324,498	$316,241	$256,632	$51,400	$ 16,466	79.1%
Benefits	82,745	113,846	57,962	15,420	9,363	70.0
Subcontract Services	10,710	5,461	4,961	500	5,249	46.3
Travel	10,879	11,900	3,000	8,900	(1,021)	27.5
Supplies	18,938[c]	13,475	8,695	4,780	5,463	45.9
Other Costs[d]	216,402	121,025	112,025	9,000	95,377	51.7
Total	$664,172	$581,948	$443,275	$90,000	$130,897	66.7%

[a] Expenditures as reported in the FY 2011-12 audit.
[b] Dollar amounts shown are what PEHSC budgeted from EMSOF and from the federal grant in FY 2011-12, except for salaries and benefits which are actual dollars as reported to us by PEHSC.
[c] We included $9,565 in computer and software costs in this category due to similar categorization used by PEHSC in state contract.
[d] Includes books and subscriptions, conference and meetings logistical costs, general liability insurance, copier lease, postage meter lease, water cooler lease, postage, printing and reproduction, office rent, telephone, legal services, and audit services.

Source: Developed by the LB&FC from actual expenditures identified in the FY 2011-12 audit of PEHSC, salary and fringe benefits for FY 2011-12 provided by PEHSC) and from the FY 2011-12 PEHSC contract with the BEMS. In some categories of expenditures, audited amounts are not identical to budgeted amounts.

During FY 2011-12, PEHSC also used income generated from prior EMS conferences (the annual EMS Conference and Rescue Conference) to cover the costs of planning and holding upcoming conferences.

PEHSC Expenditures From the EMSOF

As shown in Table 23, PEHSC received $491,949 in EMSOF funding from the department in FY 2011-12. This is up from the $352,887 in funding received in FY 1996-97. From this amount, $314,594 (71 percent) of total EMSOF expenditures went for salary and benefit costs, including Social Security, workmen's compensation, Medicare, unemployment tax, health, dental, vision, pension, and life insurance. A total of $203,217 was spent in EMSOF funds for salary and benefits (58 percent of total EMSOF expenditures) in FY 1996-97.

Subcontracted services accounted for $4,961 (1 percent) of EMSOF expenditures in FY 2011-12. Consultant services, at $19,152, accounted for 5.4 percent of PEHSC's expenditures from the EMSOF for FY 1996-97. PEHSC reported expenditures for accounting services, contract auditing expenses, and computer consultants. Travel expenditures accounted for an additional $4,889 in EMSOF spending during FY 1996-97. In FY 2011-12, the amount of EMSOF money spent on travel was $3,000. These expenditures included vehicle lease costs; costs for vehicle maintenance and operations; and lodging, subsistence, and tolls. As is the case with the regional councils, travel expenditures are governed by Commonwealth travel guidelines.

The largest remaining category of PEHSC expenditures out of EMSOF for FY 2011-12 was $112,025 in the category of other costs. In FY 1996-97, total other costs paid with EMSOF funds was $125,629. This category includes a variety of miscellaneous costs such as equipment leasing, rent payments, legal services, postage, office supplies, conference registrations and meeting expenses, printing and photocopying services, books and subscriptions, insurance, and advertising.

Financial Audits of PEHSC Expenditures

In DOH contract provisions, if the EMSOF or federal grant amount received exceeds $500,000, then the expenditures are subject to an annual audit by an independent auditor. Such reports, if required, are to be completed and submitted to the DOH within 120 days following the end of the fiscal year. We found that the PEHSC submitted an independent audit of its FY 2011-12 finances to the DOH in the time frame allowed even though grant amounts did not exceed the thresholds required for an audit to be performed. The audit report found that the results of their "tests disclosed no instances of noncompliance that are required to be reported

under *Government Auditing Standards."* The auditors also noted no matters involving the internal control over financial reporting that they considered to be material weaknesses.

Contract Compliance

We examined the Board's compliance with the terms and provisions of its contract with the DOH for FY 2011-12. The PEHSC has been operating under the terms of a one-year extension of a three-year contract (FY 2009-10 through FY 2011-12) with the DOH which expired on June 30, 2013.

In testing contract compliance, it is necessary to examine both administrative/technical matters of compliance as well as broader programmatic and functional compliance issues. We saw no evidence nor were informed by the department of instances of material noncompliance on administrative/technical matters such as bonding, handling of funds, recordkeeping, reporting, and other administrative matters. Programmatic and functional compliance was, in part, assessed by reviewing PEHSC accomplishment of its contracted work program. We found in this review that PEHSC is in compliance with the performance of its mandated primary functions under Act 37 and EMS program regulations of (1) advisory services to DOH and (2) input and assistance in revising and updating the statewide EMS plan.

We found that the Council is providing advice and assistance to the department through both formal and informal channels. Informal advice and input occurs through periodic in-person and telephone discussions between PEHSC and BEMS staff. Formal advisories are provided in the form of Votes to Recommend, or VTRs. Revising and updating the statewide EMS plan appears to be their primary function currently, although statutorily the DOH is responsible for preparing and revising a comprehensive plan for statewide EMS system development. As the State Advisory Council, PEHSC is required by statute to:

> Serve as the forum for discussion on the content of the statewide emergency medical services development plan, or any proposed revisions thereto, and advise the department as to the content of the plan.

As previously discussed, PEHSC was tasked by the department through its workplan to act as lead in the development of the most recent statewide plan which was published in 2010. Although Act 37 clearly designates the Board of Directors of PEHSC as the statewide advisory body for EMS, the Council has at times taken on duties and responsibilities that might be more likely associated with an EMS lead agency. In large measure, this occurred as a result of the Council being assigned and assuming various centralized functions which the Division of EMSS was unable to perform due to staffing and resource constraints.

For example, at one time PEHSC administered two statewide programs, the EMS training/certification registry and the Trip Sheet Data Program, and currently their contract with the department includes program administration of a grant received by the department from the Department of Health and Human Services for activities to enhance EMS for children.

The Council, which received its first contract with the DOH in 1976, has played an important and key role in EMS systems development. For example, in addition to providing ongoing recommendations to the DOH, the Council has been and remains involved in developing guidelines, developing rules and regulations, conducting research and pilot projects, designing forms, and organizing an annual statewide EMS conference.

VI. EMSOF Financial Condition and Projections

Revenue Generating Capacity of the EMSOF Funding Mechanism

As discussed earlier in this report, the primary sources of state EMS revenue are funds derived from a special EMS funding mechanism provided for in Act 1985-45, as amended by Acts 1988-121 and 2009-37. This funding mechanism includes a $10 fine that is levied on all traffic violations (exclusive of parking offenses, as amended by Act 1988-121) and a $25 fee that is imposed on all persons admitted to programs for Accelerated Rehabilitative Disposition (ARD). Monies from these sources are deposited in the EMSOF along with earned interest and fines levied by the department for violations of the act.

During the first three fiscal years of operation (1985 to 1988), the special EMS funding mechanism did not generate more than $7.7 million annually. Since the law was amended by Act 121 in 1988 to include the assessed fine on all traffic violations and the $25 fee that is imposed on all ARD admissions, annual collections through the late 1990s averaged about $10.6 million annually.[7] From FY 2002-03 through FY 2011-12, revenues from moving violations fines and ARD fees have averaged approximately $13.8 million per year, with 75 percent of that (approximately $10.4 million) available for EMS purposes. In recent years, the amount of fines and fees going into the Fund has been following a downward trend, most likely caused by collection issues which are discussed later. Table 25 shows total revenues, the EMS portion of those revenues and the percent fluctuation from FY 2002-03 through FY 2011-12.

Table 25

Dedicated EMS Funding From Fines on Traffic Violations and Fees on ARD Admissions
(FY 2002-03 Through FY 2011-12) ($ in Thousands)

Fiscal Year	Total Revenues	EMS Portion (75%)	Percent Change
2002-03	$13,290	$ 9,968	-
2003-04	13,004	9,753	(2.0)%
2004-05	13,345	10,009	3.0
2005-06	13,237	9,928	(.8)
2006-07	13,611	10,208	2.8
2007-08	15,101	11,326	10.9
2008-09	14,971	11,228	(.9)
2009-10	14,461	10,846	(3.4)
2010-11	13,692	10,269	(5.3)
2011-12	13,323	9,991	(2.7)

Source: Developed by LB&FC staff using DOH EMSOF Comparative Financial Statements

[7] Governor's Executive Budgets June 30, 1997, through June 30, 2002.

Collection of Revenue by Pennsylvania Courts

At the time of our previous audit, we relied heavily upon traffic violation numbers provided by the Pennsylvania Department of Transportation to determine the amount of revenue that should be coming into the EMSOF. Our estimated annual yield equaled the number of traffic violations x $10 plus the number of ARD admissions x $25. For this report, when we asked PENNDOT to provide us with similar data to perform this calculation, they informed us that they believe the information that we seek would be better addressed by the Administrative Office for Pennsylvania Courts (AOPC). Because AOPC does not keep data specifically for traffic violations or individual ARD dispositions we were unable to calculate the estimated amount that should be coming into the fund based on the number of individual violations written.

We were, however, able to compare the amount of fines receipts reported in the Governor's Executive Budgets versus the amounts disbursed to the Fund by the various courts in Pennsylvania. To do this we obtained, by fiscal year, from AOPC the actual amounts of funds disbursed for both moving violations and ARD admissions adjudicated at both the Common Pleas and Magisterial District level and also obtained the amounts disbursed from the Philadelphia Traffic Court.

Questions and concerns are frequently raised by persons within the EMS community that not all of the monies due the EMSOF from the $10 fine and $25 ARD fee are being remitted to the fund. Collection problems were evident during the early years of Act 45 implementation, and at least some persons believe that some counties or areas of the state are still not fully complying. As Table 26 shows, these concerns appear to be unfounded, as over a six-year combined period (FY 2006-07 through FY 2011-12), the cumulative actual discrepancy between actual fine receipts as reported in the Governor's budget and those disbursements reported from Pennsylvania's court system is only $13,961.

As mentioned previously, in the past five years there has been a downward trend in the amount of fines and fees disbursed to the EMSOF. We found that this is likely not due to deceasing violations/assessments being issued, as that number has remained relatively constant at approximately 1.4 million annually statewide excluding Philadelphia Traffic Court,[8] but due to decreasing collection rates of fines and fees after they are assessed. As Table 27 shows, collection rates over the previous six years have fallen dramatically, with the largest drop in the collection rate of

[8] Philadelphia Traffic Court reported a 41 percent decrease in total number of assessments made (both ARD and moving violations) from FY 2008-09 through FY 2011-12. However their level of fines/fees disbursed to the Fund only decreased by 20 percent during the same time frame.

Table 26

EMSOF Fine Receipts Reported in the Governor's Executive Budgets Versus Disbursement Amounts Reported by Pennsylvania Courts
(FY 2006-07 Through FY 2011-12)

Fiscal Year	Actual Fine Receipts Governor's Budget	Court	Disbursements Reported From Pennsylvania Courts	Difference
2006-07		Common Pleas	$ 939,229	
		Magisterial Districts.....	11,247,695	
		Philadelphia Traffic	1,466,537	
	$13,611,000		$13,653,461	($42,461)
2007-08		Common Pleas	$ 1,060,494	
		Magisterial Districts.....	12,469,776	
		Philadelphia Traffic	1,486,780	
	$15,101,000		$15,017,050	$83,950
2008-09		Common Pleas	$ 1,044,546	
		Magisterial Districts.....	12,271,887	
		Philadelphia Traffic	1,640,703	
	$14,970,000		$14,957,136	$ 12,864
2009-10		Common Pleas	$ 1,044,068	
		Magisterial Districts.....	11,772,673	
		Philadelphia Traffic	1,650,492	
	$14,461,000		$14,467,233	($6,233)
2010-11		Common Pleas	$ 1,060,683	
		Magisterial Districts.....	11,112,687	
		Philadelphia Traffic	1,495,070	
	$13,692,000		13,668,440	$23,560
2011-12		Common Pleas	$ 1,023,107	
		Magisterial Districts.....	11,068,330	
		Philadelphia Traffic	1,317,204	
	$13,323,000		$13,408,641	($85,641)
Total FY 2006-07 Thru FY 2011-12	$85,158,000		$85,171,961	($13,961)

Source: Developed by LB&FC staff using information from the Governor's Executive Budgets, the Administrative Offices of Pennsylvania's Courts (AOPC) and the Philadelphia Traffic Court.

fines and fees being those assessed at the Common Pleas level of our judicial system, especially the EMS moving violation fines. Overall collection rates, regardless of court level, have dropped from 96 percent to 89 percent in FY 2011-12. This downward trend is compounded in Philadelphia, where the data provided to us by the Philadelphia Traffic Court shows that the number of assessments processed has decreased by approximately 35 percent from FY 2005-06 to FY 2011-12. County by county data for summary and criminal cases processed and money disbursed at both

the Common Pleas and Magisterial District Level can be found at Appendices C and D, respectively.

Table 27

AOPC Report on EMS Fines Assessed for Traffic Violations and ARDs, and the Actual Amount of Assessments Disbursed to EMSOF

(Excludes Philadelphia Traffic Court)
(FY2006-07 Through FY2011-12)

Fiscal Year	Assessment Type[a]	Number of EM Assessments[b]	Net Assessment Amount[c]	Disbursed Amount[d]	Collection Rate
2006-07	CP-EMS	72,638	$ 676,183.10	$ 426,481.71	63%
2006-07	CP-ARD	26,893	654,686.00	585,830.76	89
2006-07	MDJS	1,198,287	11,479,853.96	11,306,809.18	98
Total.....		1,297,818	$12,810,723.06	$12,319,121.65	96%
2007-08	CP-EMS	76,942	$ 721,568.57	$ 435,049.73	60%
2007-08	CP-ARD	28,610	696,387.95	615,862.98	88
2007-08	MDJS	1,315,346	12,660,811.39	12,466,973.94	98
Total.....		1,420,898	$14,078,767.91	$13,517,886.65	96%
2008-09	CP-EMS	73,183	$ 689,183.00	$ 388,486.15	56%
2008-09	CP-ARD	27,586	677,710.15	595,574.42	88
2008-09	MDJS	1,294,740	12,496,938.36	12,269,018.46	98
Total.....		1,395,509	$13,863,831.51	$13,253,079.03	96%
2009-10	CP-EMS	72,891	$ 701,194.74	$ 361,644.36	52%
2009-10	CP-ARD	28,756	706,515.29	608,136.16	86
2009-10	MDJS	1,263,247	12,226,908.48	11,886,547.69	97
Total.....		1,364,894	$13,634,618.51	$12,856,328.21	94%
2010-11	CP-EMS	66,238	$ 645,875.16	$ 289,490.34	45%
2010-11	CP-ARD	28,259	697,599.40	571,307.16	82
2010-11	MDJS	1,259,576	11,903,261.36	11,387,120.39	96
Total.....		1,354,073	$13,246,735.92	$12,247,917.89	92%
2011-12	CP-EMS	62,633	$ 618,239.50	$ 209,552.46	34%
2011-12	CP-ARD	25,820	636,206.59	444,065.03	70
2011-12	MDJS	1,287,669	11,555,019.60	10,800,396.04	93
Total.....		1,376,122	$12,809,465.69	$11,454,013.53	89%

[a] Philadelphia does not utilize the statewide Magisterial District Judge System for their Traffic Court processing. Therefore, Philadelphia magisterial level data is not included in the MD-EMS figures.
[b] The Number of EMS Assessments represents a count of each assessment type for the given fiscal year and is not a count of court cases.
[c] The Net Assessed Amount represents the amount of monies assessed and any adjusted amount applied to the assessment.
[d] The Disbursed Amount represents all monies disbursed for the specific assessments for each fiscal year irrespective of assessment date. Assessments may have partial disbursements applied to them and may not be paid in full.

Source: Developed by the LB&FC from data provided by the Administrative Offices of Pennsylvania Courts (AOPC).

The data provided by AOPC shows that over the FY 2006-07 through FY 2011-12 timeframe a total of 94 percent of the net fines and fees for violations processed by AOPC in those years were remitted and disbursed to the fund. This is compared to the 96.7 percent that was being collected and disbursed (using the same methodology) at the time of our last study in 1998. The balance of these fines was either outstanding or considered "uncollectable" in those cases in which the violators refused to pay, were serving jail time in lieu of making payment, or left the state.

County by County Comparison

Based on AOPC information dated February 26, 2013, the district justice system in Pennsylvania, including Philadelphia Traffic Court, collected a total of $79,000,101 for the EMSOF from FY 2006-07 through FY 2011-12. Table 28 provides the county by county breakout for fines and fees collected for EMSOF by the district justice system. Table 29 provides the total amount collected and disbursed at both the Common Pleas and magisterial level for the same time frame on a county by county basis, including Philadelphia ($85,172,232). As shown when comparing both tables, from year to year, approximately 93 percent of the EMSOF funds are generated at the local level.

The EMSOF Fund Balance

The Emergency Medical Services Operating Fund is made up of two accounts. One account, the EMS portion, receives 75 percent of Fund revenues, while the Catastrophic Medical and Rehabilitation Fund (CMRF) portion receives the remaining 25 percent. In FY 1985-86, the first year of operation, $3.0 million was deposited into the EMS portion of the Fund. The balance in the EMSOF grew to as much as $23 million in FY 2005-06 as a result of lapses into the Fund by the CMRF portion of the Fund and lower EMS spending than actual revenues from about FY 1998-99 through FY 2003-04. This was due to a reserve policy established by the then Division of Emergency Medical Services (DEMS) of requesting appropriations of only a portion of anticipated revenues. This appeared a reasonable approach given that annual revenue collections from fines and fees at that time were running below estimates and because the department had not yet prepared a comprehensive EMS development plan as required by Act 45.

Table 30 presents the FY 2011-12 EMSOF financial data as a whole (i.e., for both the EMS account and the CMRF account) in the context of a comparative financial statement for the period FY 2002-03 through FY 2011-12. As depicted, this trend of increasing reserve funds in the EMSOF began to change beginning in FY 2005-06 due to increased spend down by the CMRF portion of the Fund and appropriation requests/allocations and subsequent expenditures that have outpaced total receipts (including any lapses) by the EMS community. This spend down was heightened by a $5.0 million transfer out of the Fund to the General Fund in

Table 28

EMS Fines and Fees Collected by District Justices and Philadelphia Traffic Court, by County

(FY 2006-07 Through FY 2011-12)

County	Total # of Cases	Total Amount Disbursed	County	Total # of Cases	Total Amount Disbursed
Adams	59,988	$ 568,291	Lackawanna	97,941	$ 875,125
Allegheny	633,424	5,757,962	Lancaster	306,330	2,851,740
Armstrong	32,607	295,119	Lawrence	63,413	563,369
Beaver	119,346	1,044,096	Lebanon	95,946	896,712
Bedford	98,141	945,856	Lehigh	195,177	1,776,794
Berks	262,094	2,415,168	Luzerne	184,038	1,662,821
Blair	70,846	623,485	Lycoming	78,275	695,364
Bradford	34,664	322,044	McKean	24,779	220,216
Bucks	432,304	3,966,976	Mercer	68,505	628,164
Butler	97,212	901,826	Mifflin	26,960	252,991
Cambria	89,523	816,101	Monroe	130,363	1,228,201
Cameron	5,720	54,725	Montgomery	615,998	5,643,325
Carbon	85,251	801,439	Montour	19,452	184,450
Centre	117,513	1,137,289	Northampton	187,518	1,738,410
Chester	401,920	3,788,489	Northumberland	48,737	452,094
Clarion	44,804	429,359	Perry	29,726	287,929
Clearfield	57,349	536,044	Philadelphia	1,330,467	9,056,785
Clinton	35,064	338,299	Pike	39,734	380,432
Columbia	60,937	570,794	Potter	15,660	141,615
Crawford	51,645	489,100	Schuylkill	99,672	927,816
Cumberland	237,010	2,267,380	Snyder	46,555	433,229
Dauphin	238,989	2,205,296	Somerset	96,579	909,178
Delaware	350,921	3,106,377	Sullivan	11,370	109,326
Elk	20,394	193,928	Susquehanna	25,897	245,798
Erie	138,336	1,217,992	Tioga	31,607	298,537
Fayette	82,942	696,154	Union	31,984	301,945
Forest	4,640	43,218	Venango	33,869	299,495
Franklin	84,404	788,841	Warren	18,981	171,176
Fulton	40,666	397,243	Washington	162,538	1,458,015
Greene	27,531	243,956	Wayne	26,300	237,049
Huntingdon	21,992	210,616	Westmoreland	267,605	2,492,821
Indiana	59,296	552,620	Wyoming	27,205	258,362
Jefferson	44,347	424,307	York	319,138	2,947,144
Juniata	23,684	223,283			
			Total	8,923,823	$79,000,101

Source: Developed by LB&FC staff using FY 2006-07 through FY 2011-12 data provided by AOPC and Philadelphia Traffic Court.

Table 29

Total EMS Fines and Fees Collected for the EMSOF, by County

(FY 2006-07 Through FY 2011-12)

County	Total Collection for EMSOF	County	Total Collection for EMSOF
Adams	$ 616,512	Lackawanna	$ 971,031
Allegheny	6,513,934	Lancaster	3,065,478
Armstrong	333,540	Lawrence	622,642
Beaver	1,114,115	Lebanon	1,003,656
Bedford	967,802	Lehigh	1,971,904
Berks	2,558,533	Luzerne	1,786,498
Blair	699,843	Lycoming	788,450
Bradford	348,829	McKean	260,620
Bucks	4,359,626	Mercer	690,999
Butler	1,024,784	Mifflin	274,691
Cambria	890,596	Monroe	1,370,973
Cameron	56,647	Montgomery	5,985,919
Carbon	830,206	Montour	192,187
Centre	1,297,554	Northampton	1,927,227
Chester	4,064,486	Northumberland	489,510
Clarion	456,002	Perry	311,573
Clearfield	592,217	Philadelphia	9,237,933
Clinton	360,499	Pike	406,955
Columbia	600,043	Potter	156,900
Crawford	546,750	Schuylkill	1,015,635
Cumberland	2,408,136	Snyder	454,151
Dauphin	2,368,019	Somerset	941,978
Delaware	3,317,855	Sullivan	112,815
Elk	209,705	Susquehanna	263,117
Erie	1,364,323	Tioga	317,859
Fayette	741,056	Union	318,773
Forest	49,798	Venango	337,814
Franklin	844,823	Warren	205,963
Fulton	404,343	Washington	1,553,263
Greene	285,244	Wayne	262,584
Huntingdon	233,833	Westmoreland	2,623,451
Indiana	610,009	Wyoming	275,861
Jefferson	449,718	York	3,213,038
Juniata	241,404	Total	$85,172,232

Source: Developed by LB&FC staff with data provided by the Administrative Offices of Pennsylvania Courts and Philadelphia Traffic Court.

Table 30

EMSOF Comparative Financial Statement FY 2002-03 Through FY 2011-12

($000)

	2002-03 Actual	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Actual	2007-08 Actual	2008-09 Actual	2009-10 Actual	2010-11 Actual	2011-12 Actual
Beginning Balance	$15,049	$17,849	$20,950	$22,133	$23,033	$21,210	$22,447	$21,666	$19,150	$14,842
Revenue:										
EMS - Operating Account	$ 9,968	$ 9,753	$10,009	$ 9,928	$10,208	$11,326	$11,228	$10,846	$10,269	$ 9,991
Catastrophic Medical & Rehabilitation	3,322	3,251	3,336	3,309	3,403	3,775	3,743	3,615	3,423	3,331
Interest on Securities	512	1,232	1,176	1,740	1,713	1,181	-61	254	3,241	447
EMS Fines	-	-	-	-	-	-	-	-	-	1
Other (Redeposit of Checks)	-10	-	-	-3 [a]	-	2 [b]	-	-	-	-2
Prior Year Lapses:										
Health										
EMS - Operating Account	316	333	762	321	199	98	120	144	144	211
Catastrophic Medical & Rehabilitation	1,754	2,751	2,210	1,638	254	2,455	2,077	513	1,953	1,961
Public Welfare										
Head Injury Support	898	361	-	-	-	-	-	-	-	-
Total Receipts	$16,760	$17,681	$17,493	$16,933	$15,777	$18,837	$17,107	$15,372	$19,030	$15,940
Total Funds Available	$31,809	$35,530	$38,443	$39,066	$38,810	$40,047	$39,554	$37,038	$38,180	$30,782
Expenditures (by Agency):										
Health										
EMS - Operating Account	$10,457	$11,102	$13,033	$13,033	$11,600	$11,600	$11,888	$11,888	$11,888	$10,975
Catastrophic Medical & Rehabilitation	3,000	3,000	3,000	3,000	6,000	6,000	6,000	6,000	6,450	5,250
Public Welfare										
Head Injury Support	503	478	277	-	-	-	-	-	-	-
Transfer to General Fund	-	-	-	-	-	-	-	-	5,000	-
Expenditures	$13,960	$14,580	$16,310	$16,033	$17,600	$17,600	$17,888	$17,888	$23,338	$16,225
Less Current Year Lapses (by Agency):										
Health										
EMS - Operating Account	-	-	-	-	-	-	-	-	-	-
Catastrophic Medical & Rehabilitation	-	-	-	-	-	-	-	-	-	-
Public Welfare										
Head Injury Support	-	-	-	-	-	-	-	-	-	-
Lapses	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Ending Balance - June 30	$17,849	$20,950	$22,133	$23,033	$21,210	$22,447	$21,666	$19,150	$14,842	$14,557

[a] EMS – Operating Account.
[b] Catastrophic Medical & Rehabilitation.
Source: Developed by LB&FC staff with information obtained from the Department of Health.

FY 2010-11, with an overall increase in spending of 30 percent, in that year alone. As shown, the Fund balance, including both the EMS and CMRF portions, at the end of FY 2011-12 was approximately $14.6 million, $10.9 million of which was available for EMS purposes.

Table 31 shows the EMSOF financial statement projected into the future through FY 2016-17. These projections indicate that the overall EMSOF balance/cash reserve will continue to steadily decline over the next four years by approximately $2.4 million each year due to appropriations/expenditures ($16.150 million) exceeding revenue into the Fund ($13.768 million). From FY 2012-13 to FY 2016-17 there is a 79 percent projected decrease in the Fund reserve balance.

In the last year of the projection, FY 2016-17, the EMSOF balance (cash reserve) is projected to fall to $2.572 million. This assumes a steady state of total fines and fees collected of approximately $13.3 million ($9.991 million for EMS), which is not supported by the downward trend depicted in the data provided to us by AOPC and the Philadelphia Traffic Court depicted in Tables 26 and 27. We also note that the expenditures authorized for the CMRF portion of the Fund are projected to continue into the future at $5.250 million, even though their portion of the EMSOF fines/fees receipts is only about $3.3 million annually. Their actual expenditures rose to as high as $5.7 million in FY 2006-07.

The ability of the EMSOF to contribute to funding EMS programs will be further eroded as administrative and operating costs increase with inflation. As a result, presumably the gap between available funding and the amount of annual funding needed to fully implement the statewide EMS system provided for in Act 37 will continue to widen.

In the absence of a cost estimate for the statewide EMS plan (see discussion beginning on page 22), it is difficult to assess the adequacy of the EMSOF funding mechanism or to provide documentation of EMS system funding needs to the General Assembly. Although Health Department officials have indicated that a cost estimate would be made as part of the EMS comprehensive plan development process, to date, this has not occurred. Previous funding gaps developed in 1996 by the PA Association of Regional EMS Council Directors were estimated at approximately $24 million annually.

Table 31

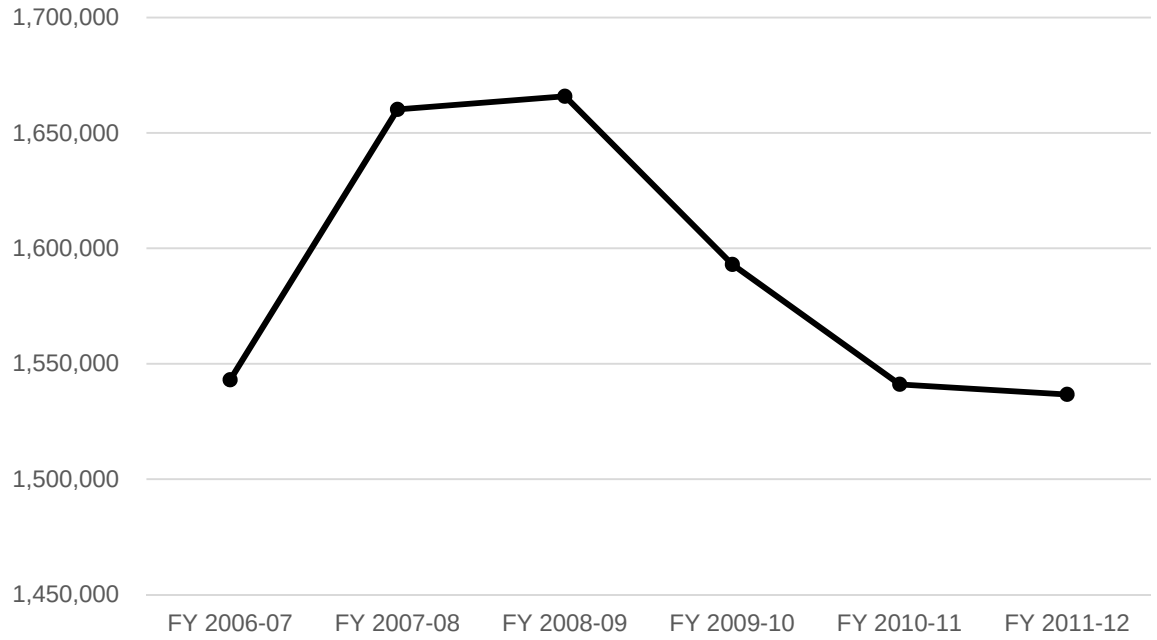
EMSOF Comparative Financial Statement
Projected FY 2012-13 Through FY 2016-17
($000)

	2012-13 Available	2013-14 Plan Yr 1	2014-15 Plan Yr 2	2015-16 Plan Yr 3	2016-17 Plan Yr 4
Beginning Balance	$14,557	$12,100	$ 9,718	$ 7,336	$ 4,954
Revenue:					
EMS - Operating Account	$ 9,991	$ 9,991	$ 9,991	$ 9,991	$ 9,991
Catastrophic Medical & Rehabilitation	3,331	3,331	3,331	3,331	3,331
Interest on Securities	445	445	445	445	445
EMS Fines	1	1	1	1	1
Other (Redeposit of Checks)	-	-	-	-	-
Prior Year Lapses:					
Health					
EMS - Operating Account	-	-	-	-	-
Catastrophic Medical & Rehabilitation	-	-	-	-	-
Public Welfare					
Head Injury Support	-	-	-	-	-
Total Receipts	$13,768	$13,768	$13,768	$13,768	$13,768
Total Funds Available	$28,325	$25,868	$23,486	$21,104	$18,722
Expenditures (by Agency):					
Health					
EMS - Operating Account	$10,975	$10,900	$10,900	$10,900	$10,900
Catastrophic Medical & Rehabilitation	5,250	5,250	5,250	5,250	5,250
Transfer to General Fund	-	-	-	-	-
Expenditures	$16,225	$16,150	$16,150	$16,150	$16,150
Less Current Year Lapses (by Agency):					
Health					
EMS - Operating Account	-	-	-	-	-
Catastrophic Medical & Rehabilitation	-	-	-	-	-
Lapses	$ 0	$ 0	$ 0	$ 0	$ 0
Ending Balance - June 30	$12,100	$ 9,718	$ 7,336	$ 4,954	$ 2,572

Source: Bureau of Emergency Medical Services.

Exhibit 16

Trend Data on Traffic Violation and ARD Admission Assessments by PA Courts*
(FY 2006-07 Through FY 2011-12)



* Includes Philadelphia. Philadelphia Traffic Court reported a 41 percent decrease in total number of assessments made (both ARD and moving violations) from FY 2008-09 through FY 2011-12, accounting for the majority of the decrease in assessments made statewide. However, their level of fines/fees disbursed to the Fund only decreased by 20 percent during the same time frame. Excluding Philadelphia, the decrease in assessments from FY 2007-08 through FY 2011-12 was 3.1 percent.

Source: Developed by LB&FC staff from information obtained from AOPC.

Other States' EMS Funding Sources and Alternatives

As discussed throughout this report, EMSOF funding is almost totally reliant on the special funding mechanism first established in Act 1985-45. The above assessment of the revenue-generating capacity of this funding mechanism from FY 2006-07 through FY 2016-17 shows that revenues are flat, and funding from existing sources appears to be maximized at approximately $10 million annually for EMS purposes. Other states' EMS budgets, nationwide, have been significantly impacted as well by the current economic downturn. This has limited the ability of many states to provide leadership beyond basic baseline regulatory functions.

In July 2011, the Federal Interagency Committee on Emergency Medical Services, in concert with the National Highway Traffic Safety Administration, released a report entitled 2011 National EMS Assessment which was the result of a two-year

effort to "better understand data that is currently being collected at the State, regional, and national levels that pertain to EMS systems, EMS emergency preparedness, and 911 communications."[9] In 47 of the 50 states, the lead agency is organizationally located within the state's health department.

One area examined was funding sources for state EMS offices. With a total of 46 states responding, the authors of the report identified 17 different funding sources for state EMS offices. On average, state EMS offices receive 33 percent of their funding from their state's general budget, 19 percent from motor vehicle related fines or fees, 7 percent from federal preparedness funds, and multiple other sources providing less than 5 percent each. Table 32 presents the results of the data that was examined.

The largest number of states, 38 (83 percent) reported receiving money from their General Fund budgets, with the average amount provided being approximately $3 million per year. The highest amount provided by a state in this category was $78,000,000 annually. The next most prevalent funding source for state EMS offices were federal in nature—federal preparedness funds and Emergency Medical Services for Children Fund (EMSC) program funds. Sixty-seven percent of states responding received EMSC funding, with the average award being almost $100,000. Fifty-two percent of states responding received Federal Preparedness funds, with the average award being $754,000. Fifteen states (33 percent) reported receiving traffic ticket or motor vehicle related fees of approximately $2.2 million annually on average. This is up from nine states that we reported as using this mechanism at the time of our previous audit in 1998. With a reported high of $24 million from this type of funding mechanism, Pennsylvania appears to fall somewhat in the middle of this group of states. At $10.4 million in FY 2011-12, Pennsylvanians provide $7.4 million more than the average from this type of funding source as reported by NHTSA. Other special state funds of $671,000, on average, were provided annually to 15 states.

In 2008, NHTSA asked seven states in the Mid-Atlantic region, including Pennsylvania, and the District of Columbia, to identify the sources of funding used to finance EMS systems. Four states and the District of Columbia indicated the primary source of funding was from tax subsidies, while Pennsylvania and one other state indicated that EMS systems were primarily financed by fees or billing for services. The report asked the EMS systems responding from Pennsylvania to identify the sources of funding for the EMS systems in their regions. All EMS systems responding reported that they received financial support through fees and bills for service and donations or fundraisers. Approximately 67 percent of respondents indicated that EMS systems in their regions were also supported with tax subsidies,

[9] *2011 National EMS Assessment,* Federal Interagency Committee on EMS.

Table 32

Funding Mechanisms in Use in Other States for EMS Purposes*

	States	Mean	Min	Max
State General Budget	38 (83%)	$3,030,054	$0	$78,000,000
Federal HRSA EMSC Funds	31 (67%)	99,664	0	325,000
Federal Preparedness (ASPR, etc.) Funds	24 (52%)	754,220	0	16,870,069
Other Special Grants and Contract Funds	17 (37%)	1,337,958	0	33,000,000
Traffic Tickets/Motor Vehicle Related Fees	15 (33%)	2,252,640	0	24,000,000
Other Special State Funds	15 (33%)	670,830	0	13,000,000
Federal NHTSA Funds	14 (30%)	52,687	0	300,000
EMS Professional Credentialing Fees	12 (26%)	88,784	0	2,005,000
Federal CDC Funds	9 (20%)	249,002	0	7,178,511
Ambulance Fees	9 (20%)	66,589	0	2,263,098
Federal HRSA Other Funds	8 (17%)	31,353	0	660,000
Federal HRSA Rural Health Funds	8 (17%)	29,304	0	790,000
Other Fees	7 (15%)	55,578	0	1,229,986
EMS Agency Fees	7 (15%)	37,443	0	1,000,076
Federal DHS Funds	6 (13%)	161,143	0	4,440,602
Federal HRSA Poison Center Funds	1 (2%)	870	0	40,000
Special Lottery Funds	0 (0%)	0	0	0

*Alaska, Florida, Massachusetts, and Maryland data unavailable.

Source: Data obtained from the NASEMSO 2011 EMS Industry Snapshot was collected using a survey distributed to the director of each state's regulatory EMS office. It should be noted that the aggregate results of any survey question is based on a combination of fact and opinion. This is dependent on each state's available data sources and operational awareness relative to each specific question. The NASEMSO Snapshot question used for this analysis was the following: "What is the budget for the State EMS Office from each of the following sources?"

and 93 percent indicated that some level of grant support was used to fund EMS systems.[10]

The Federal Emergency Management Agency (FEMA) released a report in April 2012 that, among other things, provided a description of the types of funding states utilized to fund EMS. Sources of support identified included low-interest loans, surplus vehicles and equipment, special purpose grants, matching grants, technical assistance, and subsidized training. The report does not identify the amount of funding from each of these sources that states received. The report does identify for each state, specific grants and aid programs that local EMS and fire agencies can access for state funding.[11]

[10] *Configurations of EMS Systems: A Pilot Study,* National Highway Traffic Safety Administration, pp. 8, 10, 44, March 2008.
[11] *Funding Alternatives for Emergency Medical and Fire Services, April 2012,* See Chapter 5, pp. 49-83.

An idea that has been put forth several times in Pennsylvania is to charge certification fees of EMS professionals (including course registration fee add-ons), ambulance services, and/or per ambulance fees to help defray the cost of providing licensing, inspection, and credentialing activities for the state as a whole. Table 32 shows that a total of 28 states have either EMS professional credentialing fees, ambulance fees, or EMS agency fees. Currently, in Pennsylvania there are no such fees charged, although many states contiguous to Pennsylvania have these fees (New Jersey, New York, Ohio, and Maryland). The BEMS reported to us in March 2013 that the complete cost to the Commonwealth to inspect ambulances and process applications is $1,249,310 annually. They reported, "The increase in the number of for-profit ambulances companies has caused an increase in the number of ambulances that fail the initial inspection requiring the regional EMS council and the department to make multiple appointments to inspect vehicles that are frequently in disrepair." Our analysis showed that $1,042,349 is spent on salaries alone at the regional council level for those employees directly related to the training/certification function. Training costs (above salaries) at the regional councils is reported at $588,784 statewide.

Additional alternative funding mechanisms utilized in other states include fees on driver's licenses and car registrations and surcharges on seat belt violations. In Delaware, insurance companies pay a percentage on health insurance premiums to the EMS program. The LB&FC's report on EMSOF released in 1998 suggested that consideration be given to amending the law to provide for a "differential" or higher fine for certain offenses (for example, for driving under the influence violations as was then being done in certain other states). To date, this has not occurred.

VII. Appendices

APPENDIX A

Specific Salary and Benefit Information for Regional Councils, PEHSC and the Commonwealth of Pennsylvania

Bucks County Emergency Health Services

Bucks (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. Paid By EMSOF	Other Funds	Total Cost Benefits	Amt. Paid By EMSOF	Other Funds
Director	$ 63,350.74	$ 31.68	$ 63,319.06	$ 29,099.00	$ 0.00	$29,099.00
Field Rep.	$ 50,220.77	$ 29,748.12	$ 20,472.65	$ 29,099.00	$ 9,254.64	$19,844.36
Training Coord.	$ 50,220.77	$ 29,748.12	$ 20,472.65	$ 29,099.00	$ 9,254.64	$19,844.36
Asst. Training	$ 16,705.52	$ 10,092.13	$ 6,613.39	$ 0.00	$ 0.00	$ 0.00
Quality Assur.	$ 50,694.38	$ 26,247.19	$ 24,447.19	$ 29,099.00	$ 8,779.69	$20,319.31
Adm. Asst.	$ 40,301.25	$ 21,289.52	$ 19,011.73	$ 29,099.00	$ 7,504.56	$21,594.44
Secretary	$ 39,948.40	$ 14,848.96	$ 25,099.44	$ 29,099.00	$ 6,236.56	$22,862.44
Totals	**$311,441.83**	**$132,005.72**	**$179,436.11**	**$174,594.00**	**$41,030.09**	**$133,563.91**

Regional staff at this council are considered county staff and receive Bucks County's benefit package.

Holidays: Employees receive a total of 13 paid holidays including 10 federal holidays, Good Friday, General Election Day and Primary Election Day.

Vacation Days: The length of an employee's County service determines vacation time. Vacation time is awarded on a calendar basis. Vacation time begins accruing from date of employment but cannot be taken for six months. Vacation time accrues as follows: 6 months- 5 days; 1 to 5 years- 10 days; 5 to 11 years- 15 days; 11 years get 16 days; 12 years get 17 days; 13 years get 18 days; 14 years get 19 days; 15 years to 21 years get 20 days; subsequent years up to 25 years get one extra day a year. A total of 20 vacation days may be carried over at the end of each year. At retirement, employees are paid 100 percent for up to 20 carried over days and current unused vacation.

Personal Days: Employees receive one personal day a year that is dependent on them having sick leave available. If they have sick leave available they can convert one day to personal day. Days cannot be carried over.

Sick Days: Sick leave is earned at one day per month beginning on the date of employment. Sick days may be accumulated from year to year without limit. An employee retiring or resigning after 8 years of service receives full pay for one-half of hours accumulated with a maximum payment equal to 20% of the employee's annual rate of pay. An employee with more than 200 hours in their personal sick bank may trade two sick days for one vacation day up to a maximum of 5 vacation days per calendar year in the month of March.

Health Insurance: HMO provided for employees by the county. An average of 1% of employees pay is deducted to pay toward health benefit. Spouses and dependents are covered for free. No deductible that employee must pay. Co pays are $15 for primary care physician visits, $30 for specialist visit, $100 for emergency room visits unless admitted, and $10 for generic medication and $20 for brand name medication. Co pays are not reimbursed. Employee is not granted extra pay if they opt out of health insurance. Vision and dental coverage included in health care cost. Dependents covered for dental, vision

and prescription at no extra charge. Health and life insurance is not portable. Short and long-term disability insurance available to employees at no cost. They receive 60% of base pay.

Life Insurance: Free to employees. Coverage is equal to employee's gross salary. Includes accidental death and dismemberment (ADD). Employee cannot purchase additional life insurance through the group plan.

Pension/Retirement: Follow county retirement plan. Employees not vested until five years of employment. A mandatory nine percent of employees pay is redirected toward pension from each paycheck. In 2011 a total of 8.5% and in 2012 a total of 9% was paid by the county to fund the plan. Amount each year determined by actuarial formula. Employee can request up to 19% of pay be redirected toward pension. Any additional amount is not matched by county.

Educational Expenses: This EMS region does not reimburse employees for educational expenses because they do not have the funds to do so.

Chester County Emergency Medical Services Council

Chester (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. Paid by EMSOF	Other Funds	Total Cost Benefits	Amt. Paid By EMSOF	Other Funds
Dep. Director for Field Services	$ 76,293.89	$20,123.17	$ 56,170.72	$20,979.19	$ 5,414.28	$15,564.91
ALS Coordinator	$ 52,542.83	$13,071.00	$ 39,471.8	$17,696.47	$ 4,402.36	$13,294.11
BLS Coordinator	$ 49,203.39	$12,222.00	$ 36,981.39	$17,410.30	$ 4,601.61	$12,808.69
EMS Trainer	$ 41,500.29	$10,713.00	$ 30,787.29	$15,310.61	$ 3,719.30	$11,591.31
Data Coordinator/ Support	$ 56,232.29	$19,975.00	$ 36,257.29	$18,078.89	$ 3,931.30	$14,147.59
CISM Coordinator	$ 11,970.40	$11,970.40	$ 0.00	$ 889.00	$ 889.00	$ 0.00
Reg. EMS Medical Director	$ 11,970.40	$11,419.00	$ 0.00	$ 873.00	$ 873.00	$ 0.00
Totals	**$299,713.49**	**$99,493.57**	**$199,668.52**	**$91,237.46**	**$23,830.85**	**$67,406.61**

Regional staff are considered county staff and receive the county's standard benefit package. However, EMSOF monies are used to reimburse the county for some benefit costs.

Holidays: 11 paid holidays and three floating holidays for a total of 14 holidays.

Vacation Days: Vacation time is awarded on a calendar basis from date of hire. Vacation time accrues as follows: First through fifth years receive 12 days; Sixth through fifteenth year receive 18 days; Sixteenth year and more receive 24 days. No more than 15 days of accumulated vacation leave may be carried over to the following calendar year. Any excess accumulated vacation time and accompanying salary is forfeited. Employees are paid in full for vacation time accrued. Also receive three personal days a year.

Sick Days: Six days per year for first year of employment. After first year of employment, 12 days per year. Can carry over 12 days of unused sick leave. Any employee working fulltime for eight or more years is eligible to receive payment of 25 percent of unused sick leave.

Health Insurance: HMO or Blue Cross Blue Shield coverage provided for employees and dependents after 90 days of employment. Employees must contribute to the cost of health insurance-the exact amount is determined by salary range and whether plan is for single, single and spouse, or family. Only two employees in region getting benefits. Prescription coverage is provided at no extra charge for employees and their families. Employees may opt out of health insurance coverage and will receive an

Appendix A (Continued)

extra $59 in each pay. There are no deductibles. Dental and vision coverage provided however employee has to pay additional for themselves and their dependents. Co pays for primary care physician is $10, specialist $20, emergency room $40, and for medications, $10 generic, $30 preferred brand, $45 non preferred brand. Co pays not reimbursed to employees. Health and life insurance is not portable. Short and long-term disability insurance available to employees at no cost. They receive 60% of base pay.

Life Insurance: Provided free to employees. Includes ADD. Coverage is equivalent to annual salary. Employees may purchase up to three times their annual salary and additional ADD at their own cost.

Pension/Retirement: This is a defined mandatory participation contribution plan. If hired prior to 1/1/11 employee must contribute 5% of salary to plan. If hired after 1/1/11 employee must contribute 6% of salary. Pension is determined by class basis, final salary and years of service with a minimum interest guarantee of 4%. Employees vest after 5 years of service. To be eligible employees must work a minimum of 1,000 hours annually. Employees can contribute up to an additional 10 percent to their retirement plan but this amount is not matched by the county.

Educational Expenses: No reimbursement of educational expenses.

Delaware County Emergency Health Services Council

Delaware (FY 2011-12)

Position Titles	Gross Salary 11/12	EMSOF	Other Funds	Total Cost Benefits	EMSOF	Other Funds
Regional EMS Director (PT)	$ 80,209.00	$ 0.00	$80,209.00	$ 23,029.50	$0.00	$ 47,323.31
Regional EMS Medical Director	$ 5,000.00	$ 0.00	$ 5,000.00	$ 0.00	$0.00	$ 0.00
EMS Program Coordinator	$ 61,491.93	$ 61,491.93	$ 0.00	$ 36,310.98	$0.00	$ 36,310.98
EMS Con-Ed Coordinator	$ 49,285.18	$ 49,285.18	$ 0.00	$ 29,102.90	$0.00	$ 29,102.90
EMS Education Coordinator	$ 41,192.36	$ 41,192.36	$ 0.00	$ 24,324.09	$0.00	$ 24,324.09
EMS Secretary	$ 24,451.10	$ 24,451.10	$ 0.00	$ 14,438.37	$0.00	$ 14,438.37
Totals	**$261,629.57**	**$176,420.57**	**$85,209.00**	**$151,499.65**	**$0.00**	**$151,499.65**

Regional staff are considered county staff and receive the county benefit package. All benefits come out of county budget, not EMSOF.

Number of Paid Holidays: 15 holidays for which they are paid.

Vacation Days: After the first five months, an employee earns one vacation day per month for the remainder of the year. Subject to a maximum of 10 days. Beginning on January 1st of the calendar year following the completion of the first five months, the employee is entitled to two weeks' vacation for year one through year 5; for five years through 14 years the employee is granted 15 days of vacation; for 14 years through 19 years the employee is granted 20 days of vacation; after 19 years- 25 days of vacation are granted. After completing five years of service, employees may carry five vacation days into the new calendar year. These five days must be taken before the end of February 1st. When an employee retires, they will be compensated for all earned unused vacation in a lump sum payment within 30 days. If an employee maintains perfect attendance for a full calendar year he will receive two personal days the following year. If an employee uses six days or less on vacation time in any year, he will receive one personal day the following year.

Sick Days: Earned at the rate of one day per month, excluding probationary employees. Probationary employees earns sick leave but cannot take it until their probationary period ends. Unused sick

leave shall be cumulative and available for future use provided that the balance of the credit at any time shall not exceed 30 days for non-bargaining employees. Not paid for unused sick leave upon retirement.

Health Insurance: County offers two medical plans only to full-time employees who have completed 90 days of service, one of which AmeriHealth HMO and Keystone HMO. AmeriHealth allows five free office visits. AmeriHealth takes 1% of annual salary per year for single; 1.5% of annual salary for parent and child; 2% annual salary for two adults; and 2.5% annual salary for family. Keystone HMO takes 1% of salary per year for single per paycheck; adult and child it takes $938 annually; two adults takes $1,044 annually; family takes $1,123 annually. Amount is divided by pays per year. No deductible costs. Co pays are the same for both plans-primary care physician $10, specialist $15, ER $40; generic $5; brand $15. Employees can opt out of health care coverage and will receive $100 extra annually in pay. Most employees are in Keystone HMO. Dental and vision provided in health care costs named above. Health insurance is not portable. STD and LTD offered to employees at no cost.

Life Insurance: Coverage is equal to annual salary. $1.43 deducted once a month from employees pay to help pay the premium. ADD included. Cannot purchase additional insurance through group plan.

Pension/Retirement: Ninety day probationary before eligible for pension plan. A total of 7% deducted from each paycheck for pension. County provides a percent each year to employees using a formula that is based on annual salary and years of service. Employees can contribute more to the retirement plan but it is not matched.

Educational Expenses: No reimbursement of educational expenses.

Eastern PA Emergency Medical Services Council, Inc.

Eastern (FY 2011-12 Data)

Position Titles	Gross Salary 11/12	EMSOF	Other Funds	Total cost benefits	EMSOF	Other Funds
Executive Director	$ 98,658.94	$ 98,658.94	$ 0.00	$ 14,311.57	$ 14,311.57	$ 0.00
Controller	$ 24,102.39	$ 24,102.39	$ 0.00	$ 30,093.87	$ 30,093.87	$ 0.00
Director of Operations	$ 56,426.94	$ 56,426.94	$ 0.00	$ 13,053.42	$ 13,053.42	$ 0.00
Dir Admin & Provider Services	$ 49,253.12	$ 49,253.12	$ 0.00	$ 22,329.27	$ 22,329.27	$ 0.00
Dir of Quality Improvements	$ 47,112.00	$ 47,112.00	$ 0.00	$ 12,386.46	$ 12,386.46	$ 0.00
Dir of Education Services	$ 55,998.56	$ 55,998.56	$ 0.00	$ 29,643.11	$ 29,643.11	$ 0.00
Dir EMS Provider Services	$ 48,610.69	$ 48,610.69	$ 0.00	$ 12,503.75	$ 12,503.75	$ 0.00
Emergency Preparedness	$ 64,180.54	$ 0.00	$64,180.54	$ 4,337.27	$ 0.00	$4,337.27
Administrative Assistant - PT	$ 16,237.84	$ 16,237.84	$ 0.00	$ 14,473.25	$ 14,473.25	$ 0.00
Administrative Assistant - PT	$ 14,063.50	$ 14,063.50	$ 0.00	$ 5,533.65	$ 5,533.65	$ 0.00
Administrative Assistant - FT	$ 35,616.02	$ 35,616.02	$ 0.00	$ 27,551.91	$ 27,551.91	$ 0.00
Totals	**$510,260.54**	**$446,080.00**	**$64,180.54**	**$186,217.53**	**$181,880.26**	**$4,337.27**

Holidays: Thirteen paid holidays a year.

Vacation Days: Granted to all full-time employees on the basis of 1.25 days per month during the first two years of employment. Upon completion of two years of employment, vacation time will be

granted at the rate of 1.5 days per month. Upon completion of five years of employment, vacation time is granted at the rate of 1.75 days per month. Vacation time can be accumulated to a maximum of 30 days. Unused vacation leave, to the maximum of 30 days will be paid at time of termination. No personal days are awarded.

Sick Days: Granted at the rate of eight hours or one day equivalent for each month of employment and can be accumulated to a maximum of 90 days. When employees leave employment they are not paid for sick leave.

Health Insurance: Regions health plan is a PPO. Costs to the region for health plan varies for single and family coverage. Employees must pay 10% of the premium cost. Health and vision coverage for each employee varies by whether they have single, employee and spouse, employee and child, or family coverage. Cost ranges per employee from $7,872 to $22,923 annually. For dental coverage the annual premium per employee ranges from $480 to $1613 annually. Again, employees must pay 10% of the premium cost. There are no deductibles. Co pays are $10 for primary care physician visits, $20 for visits to specialists, emergency room visits are $35, and urgent care co pay is $40. Prescription co pays are $10 for generics, $20 for preferred brand, and $40 for non-preferred. Employees receive $200 per month if they opt out of insurance coverage. Two do so. LTD and STD included in coverage. Insurance is not portable.

Life Insurance: Life insurance is provided free to employees. The amount of the insurance is for three times the salary of individual employees. Employees may not purchase additional life insurance through the plan. ADD is included.

Pension/Retirement: Region has a 403B plan. Employees are eligible if they are at least 21 years old, have been employed for at least six months, and work 1,000 or more hours per year. Region contributes 5% over and above an employee's annual salary to the tax sheltered annuity. Employee may request additional money be diverted to the pension, but region does not match.

Educational Expenses: Will reimburse educational expenses up to $1,200 a year. Employee must obtain a "C" grade or higher.

Emergency Health Services Federation, Inc.

EHSF (FY 2011-12 Data)

Position Titles	Gross Salary 11/12	EMSOF	Other Funds	Total Cost Benefits	EMSOF	Other Funds
Executive Director	$ 85,059.03	$ 85,059.03	$ 0.00	$ 32,670.23	$ 32,670.23	$ 0.00
Director of Administrative Services	$ 51,558.00	$ 51,558.00	$ 0.00	$ 27,147.35	$ 27,147.35	$ 0.00
Director of Systems Operation	$ 49,481.32	$ 49,481.32	$ 0.00	$ 30,929.76	$ 30,929.76	$ 0.00
Program Specialist	$ 39,370.59	$ 39,370.59	$ 0.00	$ 24,912.17	$ 24,912.17	$ 0.00
Program Coordinator	$ 35,080.55	$ 35,080.55	$ 0.00	$ 29,663.14	$ 29,663.14	$ 0.00
Program Coordinator	$ 34,632.00	$ 34,632.00	$ 0.00	$ 23,324.31	$ 23,324.31	$ 0.00
Program Coordinator	$ 30,576.00	$ 30,576.00	$ 0.00	$ 14,326.58	$ 14,326.58	$ 0.00
Secretary/Receptionist	$ 21,721.51	$ 21,721.51	$ 0.00	$ 22,280.00	$ 22,280.00	$ 0.00
Funded by HPP Federal Funds	$ 52,437.56	$ 0.00	$52,437.56	$ 21,232.13	$ 0.00	$ 21,232.13
EHSF Evaluators	$ 18,960.75	$ 18,960.75	$ 0.00	$ 2,236.95	$ 2,236.95	$ 0.00
EHSF Patient Actors	$ 19,714.25	$ 19,714.25	$ 0.00	$ 2,326.14	$ 2,326.14	$ 0.00
National Registry Evaluators	$ 4,720.00	$ 4,720.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
National Registry Patient Actors	$ 610.00	$ 610.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Totals	**$443,921.56**	**$391,484.00**	**$52,437.56**	**$231,049.14**	**$209,817.01**	**$21,232.13**

Appendix A (Continued)

Holidays: Eleven paid holidays.

Vacation Days: One day of vacation is earned for each month worked. Following two full years of employment vacation is earned at the rate of 1.25 days a month. Following five years of employment vacation is earned at the rate of 1.75 days a month. Following 10 years of employment vacation is earned at the rate of two days a month. Employees can accrue vacation days equal to the amount of vacation to which the employee is entitled, times two. Once the maximum has been accrued for their years of employment, additional earned vacation hours must be taken as time off from work as they are earned or they will be lost. At the time of termination, accrued vacation will be paid at a rate of 100 percent. Region also provides five personal days for each employee. Personal days cannot be carried over past the employee's service year.

Sick Days: One day of sick leave is earned for each month worked. Sick leave can accrue and be carried over to the next year up to a maximum of 30 days. When employees leave employment they are not paid for unused sick leave.

Health Insurance: PPO plan is provided free for employees and their dependents. The plan covers comprehensive major medical and prescription drug program, Dental benefits and vision care are also provided free to employees. Insurance is not portable. There is a $500 deductible for individuals and $1,000 for family coverage. Co Pay is $20 for primary physician, $40 for specialist, and $75 for emergency room visit. Prescription drug co pay is $15 for generic, $30 for preferred brand and $50 for non-preferred brand prescription drugs. Neither the deductible or co pays are reimbursed by the region. Short and long term disability also provided.

Life Insurance: Provided free to employees. Amount of coverage provided is $50,000. Also includes ADD.

Pension/Retirement: 401(K) Plan for employees is available once they reach age 21, have been employed at least six months, and have worked at least 1,000 hours. Region contributes the equivalent of six percent of the employee's annual salary to the plan. Employee does not have to contribute anything, but may do so on their own. Extra contributions are not matched by the region.

Educational Expenses: Will reimburse 100% of educational expenses if a grade of "C" or above is obtained.

EMMCO East, Inc.

EMMCO East (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. Paid By EMSOF	Other Funds	Total Cost Benefits	Amt. paid By EMSOF	Other Funds
Executive Director	$ 60,944.00	$ 60,944.00	$0.00	$24,624.77	$24,624.77	$3,440.85
Education Director	$ 51,542.40	$ 51,542.40	$0.00	$18,925.30	$18,925.30	$ 0.00
EMS Program Specialist	$ 45,385.60	$ 45,385.60	$0.00	$23,092.58	$23,092.58	$ 0.00
Administrative Assistant	$ 37,398.00	$ 37,398.00	$0.00	$16,866.74	$16,866.74	$ 0.00
Totals	**$195,270.00**	**$195,270.00**	**$0.00**	**$83,509.39**	**$83,509.39**	**$3,440.85**

Holidays: Employees receive 11 paid holidays.

Vacation Days: Employee's receive 10 days of vacation time for year one through year five of employment. Employees receive three weeks (15 days) of vacation time on July 1 of the employees fifth year of employment and each July 1 thereafter. Vacation time cannot carry over from year to year. Employees fully paid for any vacation time they have not used when they separate from employment. Full time employees also receive four days of personal time each year. It is not carried over from year to year.

Appendix A (Continued)

Sick Days: Employees receive 12 sick days per year. Sick leave cannot be carried over to following year. When employees leave they are not paid for unused sick leave.

Health Insurance: Employees may participate in the health insurance program (PPO) after working 90 days. The council covers 100% of the employee's health care insurance premium, including vision. Coverage provided for the individual employee and their dependents, except for dental which an employee must pay for to have their dependents enrolled. None do so. If a dependent has coverage available elsewhere they cannot be enrolled in any health insurance. Employees may opt out of health care but no extra pay is provided. There is no deductible. Co pay is $20 for physician and specialist visits and $65 for emergency room visits. Co pay for medication is $8 for generic and $40 for brand prescription. Insurance is not portable. Also includes LTD and STD.

Life Insurance: Employees life insurance is provided free. It includes ADD. Life insurance benefit is $75,000.

Pension/Retirement: Region offers a SEP Plan. Region contributes 6% over and above the employee's salary on a quarterly basis. Employee does not have to contribute unless they want to. Region does not match any extra contribution.

Educational Expenses: Reimburse full amount of class with prior approval if funds are available. Must obtain a "C" grade in the course.

EMMCO West, Inc.

EMMCO West (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. Paid by EMSOF	Other Funds	Total Cost Benefits	Amt. paid by EMSOF	Other Funds
Executive Director	$ 69,998.64	$ 69,998.64	$ 0.00	$ 42,584.16	$ 42,584.16	$ 2,799.95
Assistant Director	$ 49,813.20	$ 49,813.20	$ 0.00	$ 18,479.73	$ 18,479.73	$ 1,394.77
EMS System Specialist	$ 48,280.56	$ 48,280.56	$ 0.00	$ 24,090.94	$ 24,090.94	$ 1,351.86
Office Manager	$ 38,865.36	$ 38,865.36	$ 0.00	$ 16,683.29	$ 16,683.29	$ 971.63
Con-ed Specialist	$ 38,865.36	$ 38,865.36	$ 0.00	$ 18,183.49	$ 18,183.49	$ 971.63
Education Specialist	$ 38,865.36	$ 38,865.36	$ 0.00	$ 5,878.43	$ 5,878.43	$ 1,088.23
Outreach Specialist	$ 31,279.92	$ 31,279.92	$ 0.00	$ 14,090.41	$ 14,090.41	$ 782.00
Office Operations	$ 28,296.00	$ 28,296.00	$ 0.00	$ 15,805.85	$ 15,805.85	$ 622.35
Preparedness Specialist	$ 41,280.78	$ 0.00	$41,280.78	$ 25,454.90	$ 0.00	$ 959.51
Totals	**$385,545.18**	**$344,264.40**	**$41,280.78**	**$181,251.20**	**$155,796.30**	**$10,941.93**

Holidays: Observe 12 holidays.

Vacation Days: Fulltime employees are provided personal time off days(PTO) days according to the following schedule. Employees employed 60 days to four years receive 18 days. Five years to 10 years receive 23 days. Eleven years to 15 years receive 28 days. Sixteen years and greater receive 33 days. Annual carryover of PTO days may not exceed 10 days into a new year. PTO days over 10 days remaining on December 31st of each year will be reimbursed to the employee according to a schedule: 1-5 days over receive 50% reimbursement; 6 to 10 days over receive 25% reimbursement; 11 and greater days receive 10% reimbursement. Upon separation, they are paid for 100 percent of unused PTO days that were carried over.

Sick Days: Sick days see above. In addition, each employee annually receives 12 reserve sick days for use for longer term health issues. They are not an earned benefit. There is no carryover of RSD's from year to year nor are employees will not be paid for accrued RSD's upon their separation from employment.

Health Insurance: Provide PPO health insurance. Employees must participate in the cost of the health insurance premium as follows: Initial employment (after 60 days) to three years of employment an employee pays 10% of premium. From three years to six years employees pay 5% of premium. Employees who have been with the region for six or more years pay 1.5% of premium. Dependents can be added but premium costs would of course be higher. Deductible is $750. Co pays are $25 for primary care physician, $35 for a specialist and $75 for emergency room visit. Prescription copays- $10- generic, $40- brand name. Vision and dental and prescription provided free to employees. Coverage is only for employees not dependents and dependents cannot be added. Health plan is not portable. Have a health and wellness program that entitles employees a maximum of $150 every six months to help pay for health checkups or gym membership. Short and Long Term disability insurance coverage provided free. Short term begins from the first day of an accident and goes 26 weeks. Weekly benefit will not exceed 66.67% of the employee's weekly earnings. Long term disability coverage begins after short term benefits are utilized.

Life Insurance: An employee receives $75,000 in life insurance and an additional $75,000 for accidental death and up to $75,000 for dismemberment. The executive director receives $115,000 in life insurance. No cost to employee for life insurance.

Pension/Retirement: After 60 days employee can participate in SEP IRA Plan. Region pays 5% toward the employee's pension over and above their annual salary. Employees do not have to contribute out of their salary unless they want to increase the amount withheld. Region will not match, however.

Educational Expenses: No reimbursement of educational expenses.

Emergency Medical Service Institute

EMSI (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. Paid By EMSOF	Other Funds	Total cost benefits	Amt. Paid By EMSOF	Other Funds
Board of Directors	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Information and Education Ass't.	$ 41,745.60	$ 41,745.60	$ 0.00	$ 2,922.00	$ 2,922.00	$ 0.00
Education Specialist	$ 54,080.00	$ 54,080.00	$ 0.00	$ 22,350.00	$ 22,350.00	$ 0.00
Education Specialist	$ 54,080.00	$ 54,080.00	$ 0.00	$ 22,350.00	$ 22,350.00	$ 0.00
Education Specialist	$ 54,080.00	$ 54,080.00	$ 0.00	$ 10,326.00	$ 10,326.00	$ 0.00
Clinical Specialist	$ 54,080.00	$ 54,080.00	$ 0.00	$ 10,326.00	$ 10,326.00	$ 0.00
Operations Specialist	$ 54,080.00	$ 54,080.00	$ 0.00	$ 22,350.00	$ 22,350.00	$ 0.00
Licensing Manager	$ 56,285.00	$ 56,285.00	$ 0.00	$ 10,480.00	$ 10,480.00	$ 0.00
Education Coordinator	$ 67,288.00	$ 67,288.00	$ 0.00	$ 23,274.00	$ 23,274.00	$ 0.00
Operations Coordinator	$ 65,333.00	$ 65,333.00	$ 0.00	$ 11,113.00	$ 11,113.00	$ 0.00
Clinical Coordinator	$ 64,064.00	$ 64,064.00	$ 0.00	$ 11,024.00	$ 11,024.00	$ 0.00
Executive Director	$ 92,643.00	$ 92,643.00	$ 0.00	$ 25,049.00	$ 25,049.00	$ 0.00
Emergency Preparedness Manager	$ 70,333.00	$ 0.00	$70,333.00	$ 23,487.00	$ 0.00	$23,487.00
Totals	**$728,091.60**	**$657,758.60**	**$70,333.00**	**$195,051.00**	**$171,564.00**	**$23,487.00**

Appendix A (Continued)

Holidays: Eight paid holidays.

Vacation Days: Personal Time Off (PTO) granted in lieu of vacation and sick leave. PTO accrues at the rate of six hours per pay period or 18 days per year (two pay periods per month). Employees do not have to take PTO for time off that is less than a 4 hour increment however that time does need to be worked off by the employee. When an employee leaves, PTO accrued but unused shall be paid to the employee at 100 percent. Employees are not allowed to take time off during the week of the conference. A total of 40 hours of PTO may be carried over each fiscal year and employees PTO not used is forfeit. Payout to employee leaving will be at 100 percent of not more than 40 hours plus whatever has been earned in current year. An additional 3 days may be granted for bereavement leave.

Sick Days: See above.

Health Insurance: PPO Plan, including vision and dental provided for employees and dependents. Full cost of plan paid by region. No contribution from employees. No deductible. Co pay is $10 for visit to primary care physician, $20 for visit to specialist, $50 for emergency room and $10 for generic and $35 for name brand medications. Employees can opt out but receive no additional pay. There is an annual $1,000 benefit limit for the dental plan. Includes STD and LTD.

Life Insurance: Insurance free to employees. Benefit amount is $75,000, which is doubled if accidental death. Employees cannot buy additional insurance. Includes ADD.

Pension/Retirement: SEP IRA pension plan. Employees eligible after one full year of employment. Region will make contributions to an authorized account or investment fund designated by the employee of 7% over and above the employee's salary. Additional contributions can be made by employees but they are not matched by region.

Educational Expenses: No reimbursement of educational expenses.

LTS Emergency Medical Services Council

Lycoming (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. paid By EMSOF	Other Funds	Total cost benefits	Amt. Paid by EMSOF	Other Funds
Clerk	$ 30,173.11	$ 27,144.00	$ 3,029.11	$ 14,142.14	$0.00	$ 14,142.14
EMS Program Mgr	$ 60,750.57	$ 54,132.00	$ 6,618.57	$ 28,473.79	$0.00	$ 28,473.79
EMS Training Coordinator	$ 41,492.82	$ 36,699.00	$ 4,793.82	$ 19,447.68	$0.00	$ 19,447.68
Regional Licensure/Data Collector	$ 35,102.12	$ 31,512.00	$ 3,590.12	$ 16,452.36	$0.00	$ 16,452.36
EMS Coordinator	$ 34,028.80	$ 6,103.52	$27,925.28	$ 10,409.41	$0.00	$ 10,409.41
Training Supervisor	$ 29,348.80	$ 9,654.00	$19,694.80	$ 8,977.80	$0.00	$ 8,977.80
Director of Emer. Services (PT)	$ 7,029.36	$ 0.00	$ 7,029.36	$ 5,304.00	$0.00	$ 5,304.00
Totals	**$237,925.58**	**$165,244.52**	**$72,681.06**	**$103,207.19**	**$0.00**	**$103,207.19**

Regional staff are considered county staff (4 are from Lycoming, 2 are from Tioga, 1 is from Sullivan) and receive their respective county benefits package. Benefits are not paid with EMSOF funds. Health care information provided is for Lycoming County since most employees are employed by that county.

Number of Paid Holidays: Eleven paid holidays. Tioga has 12 paid holidays.

Vacation Days: Accrues immediately but can only take begin taking after six months probationary period. Lycoming County uses pooled leave accrued (vacation, sick and personal) as follows: up to

one year get 10 days of pooled leave; one year to four years is 20 days of pooled leave; five years to seven years is 23 days; 8 years to 12 years is 26 days; 12 years plus is 29 days of pooled leave. Ten days may be carried over to following year. Can sell up to 3 unused pooled leave back to county each year. When employee retires they receive 100% payment for unused pooled days (10 carried forward and unused from that year).

Tioga County vacation accrual Year 1-4 gets 10 days, 5-9 years gets 15 days 10-14 gets 20 days, 15-19 years of service gets 25 days and 20 plus years of service gets 30 days vacation per year. Also receive 2 personal days per year.

Sick Days: Additional long term sick days awarded in Lycoming County. Accrues at two days for the first year; three days for years one through seven; four days for years eight through 12; and five days for over 12 years of employment. Can carry a maximum of 10 unused long term sick days forward. Can only be used for FMLA, long term illness or operation. Upon separation, employees paid for one of every 4 long term sick days not used. Tioga County allows a carry over of 15 sick days per year. We were unable to get their accrual amount.

Health Insurance: Lycoming County offers one traditional coverage option (BCBS of NE PA) and one HMO option (First Priority Health of NE PA. Employee contribution for traditional plan is $22.20 to $56.52 per pay depending on coverage and HMO option has an employee contribution of $17.93 to $46.64 per pay depending on coverage (individual or family). Employees can opt out of health coverage and are paid $50(traditional) or $38 (HMO) per pay upon proof of coverage under other qualified plan. No employees opt out, most use HMO Plan (First Priority). Deductible for HMO plan $250 annually but does not apply to preventative care, physician or specialty office visits or ER services. Deductible for traditional plan is $200 annually. Co pays for HMO plan are $10 for primary care; $20 for specialist; $75 for special tests; $75 for emergency room visits. Prescription copays are $10 for generic ($15 for traditional plan) and $40 for brand names ($25-$40 for traditional plan). Basic dental is provided free for employees only. Employee must pay $14 to $44 per paycheck for enhanced care and to add dependents. If employee wants vision coverage they must pay $2.33 to $6.33 per pay depending on whether it is single or family coverage. Health insurance is not portable and STD and LTD must be purchased by the employee.

Life Insurance: Lycoming County: $10,000 group life insurance provided at no cost to employee. Employees can pay for additional coverage at their own expense. Also includes ADD. Tioga County provides $25,000 life insurance policy and $50,000 ADD at no cost to employee.

Pension/Retirement: Defined benefit plan. Employees must contribute 8% (9% in Tioga) of their salary and it takes five years to vest. County provides match depending on actuarial formula figured at time of retirement. Employees may contribute up to 18% of their salary, but nothing above 8% is matched by county.

Educational Expenses: No reimbursement of educational expenses.

Appendix A (Continued)

Montgomery County Emergency Medical Services

Montgomery (FY 2011-12 Data)

Position Titles	Gross Salary	Amt. Paid By EMSOF	Other Funds	Total cost benefits	Amt. Paid By EMSOF	Other Funds
EMS Director	$ 85,195.00	$ 61,012.60	$24,182.40	$ 29,503.03	$0.00	$ 29,503.03
EMS Pre-Hospital Coordinator	$ 45,413.00	$ 45,413.00	$ 0.00	$ 15,726.52	$0.00	$ 15,726.52
EMS Field Specialist	$ 44,138.00	$ 44,138.00	$ 0.00	$ 15,284.99	$0.00	$ 15,284.99
Training Coordinator	$ 58,778.00	$ 58,778.00	$ 0.00	$ 20,354.82	$0.00	$ 20,354.82
Asst Training Coordinator	$ 40,017.00	$ 40,017.00	$ 0.00	$ 13,857.89	$0.00	$ 13,857.89
EMS Administrative Assistant	$ 32,176.00	$ 32,176.00	$ 0.00	$ 11,142.55	$0.00	$ 11,142.55
EMS Program Specialist-PT	$ 6,590.00	$ 6,590.00	$ 0.00	$ 577.28	$0.00	$ 577.28
Totals	**$312,307.00**	**$288,124.60**	**$24,182.40**	**$106,447.08**	**$0.00**	**$106,447.08**

Regional staff are considered county staff and receive the county benefit package. All benefit costs paid by county, not EMSOF.

Holidays: These employees have 12 paid holidays.

Vacation Days: First year of employment a new employee receives up to 5 days of vacation depending on quarter of hire. Beginning second year of employment the employee receives 10 vacation days. Between fifth year and the 12th year the employee receives 15 vacation days; in the 13th to 18th year employee receives 20 vacation days, over 19 years the employee receives 25 days. May carry over three weeks (15 days) of vacation time to next calendar year. Upon separation, employees are paid 100% of unused vacation time up to 15 days, plus that earned in current year. Employees also receive five personal days which have to be used in the calendar year.

Sick Days: Employees receive one sick day a month. Can carry over full amount of sick days. Must work 90 days before you can take any sick days. When employee retires they will be paid 100% for 60 sick days and the rest at 25%.

Health Insurance: Three options available all through Independence Blue Cross.-2 HMO and one PPO. HMO C3F3 plan is the one chosen by most employees. This HMO health plan has a required monthly contribution of $27 to $92 per month by the employee, based on the premium for selections made by employees. The rest is paid by county. This plan covers both employees and their dependents for health care including vision and prescriptions. Must be employed six months before you qualify for health coverage. Employees can opt out of health coverage. There are no deductibles. Copays are primary care $10, specialist $10, emergency room $35; prescription $10 and $20 to $35 for brand name. Vision is covered depending on plan. Dental provided to employees by county for free; if they want to cover dependents the cost is $5 for each dependent per pay. Insurance not portable. STD and LTD included; employees receive 50% of base pay.

Life Insurance: County provides free for employees. Equals one year of salary for employee to a maximum of $200,000. ADD included. Employees cannot buy additional.

Pension/Retirement: County retirement plan starts at date of hire for fulltime employees. Employees must contribute 5% of their annual salary to plan. County assures a 4% return but actual amount is determined by actuarial formula at time of retirement. The county is obligated to fully fund to assure pay out of benefits. Employees can put more in, but it is not matched. Vest in 5 years.

Appendix A (Continued)

Educational Expenses: Reimbursement of up to $2,000 provided through County. Must maintain a "C" average.

Northeastern PA, Inc. Emergency Medical Service of (Non-profit, no union)

Northeastern (FY 2011-12 Data)

Position Titles	Gross Salary 11/12	EMSOF	Other Funds	Total cost benefits	EMSOF	Other Funds
Director	$ 75,960.00	$ 75,960.00	$ 0.00	$ 24,333.77	$ 24,252.00	$ 81.77
MIS/Programmer	$ 57,514.00	$ 57,505.00	$ 9.00	$ 23,000.51	$ 22,990.00	$ 10.51
Training Coordinator	$ 48,372.00	$ 48,340.00	$ 32.00	$ 18,370.40	$ 18,366.00	$ 4.40
Medical Care Coordinator	$ 50,010.00	$ 50,010.00	$ 0.00	$ 21,250.53	$ 21,246.00	$ 4.53
Prehospital Care Coordinator	$ 37,520.00	$ 37,518.00	$ 2.00	$ 15,807.22	$ 15,805.00	$ 2.22
EMS Development Specialist	$ 13,590.00	$ 13,590.00	$ 0.00	$ 3,031.12	$ 3,030.00	$ 1.12
Executive Secretary	$ 36,192.00	$ 36,189.00	$ 3.00	$ 16,877.21	$ 16,875.00	$ 2.21
Data/Secretary	$ 32,568.00	$ 32,565.00	$ 3.00	$ 14,937.20	$ 14,935.00	$ 2.20
Emergency Preparedness Specialist	$ 41,652.00	$ 0.00	$41,652.00	$ 36,735.81	$ 0.00	$36,735.00
Totals	**$393,378.00**	**$351,677.00**	**$41,701.00**	**$174,343.77**	**$137,499.00**	**$36,843.96**

Number of Paid Holidays: Eleven paid holidays.

Vacation Days: Computed from date of hire to June 30th of each year. Must complete six months of employment before annual leave can be taken. Vacation leave accrues as one year to five years 10 working days, five years to 10 years 12 working days, 10 years and over 15 working days. Can carry over full amount not taken to next year to a maximum accrual of two years. Upon separation employee paid 100 percent of accrued unused annual leave subject to 2 year maximum. One personal day also awarded each year.

Sick Days: Sick leave granted on fiscal year basis. Accrues at the rate of one day of sick leave for every month worked up to a maximum of 12 days per year. Sick leave may be accumulated to a maximum of 90 days. Not paid for unused sick leave.

Health Insurance: Region provides PPO health care insurance, including basic vision and dental, for all full time employees and their family. Premiums are paid in full be region. $250 deductible. Co pays are $15 for primary care, $30 for specialists and $75 for ER; prescription are $0 for generic and between $15 and $50 for brand name. Employees may opt out as long as the plan participation requirements established by the insurance carrier can be maintained by the region. Employees that opt out will be reimbursed 25% of the savings that the region realizes by their opting out provided the plan participation requirements set by the carrier can be maintained. Insurance is not portable. Long term disability insurance provides a weekly benefit of 60% of base salary not to exceed the maximum monthly benefit of $3,000. The elimination period is 180 days as defined by the insurance carrier. No short term disability plan

Life Insurance: Group life insurance of $10,000 for each employee is provided free. Employees cannot buy additional coverage.

Appendix A (Continued)

Pension/Retirement: A SEP Plan is provided to employees. Employer contributions are set at an additional 8% of employee's annual compensation. Employees can contribute more but is not matched. Vest after 30 days of employment.

Educational Expenses: No reimbursement of educational expenses.

Philadelphia Emergency Medical Services Council

Philadelphia (FY 2012-13 Data)

Position Titles	Gross Salary 11/12	EMSOF	Other Funds	Total cost benefits	EMSOF	Other Funds
Regional Director	$ 96,037.00	$ 0	$ 96,037.00	$ 34,657.31	$ 0.00	$ 34,657.31
Training Coordinator	$ 59,007.00	$ 0	$ 59,007.00	$ 23,971.58	$ 0.00	$ 21,613.37
Support Clerk	$ 39,487.56	$ 39,487.50	$ 0.00	$ 22,943.09	$ 22,943.09	$ 0.00
Quality Assurance Coordinator	$ 65,910.00	$ 65,910.00	$ 0.00	$ 31,674.69	$ 31,674.69	$ 0.00
Licensure Coordinator	$ 65,910.00	$ 65,910.00	$ 0.00	$ 24,376.01	$ 24,376.01	$ 0.00
Contract Coordinator	$ 66,963.00	$ 66,963.00	$ 0.00	$ 25,380.45	$ 25,380.45	$ 0.00
Program Specialist	$ 46,897.50	$ 46,897.50	$ 0.00	$ 23,843.11	$ 23,843.11	$ 0.00
Program Specialist[a]	$ 0.00	$ 24.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Totals[b]	**$440,212.06**	**$285,168.00**	**$155,044.00**	**$ 186,846.24**	**$128,217.35**	**$56,270.68**

[a] Position never filled

[b] For Philadelphia, FY 2012-13 salary and benefit data is presented.

This regional council has three different unions representing employees in the region. For the current union covered employees, two are represented by local #22; one is represented by district council #33; and four are represented by district council #47. Salary and benefits for the two employees in Council 22 are paid entirely by the City, not EMSOF.

Number of Paid Holidays: Local #22 -12 days. Councils #33 and #47- 10 holidays.

Vacation Days: Vacation days for all three unions is the same- up to 4 years of employment get 10 days, 5-9 gets 15 days , 10-19 gets 20 days and 20 plus years gets 25 days of vacation. Maximum carryover for Local 22 is 592 days and Councils 33 and 47 can carry 70 days. Upon separation employees receive 100 percent of their pay for all unused carried vacation days. In addition, all employees receive four personal leave days on a fiscal year that must be used before the end of the fiscal year.

Sick Days: Sick leave is awarded to employees of all unions at the rate of 20 days per year. Local 22 allows unlimited accrual and are paid for 60% of all accrued days upon separation. Councils 33 and 47 are allowed 200 maximum accrued sick days and are paid for 40% of them upon separation.

Health Insurance: Three union plans: ***(1) Local #22*** has 2 options-Keystone Health Plan East (HMO) and Blue Cross Personal Choice (PPO). There is no required employee contribution for employees and their dependents and there are no deductible. Prescription, dental and vision coverage paid by region. Generic medications are mandatory unless none are available. No co pays for primary and specialist care. Co pay for emergency room visits are $35.Co pay for generic drugs is $1.00; name brand drugs is $10. LTD and STD included in health care coverage.

(2) Union District Council 33 has Keystone Health Plan East HMO plan. Uses a network of providers. Employee must pay from $33 to $82 from each paycheck depending on coverage selected.

Appendix A (Continued)

No deductible for individual or dependents family. Out-of-pocket limit on expenses is in-network individual of $1,500 and family of $3,000. Dental and vision coverage for employee and dependents provided for free. Primary physician co pay is $20; Specialist co pay is $40; diagnostic tests and imaging co pay is $40, emergency room co pay is $200. Generic drugs co pay is $10, brand name drugs co pay is $25-$40; STD and LTD included in health care coverage.

(3) AFSCME District Council 47: Employees offered an Independent Blue Cross Personal Choice option, or a choice of two Keystone Health Plan East HMO options. Employee must pay from $33 to $82 per paycheck depending on coverage selected. Co pays are 20 for primary 40 for specialist and $200 for emergency room. Prescription co pays are $10 for generic drugs, $25-40 for brand name drugs.

Dental and vision provided for employees and dependents free of charge. Up to $100 maximum in vision benefits available annually to employee and each dependent. Under dental plan many services covered at 100% of maximum allowable charges, while others require the employee to pay a coinsurance amount. Plan will cover up to $2,500 per person per year. Each covered person must meet an annual deductible of $25 per person or $75 for family.

Life Insurance: Local #22--$25,000 of coverage, free to employees. Council #33 $20,000 policy, employees pay $10 per pay toward cost Council #47—policy is $30,000 worth of coverage, employee pays $10 per pay toward cost. Only council #47 employees can purchase additional life insurance at their own cost for themselves and their families. They also can purchase long term care insurance for themselves and their parents. ADD included in coverage.

Pension/Retirement: The pension plan is a defined benefit plan. Employees must work for 10 years before they vest. Local #22 employees have 8.4% of their gross taken out every year; Councils 33 and 47 have 7.27 % taken out of their gross pay every year as their contribution. The amount the city puts in every year is determined by an actuarial formula. Employees can not contribute additional funds towards retirement.

Educational Expenses: Not provided for EMS employees.

Seven Mountains Emergency Medical Services Council

Seven Mountains (FY 2011-12 Data)

Position Titles	Gross Salary 11/12	EMSOF	Other Funds	Total cost benefits	EMSOF	Other Funds
Executive Director	$ 51,867.92	$ 51,867.92	$ 0.00	$16,109.99	$16,109.99	$ 0.00
Regional Edu. Coordinator	$ 38,624.04	$ 38,624.04	$ 0.00	$17,958.92	$17,958.92	$ 0.00
EMS Field Specialist	$ 38,624.04	$ 38,624.04	$ 0.00	$18,747.50	$18,747.50	$ 0.00
Administrative Assistant	$ 41,360.02	$ 41,360.02	$ 0.00	$14,295.46	$14,295.46	$ 0.00
EMS Preparedness Specialist	$ 34,960.00	$ 0.00	$34,960.00	$16,971.92	$ 0.00	$16,971.92
Totals	**$205,436.02**	**$170,476.02**	**$34,960.00**	**$84,083.79**	**$67,111.87**	**$16,971.92**

Holidays: Eleven paid holidays.

Vacation Days: Paid vacation is provided as follows: First year receive .5 days per month; Year 2-5 receive one day per month; year 6 through 12 receive 1.5 days per month; year 12 and over receive 2 days per month. Employees may carry over no more than a maximum of 24 vacation days into the succeeding calendar year. Vacation days are reimbursable upon termination for a maximum of 24 carried over and those unused in current year. Three personal leave days are provided per year.

Appendix A (Continued)

Sick Days: One day per month, not to be accumulated in excess of 120 working days. Sick leave is reimbursable upon separation at the rate of one half for each day of accumulated sick leave to a maximum of 30 days.

Health Insurance: PPO provided from date of hire, as well as dental insurance. Paid 100 percent by region even for dependent coverage. In network deductible is $1,250 for employee and $2,500 for employee and dependents. The region pays for $1,200 of it. After the deductible is satisfied, co pays for in network are $15 for primary care; $25 for specialist; $100 for emergency room. Out of network employee pays 20% of total cost after deductible Prescription coverage is also provided at no cost to employee even for dependents. Co pays are $10 for generic and $25 for brand medications. Vision insurance is not provided. Can opt out of health care coverage, but no extra pay. Health insurance not portable.

Life Insurance: Life insurance equal to two times the employee's annual salary is provided free. Accidental death and dismemberment equal to two times the employee's salary is provided. Disability benefits begin first day for accidents and eighth day of total disability after exhausting available sick leave for sickness. Payments computed at approximately 67% of gross salary up to a maximum of $600 per week. Maximum of 13 weeks of benefits.

Pension/Retirement: Tax deferred variable investment plan (403b). Participation in the plan, including vesting begins immediately. Region contributes a minimum of 3% above employee's salary. Region will match employee's contribution up to an additional 4% of employee's annual salary for a total possible region contribution of 7%. Employee must decide to have additional amount taken out of pay to get the region match of 4%. Three employees do, two do not.

Educational Expenses: If money available region will look at the request.

Southern Alleghenies Emergency Medical Services Council, Inc.

Southern Alleghenies (FY 2011-12 Data)

Position Titles	Gross Salary	EMSOF	Other Funds	Total cost benefits	EMSOF	Other Funds
Executive Director (SLJ)	$ 77,924.00	$ 77,924.00	$ 0.00	$ 20,984.00	$ 20,984.00	$ 0.00
Deputy Director (CLM)	$ 64,495.00	$ 64,495.00	$ 0.00	$ 27,973.00	$ 27,973.00	$ 0.00
Operations Officer (DTE)	$ 52,635.00	$ 52,635.00	$ 0.00	$ 13,838.00	$ 13,838.00	$ 0.00
EMS Program Specialist II (LAD)	$ 46,664.00	$ 46,664.00	$ 0.00	$ 18,380.00	$ 18,380.00	$ 0.00
EMS Program Specialist II (RAH)	$ 45,849.00	$ 0.00	$45,849.00	$ 13,236.00	$ 0.00	$13,236.00
Program Specialist I (HEE)	$ 38,739.00	$ 20,598.00	$18,141.00	$ 24,017.00	$ 11,763.00	$12,254.00
Program Assistant II (RLT)	$ 34,883.00	$ 34,883.00	$ 0.00	$ 12,727.00	$ 12,727.00	$ 0.00
Program Assistant I (DJM)	$ 25,154.00	$ 25,154.00	$ 0.00	$ 21,599.00	$ 21,599.00	$ 0.00
Program Assistant I (DLP)	$ 11,112.00	$ 5,556.00	$ 5,556.00	$ 1,634.00	$ 817.00	$ 817.00
MRC Clinical Coordinator (PCM)	$ 13,181.00	$ 0.00	$13,181.00	$ 1,983.00	$ 0.00	$ 1,983.00
Temporary-Cleaning (KLW)	$ 1,100.00	$ 1,100.00	$ 0.00	$ 170.00	$ 170.00	$ 0.00
Temporary-Cleaning (JLC))	$ 400.00	$ 400.00	$ 0.00	$ 62.00	$ 62.00	$ 0.00
Totals	**$412,136.00**	**$298,009.00**	**$82,727.00**	**$156,603.00**	**$128,313.00**	**$28,290.00**

Appendix A (Continued)

Number of Paid Holidays: 10 days.

Vacation Days: Instead of separate vacation and sick time the region awards Paid Time off (PTO). Employees earn PTO as follows: 0 to 6 months- 1.5 days per month; 6 months to 36 months is 2 day per month; 37 months and over accrues as 2.25 days per month. PTO can be accrued for 30 days for the first five years, 35 days for six years through 10 years, and 40 days for 10 years and beyond. Only 40 days may be carried over to next calendar year. If employee leaves they are paid 100% of accrued PTO up to a maximum of 40 days. No personal days awarded.

Sick Days: See vacation days.

Health Insurance: PPO Plan and Opt out. Single coverage 100% paid by region for employees. For family coverage, employee pays 10% of difference between single and family premium rates. For FY 2011-12 the region paid $59,632 in health care costs and employees paid $3,229. The region also paid $18,466 to employees to reimburse for alternative health care coverage. Co Pays are primary physician $10; Specialist $10, emergency room $50. Medications- $15 for generic and $30 for brand name; Deductible applies only to out-of-network care. Out-of-network deductible is $250 for individual and $500 for family. Out-of-pocket maximum for out-of-network care is $10,000 for individual and $20,000 for family. If an employee's spouse is able to get family coverage through their job the region will reimburse the full cost of the difference between individual and family coverage cost to the employee. This amounted to $18,466 for FY2011-12. Dental coverage provided free for employees and their dependents, but there is no vision coverage. Benefit includes STD and LTD, paid fully by region. Insurance is not portable.

Life Insurance: 100% paid by region. Life/accidental death and disability program has double indemnity for an accidental death. Amount of coverage approximates employees' salaries. Employees can buy more life insurance at own cost.

Pension/Retirement: 403 (b) plan. Can participate after 6 months. 100% paid by region over and above employee salary at the following rates: 2% of gross pay per month for one year; 4% of gross pay per month for years 1 thru 2; 7% of gross pay per month for years 2 and over. Employees can contribute additional, but no match provided.

Educational Expenses: If funds are available will pay for training to improve performance. In the past they also paid for college classes.

Susquehanna Emergency Health Services Council, Inc.

Susquehanna (FY 2011-12 Data)

Position Titles	Gross Salary 11/12	EMSOF	other funds	Total Cost Benefits	EMSOF	Other Funds
Executive Director	$ 50,003.20	$ 50,003.20	$0.00	$13,859.69	$13,859.69	$0.00
EMS Specialist	$ 35,289.79	$ 35,289.79	$0.00	$12,500.00	$12,500.00	$0.00
Training Coordinator	$ 8,908.42	$ 8,908.42	$0.00	$10,650.00	$10,650.00	$0.00
Secretary	$ 24,793.60	$ 24,793.60	$0.00	$ 6,348.00	$ 6,348.00	$0.00
Totals	**$118,995.01**	**$118,995.01**	**$0.00**	**$43,357.69**	**$43,357.69**	**$0.00**

Number of Paid Holidays: Recognize 11.5 holidays.

Vacation Days: Date of employment to two years employee receives 10 days per calendar year. Two to five years of service receives 15 vacation days. Five years and over receive 21 days per calendar year. Can carry over all vacation days but maximum payout when employee leaves is 15 calendar days. No personal days awarded.

Sick Days: Accrue one day per month up to a maximum of 10 days annually. No carryover to next year of sick leave. Not paid for unused sick leave.

Appendix A (Continued)

Health Insurance: PPO Plan. Annual premium is $30,000. Region pays 90% of the annual cost of health insurance. Employees responsible for 10% of their premium cost which is different depending on selections made. Deductible is $250 annually per person. Co pays are $20 for personal physician, $40 for specialist, emergency room is $50 and medication is $10 for generic and $15 for brand. Vision paid 100% by region. Dependents cannot be added. Dental coverage paid 100% for employee and 50% paid for additional eligible dependents. Dental coverage for dependents costs each employee $34 per month. Employees can opt out of health care coverage but would only save the 10% of the premium they are responsible for. Insurance is not portable and STD and LTD included at no cost to employee.

Life Insurance: 100% paid by region. Coverage is for two times the salary of the employee unless medically disapproved then coverage amount is only equal to the employee's salary. Employees cannot pay for additional life insurance. Accidental death and dismemberment included in life insurance premium cost.

Pension/Retirement: SEP IRA Plan. Employee must work at least 1,000 hours a year and be employed at 1,000 hours annually before they are eligible. 5% over and above employee's salary is contributed by region. Employees do not have to contribute anything unless they elect to have more taken from their paycheck.

Educational Expenses: Do not reimburse educational expenses.

Pennsylvania Emergency Health Services Council

PEHSC (FY 2011-12 Data)

Position Titles	Gross Salary 11/12	Amt. Paid By EMSOF	Other Funds/ EMSC	Total cost benefits	EMSOF	Other Funds/ EMSC
Executive Director	$ 84,819.12	$ 84,819.12	$ 0.00	$ 9,947.64	$9,947.64	$ 0.00
Office Manager	$ 38,561.76	$ 38,561.76	$ 0.00	$22,023.90	$22,023.90	$ 0.00
EMS Systems Specialist	$ 53,332.32	$ 53,332.32	$ 0.00	$ 6,429.28	$ 6,429.28	$ 0.00
EMSC Program Manager	$ 55,546.08	$ 4,146.08	$51,400.00	$17,528.89	$ 2,108.89	$15,420.00
Administrative Assistant	$ 29,107.20	$ 29,107.20	$ 0.00	$9,654.60	$9,654.60	$ 0.00
EMS Systems Specialist	$ 46,665.08	$ 46,665.08	$ 0.00	$7,797.75	$7,797.75	$ 0.00
TOTAL	**$308,031.56**	**$256,631.56**	**$51,400.00**	**$73,382.06**	**$57,962.06**	**$15,420.00**

Number of Paid Holidays: Nine paid holidays.

Vacation Days: Vacation Time for professional staff: One month to 5 years is 15 days of vacation. Five years or more is 20 days of vacation annually.

Vacation time for secretarial staff: One month to 5 years is 10 days of vacation. Five years or more is 15 days of vacation annually.

A total of 45 days of vacation can be carried over at the end of the calendar year. Can accrue up to one-and-a-half years of vacation for which an employee will be paid 100%. Payout is not in one lump sum but is paid out over time as if employees still receives a paycheck. No personal days awarded.

Sick Days: Employees accrue sick leave at the rate of one day per month of service. Sick leave may be used after the first 90 days of service. Sick leave is accrued up to a maximum of 120 days to be used, but employees are not paid for unused accrued sick days.

Health Insurance: PPO Plan through the PA Chamber of Commerce. Provided free to employees, including coverage for dependents. Vision coverage is included in health plan cost. Deductible is $250 for individuals and $500 for family coverage. Deductible is paid for by PEHSC. Co pays are $20 for

primary care provider, $20 for specialists, and $50 for emergency room. Prescriptions drug program has co pays of $8 for generic, $35-$50 for brand name. Routine preventive care visits are covered 100%. Dental coverage provided free for employees and their dependents. Employees can opt out of health care. Short term disability gives 60% of weekly salary to employee to a maximum of $500 a week. Duration of coverage is 13 weeks. Long term disability gives 60% of salary to a maximum of $5,000 monthly. Duration of coverage- age 65 for injury and five years for sickness. Insurance is not portable

Life Insurance: Provided free to employees. Benefit amount is for three times an employee's salary with a maximum of $100,000. Cannot buy additional coverage.

Pension/Retirement: Simple IRA Plan. Employee chooses percent to have taken out of their pay and up to 3% is matched by PEHSC.

Educational Expenses: Do not reimburse educational expenses.

Employees Under the Governor's Jurisdiction

Number of Paid Holidays: There are 11 holidays for employee under the Governor.

Vacation Days: Employees hired prior to July 1, 2011 shall be eligible for annual leave after 30 calendar days of service with the following schedule: 0 to 3 years -7 days of annual leave; Three years to 15 years of employment- 15 days of leave annually; fifteen years and to 25 years of employment- 20 days of leave annually. Over 25 years of employment- 26 days of leave annually. Employees hired after July 1, 2011 shall be eligible for annual leave at the same schedule except those over 15 plus years of employment they shall only be eligible for a maximum 20 days of vacation.

Unused annual leave shall be carried over to a maximum of 45 days. However, employees will be permitted to carry over annual leave in excess of the forty-five day limit into the first seven (7) pay periods of the next calendar year. Any days carried over which are not scheduled and used during the first seven (7) pay periods of the next calendar year will be converted to sick leave, subject to a 300 day limitation. Employees separated from the service for any reason prior to taking their vacation, shall be compensated 100 percent for the unused vacation they have accumulated up to the time of separation. Employees are also eligible for 1-4 personal days per year depending on length of service, which can also be carried over 7 pay periods.

Sick Days: 13 sick days (11 days after January 1, 2012) awarded annually. Employees must work 30 calendar days to use paid sick leave. Employees may accumulate sick leave up to a maximum of 300 days paid upon separation at the following schedule: employees with 0 to 100 sick leave days will be paid for 30% of their accumulated sick leave, employees with 101 to 200 of accumulated sick leave will be paid for 40% of their accumulated sick leave; employees with 201 to 300 accumulated sick days will be paid for 50% of their accumulated sick leave. In addition, employees with more than 300 accumulated sick days are paid 100% for unused sick leave earned in the last year of employment. To be eligible for sick leave payout employees must have worked a minimum of five years.

Health Insurance: Provided through the Pennsylvania Employees Benefit Trust Fund (PEBTF). Options are a PPO and an HMO. Most employees are in the PPO. Coverage includes dental, vision and prescription coverage. Employee contributions towards health coverage have two components:

- 3% of employees base salary which is reduced to 1.5% if the employee elects to participate in the disease prevention/wellness program.
- For employees hired after August 1, 2003, they pay an additional cost to enroll in the PPO due to the additional cost of the plan. For 2013, the "buy-up" cost for single coverage is $46.32 per month and the "buy-up" cost for family coverage is $117.34 per month

The health benefits have no annual deductible, a $15 primary care copayment, $25 specialist copayment, and a $50 emergency room copayment (in-network) that's waived, if admitted. Prescription co pay is $10

Appendix A (Continued)

for generic and $18-36 for brand name. Employees do not receive additional pay for opting out of health care coverage.

Life Insurance: Group Life Insurance is 100% state-paid, and is equal to an employee's annual salary to a maximum of $40,000 for most groups. Eligible employees can purchase additional life insurance coverage at their expense. May purchase in amounts of one, two, three, four or five times their annual pay up to $500,000.

Pension/Retirement: Defined benefit plan for current employees; employees hired after January 1, 2011 vest in 10 years. Most employees contribute 6.25% of their salary toward retirement. The retirement benefit is based on a formula that considers years of service, class of service, salary level and age. Employees may participate in a deferred compensation program which is not matched by the state.

Educational Expenses: On a limited basis, the commonwealth will reimburse for specific courses for academic credit if they are needed for an employee's job duties, but not for pursuit of an academic degree per se.

APPENDIX B

Appendix A, B and D[1] of DOH Standard Regional Council Grant Agreement

Appendix A Work Statement of Standard Regional Contract

I. **AGREEMENT PURPOSE**

The purpose of this Grant Agreement is for the Grantee to serve as the Regional Emergency Medical Services (EMS) Council responsible for the initiation, expansion, maintenance and improvement of all regional EMS systems within a specific geographic area (region) of the Commonwealth.

II. TASKS

A. The Grantee shall administer written and practical examinations for EMS training programs certified by the Department, including Rescue and Automatic External Defibrillation programs, and shall secure all examination questions, materials and score information to protect the integrity of all examinations. Potential breaches of security must be reported in writing to the Department by the end of the next business day.

B. The Regional EMS Council Director or designee shall attend or participate in all monthly Regional Directors' meetings, at locations to be determined by the Department, and teleconferences, unless approved otherwise by the Department.

The following references are to Title 28 Health and Safety, Chapters 1001 -1015, Emergency Medical Services, issued under the Emergency Medical Services Act 1985-45, as amended, 35 P.S. Section 6921 et seq. (EMS Act).

C. In accordance with §1001.7 Comprehensive Regional EMS Development Plan, the Grantee shall:

1. Develop a Regional EMS Development Plan that coordinates and improves the delivery of EMS in the Grantee's region. The Regional EMS Development Plan shall contain:
    a. An inventory of all EMS resources available in the region;
    b. An assessment of the effectiveness of existing EMS resources and a determination of the need for additional services;
    c. A statement of tasks and specific measurable objectives for delivery of EMS to persons in heed of EMS in the region;
    d. Identification of inter-regional problems and recommended tasks to resolve those problems;
    e. Methods to be used in achieving stated tasks;
    f. A method for evaluating achievement of the stated tasks;
    g. Estimated costs for achieving the stated tasks;
    h. Other information as requested by the Department.
2. Annually update the Regional EMS Development Plan.

D. In accordance with §1001.25 Technical Assistance, the Grantee shall: Provide technical assistance to all EMS organizations and all EMS providers within the geographical area in matters such as, but not limited to, communications, public education, information management, recruitment and retention of EMS personnel, ambulance management and reimbursement to providers of EMS.

E. In accordance with §1001.41 Data and Information Requirements for Ambulance Services, the Grantee shall:

1. Collect, maintain and report to the Department all patient care data and information in paper or electronic format as approved by the Department;

[1] Appendix C of the agreement is the individual annual EMSOF budget allocations/anticipated expenditures for the specific regional council.

1. Oversee and manage the accuracy, reliability and timeliness of patient care reporting in accordance with the Department requirements.

F. In accordance with §1001.62 Regional Programs, the Grantee shall:
   1. Maintain a Regional EMS Quality Improvement Plan to monitor the delivery of EMS, specific to emergency medical care provided by EMS personnel;
   2. Conduct quality improvement audits on the regional EMS system, to include Advance Life Support Medical Directors and Medical Command Facilities;
   3. Facilitate the Regional Quality Improvement Committee, which shall recommend to the Grantee ways to improve the delivery of prehospital EMS care within the region;
   4. Investigate all complaints received from the public concerning the quality of care rendered by EMS personnel and forward recommendations and findings to the Department.

G. In accordance with §1001.83 Complaints, the Grantee shall: When assigned by the Department, investigate complaints related to the delivery of EMS within the region, to include complaints reported against providers, organizations, agencies, hospitals and trauma centers.

H. In accordance with §1001.101 Governing Body, the Grantee shall: Have in place a governing body, such as a board, with no more than one Grantee staff person as a member. The governing body shall:
   1. Adopt written policies which include the method, qualifications, and criteria for membership, frequency of meetings, purpose, philosophy and organizational structure;
   2. Select a Director as the person officially responsible to the governing body;
   3. Make available to the public an annual report which includes the activities and accomplishments, a financial statement of income and expenses, and a statement disclosing the names of officers and directors for the preceding year.

I. In accordance with § 1001.123 Responsibilities, the Grantee shall:
   1. Organize, maintain, implement, expand and improve the EMS system within the Grantee's assigned region;
   2. Advise 9-1-1 Dispatch Centers and Municipal and County Governments regarding EMS resources available for dispatching and recommended dispatching criteria that may be developed by the Department or by the Grantee, as approved (prior and in writing) by the Department;
   3. Develop, maintain, implement, expand and improve all programs of medical coordination, subject to prior written approval by the Department;
   4. Provide training programs to all EMS personnel, which shall include continuing education programs and programs that lead to EMS certification or recognition by the Department;
   5. The Grantee shall develop and implement additional educational programs, as determined by the Grantee or the Department;
   6. Monitor all medical command facilities and prehospital personnel for compliance with minimum standards established in § 1009 Medical Command Facilities;
   7. Facilitate the integration of all medical command facilities into the Grantee's regional EMS system in accordance with Department established policies and guidelines;
   8. Implement existing statewide protocols for the triage, treatment, transport and transfer of patients to the most appropriate facility. Protocols, as posted on the Department's website, shall be distributed to the providers of EMS within the Grantee's region;
   9. Assist all regional prehospital personnel and ambulance services to meet the Department's licensure, certification, recertification, recognition, registration and continuing education requirements;
   10. Apprise all regional Medical Command Facilities and Advanced Life Support (ALS) ambulance services when any Paramedic or prehospital registered nurse has had medical command authorization removed by an ALS Service Medical Director;

11. Develop a conflict of interest policy and require all Grantee's employees and officials to agree to the policy in writing;
12. Approve all Medical Command Physicians in accordance with § 1003.4 (relating to medical command physician).

J. In accordance with § 1001.43 Disasters, the Grantee shall:
   1. In the event of a potential or actual disaster, mass casualty situation or other substantial threat to public health, assist federal, state or local agencies, upon request, with onsite mitigation, technical assistance, situation assessment, coordination of functions or post-incident evaluations;
   2. Maintain an inventory of all EMS resources and personnel available to respond to a disaster, mass casualty situation or other substantial threat to public health on a volunteer basis as conditions or circumstances require, and recruit volunteers as needed;
   3. Attend at least 90% of the local Regional Counter-Terrorism Task Force meetings;
   4. Maintain a Regional Disaster Plan which shall include:
      a. Relocation of Grantee's office in order to continue operations during a disaster;
      b. Provisions for 24-hours operation in the event of a disaster.

K. In accordance with §1001.161 Research, the Grantee shall:
   1. Assist any person, agency or organization in clinical investigations or studies that relate to patient care or EMS system enhancements and improvements;
   2. Conduct research or studies in accordance with the Department's requirements for research projects involving human subjects. No proposed research and study shall be conducted unless the research or study received prior written approval by the Department.

L. In accordance with Chapter 1003 Subchapter A. Administrative and Supervisory EMS Personnel, the Grantee shall:
   1. Retain a Regional EMS Medical Director who shall carry out the following duties:
      a. Assist the Grantee to approve or reject applications for all medical command physicians;
      b. Maintain liaison With the Department EMS Medical Director;
      c. Assist the Department to establish criteria for level of care and type of transportation in various medical emergencies;
      d. Conduct quality improvement audits of the Grantee's Regional EMS System;
      e. Serve on the state EMS Quality Improvement Committee;
      f. Serve as Chairperson of the Regional Medical Advisory Committee;
      g. Facilitate continuity of patient care during inter-regional transport;
      h. Recommend to the Department suspension, revocation or restriction of prehospital personnel certifications and recognitions;
      i. Review regional EMS plans, procedures and processes for compliance with state standards for emergency medical care;
      j. Meet the minimum qualifications for Regional EMS Council Medical Director, as stated in § 1003.2(b).
   2. With assistance from the Regional EMS Medical Director, approve physicians to serve as Medical Command Physicians to provide regional medical command to prehospital personnel, and give notice of such approvals to the Department;
   3. Collect and maintain notifications from each Medical Command Facility within the Grantee's region explaining the circumstances under which medical command shall be given;
   4. Receive recommendations and advice from regional ALS Service Medical Directors regarding medical treatment protocols, and regional and statewide quality improvement plans.

Appendix B (Continued)

A. In accordance with Chapter 1003 Subchapter B. Prehospital EMS Personnel, the Grantee shall:

1. Receive, review and process all applications for EMS Provider Certification in accordance with the Department's certification process, and provide certification materials to certifiable applicants or non-certification materials to applicants who are not certifiable;
2. Input all EMS Provider Certification data into the electronic EMS Registry system;
3. Assist the Department, as directed, in disciplinary and corrective actions of EMS providers who violate a duty imposed by the EMS Act or for other reasons as determined by the Department which pose a threat to the health and safety of the public;
4. Assist and support public education opportunities in educating the public on the EMS system, disaster management and first aid through means such as, but not limited to, training programs, printed materials, and exhibits at public events.

B. In accordance with Chapter 1005 Licensing of Basic Life Support and Advanced Life Support Ground Ambulance Services, and Chapter 1007 Licensing of Air Ambulance Services, the Grantee shall:

1. Receive, review and process all new, amendment and renewal applications for Ground Ambulance Service License and Air Ambulance Service License in accordance with the Department's ambulance licensing process;
2. Conduct inspections of the applicant's ambulance service to include: records for compliance with all required documentation, personnel for compliance with minimum staffing and personnel requirements, each vehicle or aircraft listed on the application for compliance with vehicle/aircraft, equipment and supplies requirements, as published in the Pennsylvania Bulletin, for the level of license for which the applicant is applying;
3. Forward all inspection results and written recommendation for license to the Department for final determination;
4. Assist the Department, as directed, in disciplinary and corrective actions of Ambulance Service Providers who violate a duty imposed by the EMS Act or for other reasons as determined by the Department which pose a threat to the health and safety of the public;
5. Assist applicants on the ambulance service license process.

C. In accordance with Chapter 1009 Medical Command Facilities, the Grantee shall:

1. Receive, review and process all new and renewal applications for Medical Command Facility in accordance with the Department's Medical Command Facility Recognition (MCFR) process, as per § 1009.2 and the Department's written procedure manual;
2. Conduct an onsite inspection of the applying facility to verify information contained within the new application is accurate and facility meets the regulatory operational criteria, as per § 1009.1 and the Department's written procedure manual;
3. Forward all inspection results and written recommendation for recognition to the Department for final determination;
4. Assist the Department, as directed, in withdrawal of Medical Command Facility Recognition due to a facility's failure to meet the regulatory standards for recognition as a Medical Command Facility;
5. Receive and process all Discontinuation of Service Notices from Medical Command Facilities who intend to discontinue service, in accordance with the Department's discontinuation of service process, as per § 1009.6 and the Department's written procedure manual; .
6. Conduct a review and inspection of Medical Command Facilities when requested by the Department to audit for continued compliance with regulatory operational criteria, as per § 1009.1 and the Department's written procedure manual.

D. In accordance with Chapter 1011 Accreditation of EMS Training Institutes, the Grantee shall:

1. Receive, review and process all new and renewal applications for accreditation as an EMS Training Institute in accordance with the Department's Accreditation of EMS Training Institutes process, as per § 1011.3;
2. Conduct an onsite inspection of the applying institute for compliance with the regulatory EMS Training Institute Accreditation standards, as per § 1011.1;
3. Forward all inspection results to the Department with either an endorsement for accreditation or a detailed explanation as to why the applying institute should not be accredited;
4. Assist the Department, as directed, in denial, restriction, withdrawal or condition of accreditation of an EMS Training Institute due to an institute's failure to meet the regulatory standards for EMS Training Institute Accreditation, as per § 1011.1;
5. Provide information to EMS education providers regarding EMS Training Institute Accreditation.

E. In accordance with Chapter 1013 Special Event EMS Plans, the Grantee shall:

1. Provide technical assistance to any person, agency or organization responsible for the management and administration of special events in developing a Special Event EMS Plan;
2. Receive, review and process all Special Event EMS Plans from applicants seeking Department approval of an EMS Plan for an upcoming special event in accordance with the Department's Special Event Planning process and standards, as per §1013.1;
3. Forward the applicant's Special Event EMS Plan and written recommendation to the Department for final determination;
4. Review and maintain a Special Event Report from the person, agency or organization who submitted the Special Event Plan.

F. In accordance with Chapter 1015 Quick Response Service (QRS) Recognition Program, the Grantee shall:

1. Receive, review and process all new and renewal applications for QRS Recognition in accordance with the Department's QRS Recognition process, as per § 1015.1;
2. Conduct an on-site inspection of each applicant's QRS service to determine if the applicant satisfies the regulatory criteria for QRS Recognition;
3. Forward all inspection results and recommendation for recognition to the Department for final determination;
4. Assist the Department, as directed, in withdrawal of QRS Recognition due to a QRS's failure to meet the regulatory standards for recognition as a QRS;
5. Receive and process Discontinuation of Service Notices from regional QRSs who intend to discontinue service, in accordance with the .Department's discontinuation of service process, as per § 1015.2.

G. Supply Order Form shall be submitted to the Department on a form approved by the Department and shall contain the following:

1. Amount of each supply item needed;
2. Name, address, phone number and contact person of the office submitting the order form.

III. TIMELINES

A. Quarterly Progress Report shall be submitted to the Department within 15 calendar days from the last day of each quarter, within which the work is performed. Quarters are based on state fiscal year. The reporting period shall be as follows:

Quarter	Reporting Period
1	July 1 - September 30
2	October 1 - December 31
3	January 1 - March 31
4	April 1 - June 30

B. Monthly Patient Care Report shall be submitted to the Department within 45 calendar days from the last day of each month within which the work is performed.

C. Comprehensive Annual Report shall be submitted to the Department within 30 calendar days of the end of each state fiscal year (i.e. June 30)..Supply Order Form shall be submitted to the Department on an as-needed basis.

D. Supply Order Form shall be submitted to the Department on an as-needed basis.

E. The Grantee shall submit a written request to the Department for an extension and receive written approval from the Department for an extension if any report in this section cannot be submitted in compliance with the time requirements,

F. The Grantee shall perform all duties and responsibilities set forth in this Work Statement by June 30 of each state fiscal year. If, during the state fiscal year, the Grantee is aware that implementation of these tasks is subject to delay, the Grantee shall notify the Department immediately in writing, and thereafter apprise the Department of its progress on a regular basis in writing or as directed by the Department.

G. The Regional Quality Improvement Committee shall meet once every 90 calendar days, at locations to be determined by the Committee. Grantee shall provide reports and recommendations of the Committee to the Department within 30 calendar days after the Committee meeting.

H. The Grantee shall, after receiving a Department assigned investigation, forward recommendations, based on the outcome of the complaint investigation, to the Department within 60 calendar days, unless the Department approves an extension.

I. Review and update the Regional Disaster Plan by March of each calendar year.

J. Provide written notification to the Department of any change in status of the current Regional EMS Medical Director within five business days of the change.

K. The Grantee shall, after the receipt of any EMS Training Institute Accreditation application, conduct an onsite inspection of the applying institute within 45 calendar days.

L. The Grantee shall receive a Special Event Report from the person, agency or organization who submitted the Special Event Plan within 30 calendar days following the Special Event.

IV. REPORTING REQUIREMENTS

A. Quarterly Progress Report shall be submitted to the Department in the format approved by the Department and shall contain the following for the quarter ending:

1. Funding information to include amount of state and federal monies spent and total amount spent;
2. Number of Ambulance, Quick Response and Rescue Services requesting funding support;
3. Summary of the activities and accomplishments of the Grantee during the quarter towards meeting the purpose and tasks of this Grant Agreement;
4. Other information as deemed necessary by the Department.

B. Monthly Patient Care Report shall be submitted to the Department in the format and method approved by the Department and shall contain the following:

All patient care data received from regional ambulance services for calls to which the services responded that resulted in patient care, assessment or refusal of the patient to be assessed.

C. Comprehensive Annual Report shall be submitted to the Department in the format approved by the Department and shall contain the following for the state fiscal year ending: .

1. Funding information to include amount of state and federal monies spent, and total amount spent;
2. Number of Ambulance, Quick Response and Rescue Services requesting funding support;
3. Summary of the activities and accomplishments of the Grantee towards meeting the purpose and tasks of this Grant Agreement;
4. Other information as deemed necessary by the Department.

Appendix B (Continued)

V. EVALUATION COMPONENT

A. The Department will evaluate the Grantee annually in writing to determine the Grantee's performance and effectiveness in meeting the needs of its region in planning, developing, maintaining, expanding, improving and upgrading the EMS system in its region. The Grantee's strengths will be identified as well as areas where improvement is needed.

B. The Department will rate the Grantee's performance overall as:' 'Outstanding, Commendable, Satisfactory, or Unsatisfactory.

VI. STATE HEALTH IMPROVEMENT PLAN (SHIP) INITIATIVE (REV. 12/05):

A. The Department's SHIP emphasizes prevention, elimination of disparities, community empowerment, and coordination of state resources at the local level. The Department has formally affiliated with a number of organized Community Health Improvement Partnerships, which serve to mobilize their communities to assess and address local health issues. In the interest of local coordination, the Department requires contractors/grantees to participate in partnership activities. A complete listing of the Community Health Improvement Partnerships may be found on the Internet at http://www.dsf.health.state.oa.us/health/lib/health/oartnerships.pdf or Grantee may contact the Department's Bureau of Health Planning at (717) 772-5298.

B. Grantee shall participate as a member in the Community Health Improvement Partnership within the Grantee's service area. Participation shall include, but not be limited to, the following:

1. Contact the partnership and arrange a meeting to exchange information about the Grantee organization and the Partnership.
2. Inform the partnership about the objectives of this grant contract.
3. Discuss and develop a work plan to demonstrate how the Grantee and Partnership will work cooperatively on activities, data sharing, and exchange of knowledge and skills, which will support and strengthen the health status of the community.
4. Submit an annual work plan signed by the Grantee and a representative of the Community Partnership within 60 days of the start date of this contract.
5. Participate in partnership meetings, task forces, committees or local events as appropriate.
6. Include in all required reports to the Department a brief summary of activities conducted with the Community Partnership, and share that portion of the report with the Partnership.

C. If the grant is for a regional or multi-county project, the Grantee shall attend at least one quarterly meeting of the Local Advisory Council in their region per year to make partnerships aware of the activities and services provided through the contract to communities in the region.

D. If the grant is for a statewide project, the Grantee shall attend at least one meeting of the SHIP Steering Committee to make a brief presentation on the project.

Appendix B Payment Provisions of Standard Regional Contract

The Department agrees to pay the Contractor for services rendered pursuant to this Contract as follows:

A. Subject to the availability of state and federal funds and the other terms and conditions of this Contract, the Department will reimburse Contractor in accordance with Appendix C, and any subsequent amendments thereto, for the costs incurred in providing the services described in this Contract.

B. Payment to the Contractor shall be made in accordance with the Budget set forth in Appendix C, and any subsequent amendments thereto, as follows:

1. The Department shall have the right to disapprove any expenditure made by the Contractor that is not in accordance with the terms of this Contract and adjust any payment to the Contractor accordingly.
2. In order to provide adequate cash flow, monthly payments will be through a recurring payment system for services rendered pursuant to this Contract. Monthly payments will be 1/12 of the Contract budget column entitled "EMSOF Fund 10505", minus funds for Pre-hospital Providers in Category III

Subcontract Services and any line item marked with an asterisk for the appropriate state fiscal year and any subsequent amendments thereto. Should this Contract be increased or decreased during the term of the Contract, the remaining payments for the appropriate fiscal year will be adjusted accordingly.

3. Supplemental Payments, in addition to the recurring monthly payments, will be made monthly upon submission of an itemized invoice for services rendered pursuant to this Contract using the invoice format in Attachment 1 to this Appendix. Supplemental payments will be for funds expended to Pre-hospital Providers in Category III Subcontract Services, and any line item marked with an asterisk in the Contract budget for the appropriate state fiscal year and any subsequent amendments thereto.
4. An original of invoices and a detailed accounting itemized in accordance with the Contract budget shall be sent by the Contractor directly to the address as listed in Attachment 1 to this Appendix.
5. The Contractor has the option to reallocate funds between and within budget categories, subject to the following criteria:
    a. Reallocation of funds between budget categories by the Contractor shall not occur more than once each half of the state fiscal year and the cumulative reallocation of funds between budget categories shall not exceed 10 percent of the amount budgeted for the category to which the funds are being transferred or from which the funds are being transferred during the state fiscal year. The Contractor shall promptly notify the Department in writing of such transfers. Reallocation of funds between budget categories exceeding 10 percent, requires prior written approval by the Department. Reallocation (budget revision) requests shall be submitted to the Project Officer of the Department of Health no later than April 15 of each state fiscal year.
    b. Contractor may not reallocate funds to, or move funds within, the Personnel Services Category of the Budget (Appendix C), and any subsequent amendments thereto, to increase staff personnel or fringe benefit line items except that in the event the Contractor is subject to a collective bargaining agreement or other union agreement and, during the term of this Contract, salaries, hourly wages, or fringe benefits under this Contract are increased because of a renegotiation of that collective bargaining agreement or other union agreement. Contractor may reallocate funds to cover such increase. In such case, the Contractor must obtain the Department's prior written approval for such reallocation. Contractor shall submit to the Department written documentation of the new collective bargaining or other union agreement, which necessitates such reallocation. In addition, this paragraph is not intended to restrict any employee from receiving an increase in salary based on the employer's fee schedule for the job classification. However, all increases are subject to the availability of funds awarded under this Contract. The Commonwealth is not obligated to increase the amount of award.
    c. Contractor may not reallocate funds from the Pre-hospital Providers in Category III Subcontract Services of the Budget (Appendix C), and any subsequent amendments thereto, without the Department's prior written approval for such reallocation.
6. Unless otherwise specified elsewhere in this Contract, the following shall apply. Contractor shall submit monthly invoices within 30 days from the last day of the month within which the work is performed. The final invoice shall be submitted within 90 calendar days of the end of each state fiscal year (i.e., June 30) of the Contract. The Department will neither honor nor be liable for invoices not submitted in compliance with the time requirements in this paragraph unless the Department agrees to an extension of these requirements in writing. The Contractor shall be reimbursed only for services acceptable to the Department.
7. Any payments received in excess of actual expenditures shall be returned to the Department within 90 calendar days of the end of each state fiscal year (i.e., June 30) of the Contract. These funds shall be returned to the Department by check payable to the Commonwealth of Pennsylvania. The check shall be submitted to the Bureau of Emergency Medical Services, Room 606 Health and Welfare Building, 625 Forster Street, Harrisburg, PA 17120-0701.
8. The Contractor shall be accountable for all funds received under this Contract and revenue generated from the use of such funds. Contract funds shall be deposited into insured, interest-bearing accounts. The Contractor, when a non-government entity, shall obtain bonding in the

amount of $150,000, with a Loss Payable Endorsement to the Pennsylvania Department of Health. The Contractor's cost of such bonding shall be reimbursed by the Department under this Contract when such cost appears in the Budget as a reimbursable item. The Contractor shall provide the Department with evidence of such bonding when the Contract is executed. Utilization of interest earned from funds received under this Contract is subject to the Department's prior written approval. Unused interest income shall be returned to the Department within 90 calendar days of the end of each state fiscal year (i.e., June 30) of the Contract.

9. The Department, at its option, may withhold the last 20 percent of reimbursement due under this Contract, until the Project Officer has determined that all work and services required under this Contract have been performed or delivered in a manner acceptable to the Department. The Department may withhold monthly payments when the Contractor defaults in submission of reports identified within this Contract.
10. The Commonwealth will make payments through the Automated Clearing House (ACH) Network. The Pennsylvania Electronic Payment Program (PEPP) establishes the Automated Clearing House Network as the preferred method of payment in lieu of issuing checks. The ACH enrollment form may be obtained at: http://www.oit.state.pa.us/bfm/cwp/view.asp?a=3&g=178874 and can be completed online, as applicable.
    a. Within 10 days of award of the contract or purchase order, the contractor must submit or must have submitted its ACH information within its user profile in the Commonwealth's procurement system (SRM). Within 10 days of award of the grant agreement the recipient must submit or must have submitted its ACH information to the Commonwealth's Central Vendor Management Unit at 717-214-0140 (FAX) or by mail to the Central Vendor Management Unit, Bureau of Financial Management, Verizon Tower - 6th Floor, 303 Walnut Street, Harrisburg, PA 17101-1830.
    b. The contractor must submit a unique invoice number with each invoice submitted. The unique invoice number will be listed on the Commonwealth of Pennsylvania's ACH remittance advice to enable the contractor to properly apply the state agency's payment to the invoice submitted.
    c. It is the responsibility of the contractor to ensure that the ACH information contained in SRM (for contracts or purchase orders) or in the Commonwealth's Central Vendor Master File (for grant agreements) is accurate and complete. Failure to maintain accurate and complete information may result in delays in payments.
    d. In the event this language conflicts with language contained elsewhere in this agreement, the language contained herein shall control.

Appendix D Program Specific Provisions of Standard Regional Contract

I. The Grantee's distribution of funds from the Emergency Medical Services Operating Fund (EMSOF) to prehospital providers (as defined in 28 Pa. Code § 1001.2) is contingent upon the prehospital providers documenting matching funds. The required matching funds shall be paid or committed by prehospital providers in the required ratios to the funds provided by the Grantee. The equipment and eligible expenditures to which the EMSOF funds may be applied, the allowable costs for equipment, and the percent (ratio) of EMSOF funds that may be applied towards equipment are published annually in the Pennsylvania Bulletin (Attachment 1). The equipment and eligible expenditures, allowable costs and percents (ratios) may change based upon superseding notices published in the Pennsylvania Bulletin. The Department, in its sole discretion, may fully or partially waive the matching fund requirement to a prehospital provider based upon provider hardship. The Grantee shall secure and retain documentation of actual equipment purchased or other eligible expenditures made by the prehospital provider; the actual amount of EMSOF funds expended or to be expended for equipment or other eligible expenditures; and the actual total cost for all equipment and eligible expenditures. If the Grantee fails to secure and retain documentation for the equipment purchased and other eligible expenditures made by the prehospital provider, this Agreement’s remaining EMSOF funds, dedicated for such purpose, shall be unavailable. The Grantee must obtain prior written approval for distribution of EMSOF funds to prehospital providers.

Appendix B (Continued)

II. Funds disbursed through this Agreement shall not be used to pay for any of the following:

A. Payment to any member of the Grantee's Board of Directors, other governing body, or any of its committees except as authorized by this paragraph. Excluded from these provisions are payments to employees of the Grantee who serve on such bodies, as otherwise provided in this Agreement, and payments to members for travel and subsistence expenses in accordance with the Commonwealth Travel and Subsistence Rates when traveling on business related to duties imposed by this Agreement. Prohibited payments include salaries, wages, stipends or similar forms of compensation, rents and royalties.

B. Any cost that is incurred by individuals or organizations, other than the Grantee or subcontractor pursuant to a subcontract approved by the Department, in accordance with this Agreement.

C. Costs incurred prior to the effective date of this Agreement or the letting of purchase orders for goods or services prior to the approval date of this Agreement.

D. Bad debts - any cost arising from uncollectible accounts or other claims and related charges.

E. Contingencies - contributions to a contingency reserve or any similar provisions for unforeseen events.

F. Contributions, gifts and greeting cards.

G. Dues and costs associated with memberships in professional or other societies or organizations, unless approved prior and in writing by the Department.

H. Entertainment - costs of amusements, social activities and incidental related costs, such as meals, beverages, lodging, rentals, transportation and gratuities.

I. Fines and Penalties - costs resulting from violations of, or failure to comply with federal, state and local laws.

J. Foreign Travel- costs associated with foreign travel.

K. Land and Buildings - costs associated with acquisition of land or buildings.

L. Costs that are shared with other federal, state or local programs, unless specified as an exception.

M. Retroactive charges for prior Agreement periods.

N. Equipment, which is owned by the Grantee, may not be charged as a rental cost for purposes of this Agreement.

O. Lease obligations for rent that extend beyond the termination date of this Agreement.

P. Costs for travel or expenditures for persons other than the Grantee's employees, unless the Grantee has received prior written Department approval for such travel.

Q. Legal fees for any suit or conflict against the Commonwealth or U.S. Government or any agency or official of either.

R. In the event the Grantee has self-insured status under the laws of Pennsylvania, insurance benefits or claims paid are not reimbursable under this Agreement without prior written approval from the Department. The Department may, in its sole discretion, refuse to reimburse such expenditures.

S. The Grantee agrees to permit audit by the Commonwealth of Pennsylvania, or agent thereof, of all expenditures made pursuant to the terms of this Agreement, which includes an audit of records to verify required matching funds.

III. If the Grantee has advance knowledge that the Regional EMS Council Director will discontinue serving as the Director at some future date, regardless of whether the date is certain or uncertain, the Grantee shall notify the Department within 24 hours. If at any time during this Agreement period, the Regional EMS Council Director discontinues serving as the Director of the Regional EMS Council, for any reason, without the Grantee having prior notice, the Grantee shall notify the Department immediately, but in any case, within 24 hours of the departure. The Grantee shall not fill the vacant Regional EMS Council Director position unless and until the Department authorizes the Grantee to do so in writing. Upon receipt of the notice from the Grantee, the Department will conduct an evaluation to determine whether the regional EMS system served by the regional EMS council would be more efficiently served

Appendix B (Continued)

by a different regional EMS council arrangement, such as, but not limited to, the regional EMS system being consolidated with another regional EMS system that would be overseen by a single regional EMS council, or the regional EMS system being divided into parts with different parts being included in different regional EMS systems. The Department will make its determination and inform the Grantee of its determination within 30 business days after it receives notification from the Grantee. If the Department determines that a different regional EMS system arrangement is appropriate, the Department will so inform the Grantee and any other relevant regional EMS council, and assist the involved regional EMS councils achieve the restructuring desired by the Department. If at any time following 30 business days after giving such notice, the Department concludes that insufficient progress is being made, the Department may elect to terminate this Agreement.

IV. The Grantee shall require any employee of the regional EMS council who is responsible for making, taking or recommending, for the regional EMS council management, decisions or any action of a nonminsterial nature with regard to contracting or procuring; administering or monitoring disbursements of funds; or inspecting, licensing, regulating or auditing a person regulated under the Act; to file with the Department, on a form provided by the Department, a statement of financial interest that identifies any secondary employment of that employee, and any ownership interest that employee has in an entity regulated by the Department under the Act or to which the regional EMS council, another regional EMS council or the Department distributes funds by Agreement or otherwise.

V. The Grantee, if requested by the Department, shall require an employee of the Grantee to seek a State Ethics Commission opinion as to whether the Public Official and Employee Ethics Act prohibits the employee from engaging in an activity specified by the Department.

VI. The Grantee shall prohibit any board member, officer, director or employee of the Grantee from using that person's office or employment, or any confidential information received through that person holding such office or employment, for the private pecuniary benefit of that person, that person's spouse, or a business with which that person or that person's spouse is associated. This prohibition does not include an action having a de minimis economic impact or which affects to the same degree a class consisting of the general public or a subclass consisting of an industry, occupation or other group which includes that person, or that person's spouse, or a business with which that person or that person's spouse is associated.

VII. The Grantee shall require the Regional EMS Council Director to notify it within 24 hours of a felony or misdemeanor charge that has been filed against the Director. The Grantee shall notify the Department of the charge or charges within 24 hours of receiving the information from the Director or other source.

The Department will conduct an inquiry and make a determination as to whether the Regional EMS Council Director shall continue to perform the duties of Director pending the outcome of the Department's investigation.

If the Department directs the Grantee to remove its Director due to pending criminal charges, the Grantee shall remove that person from the position of Director unless and until the Department makes a subsequent determination that the person may resume the duties of the Regional EMS Council Director. If the Department decides that the person need not be removed as Regional EMS Council Director or may resume the duties of the Regional EMS Council Director, prior to the conclusion of the criminal proceedings, the Department may, nevertheless, direct the Grantee to remove that person as the Regional EMS Council Director at the conclusion of the criminal proceedings if the Director is convicted of a misdemeanor or felony. The Grantee shall abide by the Department's decision.

VIII. The following thresholds shall apply to procurement of supplies and services:

A. $5,000 - $10,000.....:.. Informal bid with three written quotes.

B. Greater than $10,000... Formal competitive sealed bid.

C. Supplies shall include, but not be limited to, equipment, materials, and printing.

D. Services shall include, but not be limited to, the furnishing of labor, time or effort. The term shall not include the routine operation or maintenance of existing structures, buildings, or real property, employment agreements or collective bargaining agreements, utility services and those services provided by public utilities such as electrical, telephone, water and sewage services.

Appendix B (Continued)

IX. The Department permits the employment of qualified relatives of employees as long as such employment does not, in the opinion of the Department and or Council, create actual conflicts of interest. For purposes of this policy, "immediate family" is defined as a spouse, child, parent, sibling, grandparent, grandchild, aunt, uncle, first cousin, corresponding in-law, "step" relation or any member of the employee's household. The Council shall use sound judgment in the placement of related employees in accordance with the following guidelines:

A. Individuals who are related by blood, marriage, or reside in the same household are permitted to work in the Council, provided no direct reporting or supervisor to subordinate relationship exists. That is, no employee is permitted to work within "the chain of command" when one relative's work responsibilities, salary, hours, career progress, benefits or other terms and conditions of employment could be influenced by the other relative.

B. Related employees may have no influence over the wages, hours, benefits, career progress and other terms and conditions of the other related staff members.

C. Employees who marry while employed, or become part of the same household are treated in accordance with these guidelines. That is, if in the opinion of the Department and or Council, a conflict arises as a result of the relationship, one of the employees will be transferred within 30 business days.

D. Any exceptions to this policy must be approved by the Department in writing.

Source: Standard contract the Department of Health establishes with each regional council for EMSOF.

APPENDIX C

The Amount of Money Disbursed and the Number of Cases With Disbursements for the Emergency Medical Services (Act 1985-45) Assessment Between 7/1/2006 and 6/30/2012 in CPCMS

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Adams	**$21,438.62**	**2,648**	**677**
2006-2007	$3,438.94	357	117
2007-2008	$3,228.73	381	91
2008-2009	$3,730.91	421	127
2009-2010	$3,486.21	437	112
2010-2011	$3,668.33	505	110
2011-2012	$3,885.50	547	120
Allegheny	**$328,437.46**	**29,921**	**6,415**
2006-2007	$39,627.03	3,439	974
2007-2008	$50,935.05	4,367	1,062
2008-2009	$57,079.65	4,895	1,241
2009-2010	$58,927.35	5,464	990
2010-2011	$62,816.06	6,109	1,057
2011-2012	$59,052.32	5,647	1,091
Armstrong	**$10,907.70**	**1,510**	**192**
2006-2007	$1,658.01	179	28
2007-2008	$1,881.53	228	25
2008-2009	$1,928.54	236	34
2009-2010	$1,539.47	251	31
2010-2011	$2,080.89	304	47
2011-2012	$1,819.26	312	27
Beaver	**$23,385.16**	**2,042**	**471**
2006-2007	$4,449.47	347	86
2007-2008	$3,903.89	337	82
2008-2009	$4,077.95	350	99
2009-2010	$4,163.60	355	70
2010-2011	$3,683.41	345	75
2011-2012	$3,106.84	308	59
Bedford	**$11,960.45**	**1,186**	**281**
2006-2007	$2,015.22	189	54
2007-2008	$2,134.51	202	47
2008-2009	$1,931.34	202	40
2009-2010	$2,356.13	216	62
2010-2011	$1,842.99	198	45
2011-2012	$1,680.26	179	33
Berks	**$48,185.91**	**3,318**	**1,628**
2006-2007	$9,222.56	619	254
2007-2008	$8,343.03	533	301
2008-2009	$8,404.94	553	301
2009-2010	$7,516.81	514	275
2010-2011	$7,609.61	553	257
2011-2012	$7,088.96	546	240
Blair	**$36,521.57**	**3,931**	**403**
2006-2007	$6,587.60	586	50
2007-2008	$6,865.25	670	74
2008-2009	$6,151.01	634	70
2009-2010	$5,996.20	686	78
2010-2011	$5,775.65	692	72
2011-2012	$5,145.86	663	59
Bradford	**$9,094.00**	**1,175**	**114**
2006-2007	$1,152.22	146	17
2007-2008	$1,897.43	234	17
2008-2009	$1,535.67	206	15
2009-2010	$1,379.60	196	13
2010-2011	$1,539.33	185	28
2011-2012	$1,589.75	208	24

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Bucks	**$179,677.69**	**13,339**	**4,736**
2006-2007	$34,237.20	2,304	623
2007-2008	$34,668.84	2,377	831
2008-2009	$29,721.71	2,161	879
2009-2010	$29,281.45	2,327	844
2010-2011	$25,246.47	2,114	759
2011-2012	$26,522.02	2,056	800
Butler	**$46,493.11**	**4,899**	**907**
2006-2007	$7,853.59	760	164
2007-2008	$8,689.61	763	161
2008-2009	$8,090.70	811	160
2009-2010	$7,492.52	819	130
2010-2011	$7,203.62	873	139
2011-2012	$7,163.07	873	153
Cambria	**$23,786.23**	**2,497**	**537**
2006-2007	$3,750.57	383	87
2007-2008	$4,024.62	410	102
2008-2009	$4,271.65	442	110
2009-2010	$4,171.04	444	88
2010-2011	$4,060.74	455	74
2011-2012	$3,507.61	363	76
Cameron	**$345.41**	**50**	**8**
2006-2007	$21.08	2	2
2007-2008	$93.56	7	3
2008-2009	$94.44	8	2
2009-2010	$41.23	9	
2010-2011	$46.26	13	
2011-2012	$48.84	11	1
Carbon	**$14,967.60**	**1,380**	**207**
2006-2007	$2,483.74	194	34
2007-2008	$3,262.74	263	42
2008-2009	$2,144.34	200	34
2009-2010	$2,379.29	234	27
2010-2011	$2,145.68	227	29
2011-2012	$2,551.81	262	41
Centre	**$70,792.58**	**4,748**	**463**
2006-2007	$9,455.74	607	53
2007-2008	$10,112.56	592	103
2008-2009	$12,689.84	877	74
2009-2010	$12,602.33	850	99
2010-2011	$12,350.81	880	71
2011-2012	$13,581.30	942	63
Chester	**$123,958.87**	**11,623**	**2,549**
2006-2007	$25,206.60	2,190	511
2007-2008	$26,209.82	2,456	411
2008-2009	$23,483.21	2,245	380
2009-2010	$21,790.92	2,196	315
2010-2011	$14,033.95	1,307	491
2011-2012	$13,234.37	1,229	441
Clarion	**$8,767.79**	**832**	**155**
2006-2007	$1,553.98	115	37
2007-2008	$1,307.90	133	23
2008-2009	$1,686.51	148	23
2009-2010	$1,337.33	147	14
2010-2011	$1,665.64	158	25
2011-2012	$1,216.43	131	33
Clearfield	**$34,371.05**	**3,105**	**133**
2006-2007	$3,866.51	339	8
2007-2008	$5,598.78	445	15
2008-2009	$6,200.79	535	43
2009-2010	$6,104.42	572	28
2010-2011	$6,363.00	599	19
2011-2012	$6,237.55	615	20

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Clinton	**$5,454.43**	**743**	**72**
2006-2007	$630.30	72	18
2007-2008	$566.71	93	13
2008-2009	$820.35	128	5
2009-2010	$1,021.66	131	15
2010-2011	$1,149.49	143	14
2011-2012	$1,265.92	176	7
Columbia	**$8,574.29**	**945**	**227**
2006-2007	$1,573.71	152	42
2007-2008	$1,466.49	165	24
2008-2009	$1,284.26	131	48
2009-2010	$1,609.28	160	45
2010-2011	$1,145.10	157	31
2011-2012	$1,495.45	180	37
Crawford	**$33,014.65**	**3,009**	**263**
2006-2007	$5,975.07	488	39
2007-2008	$5,949.02	503	42
2008-2009	$5,431.25	511	50
2009-2010	$4,900.11	494	55
2010-2011	$4,917.12	487	38
2011-2012	$5,842.08	526	39
Cumberland	**$40,546.18**	**4,899**	**959**
2006-2007	$5,598.35	570	142
2007-2008	$6,237.60	635	166
2008-2009	$6,957.12	783	175
2009-2010	$6,961.36	882	151
2010-2011	$7,186.37	983	168
2011-2012	$7,605.38	1,046	157
Dauphin	**$92,060.19**	**5,602**	**636**
2006-2007	$14,736.57	813	110
2007-2008	$14,747.61	887	127
2008-2009	$15,440.46	961	110
2009-2010	$14,312.68	939	104
2010-2011	$16,170.87	990	97
2011-2012	$16,652.00	1,012	88
Delaware	**$65,383.65**	**4,263**	**4,875**
2006-2007	$7,365.19	863	204
2007-2008	$15,032.58	657	1,298
2008-2009	$11,334.58	634	885
2009-2010	$11,280.98	734	863
2010-2011	$10,900.43	705	857
2011-2012	$9,469.89	670	768
Elk	**$3,242.01**	**438**	**73**
2006-2007	$735.41	69	13
2007-2008	$601.19	76	13
2008-2009	$465.96	60	15
2009-2010	$634.31	90	14
2010-2011	$391.66	77	10
2011-2012	$413.48	66	8
Erie	**$65,294.53**	**6,822**	**421**
2006-2007	$13,549.34	1,137	61
2007-2008	$13,880.93	1,272	75
2008-2009	$11,132.05	1,183	83
2009-2010	$9,219.25	1,065	65
2010-2011	$8,717.50	1,068	62
2011-2012	$8,795.46	1,097	75
Fayette	**$13,883.10**	**2,005**	**355**
2006-2007	$1,814.72	250	47
2007-2008	$2,245.37	338	54
2008-2009	$2,332.03	338	67
2009-2010	$2,411.14	320	66
2010-2011	$2,306.78	348	61
2011-2012	$2,773.06	411	60

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Forest	**$2,850.60**	**253**	**48**
2006-2007	$666.81	31	16
2007-2008	$486.65	30	11
2008-2009	$474.93	54	6
2009-2010	$341.90	36	7
2010-2011	$376.82	47	6
2011-2012	$503.49	55	2
Franklin	**$21,662.85**	**2,390**	**691**
2006-2007	$2,242.86	145	116
2007-2008	$2,907.56	279	88
2008-2009	$3,454.29	357	103
2009-2010	$4,192.65	462	141
2010-2011	$4,425.24	520	131
2011-2012	$4,440.25	627	112
Fulton	**$2,465.03**	**272**	**81**
2006-2007	$352.19	25	17
2007-2008	$390.25	33	18
2008-2009	$345.46	47	7
2009-2010	$404.97	52	10
2010-2011	$512.93	54	17
2011-2012	$459.23	61	12
Greene	**$27,276.87**	**1,277**	**77**
2006-2007	$4,008.92	187	12
2007-2008	$4,406.23	211	11
2008-2009	$4,549.89	210	15
2009-2010	$4,326.02	214	9
2010-2011	$5,023.76	231	14
2011-2012	$4,962.05	224	16
Huntingdon	**$8,953.12**	**976**	**118**
2006-2007	$1,618.47	174	10
2007-2008	$2,095.56	200	9
2008-2009	$1,284.67	148	27
2009-2010	$1,357.40	138	31
2010-2011	$1,240.31	150	21
2011-2012	$1,356.71	166	20
Indiana	**$12,257.40**	**1,673**	**477**
2006-2007	$2,250.20	271	88
2007-2008	$2,432.52	309	101
2008-2009	$2,081.66	278	97
2009-2010	$1,832.95	261	67
2010-2011	$1,764.90	269	62
2011-2012	$1,895.17	285	62
Jefferson	**$11,511.12**	**1,321**	**124**
2006-2007	$1,522.18	183	18
2007-2008	$1,857.09	224	24
2008-2009	$1,935.31	237	19
2009-2010	$2,059.59	220	21
2010-2011	$1,947.59	216	22
2011-2012	$2,189.36	241	20
Juniata	**$8,415.02**	**695**	**64**
2006-2007	$1,227.42	88	5
2007-2008	$1,391.54	110	9
2008-2009	$2,004.41	150	17
2009-2010	$1,469.69	129	14
2010-2011	$1,054.45	106	7
2011-2012	$1,267.51	112	12
Lackawanna	**$20,629.82**	**2,760**	**441**
2006-2007	$3,357.83	334	69
2007-2008	$3,750.48	441	89
2008-2009	$3,805.40	482	73
2009-2010	$3,197.63	487	60
2010-2011	$3,148.83	476	82
2011-2012	$3,369.65	540	68

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Lancaster	**$119,798.93**	**8,494**	**1,257**
2006-2007	$15,140.52	1,042	172
2007-2008	$19,846.76	1,311	204
2008-2009	$21,049.18	1,358	245
2009-2010	$20,819.30	1,521	220
2010-2011	$21,008.39	1,582	204
2011-2012	$21,934.78	1,680	212
Lawrence	**$19,939.10**	**2,292**	**176**
2006-2007	$3,180.14	338	12
2007-2008	$3,292.14	356	28
2008-2009	$3,563.21	395	35
2009-2010	$3,221.60	395	23
2010-2011	$3,123.86	368	44
2011-2012	$3,558.15	440	34
Lebanon	**$76,450.95**	**5,357**	**246**
2006-2007	$10,592.91	756	17
2007-2008	$13,320.47	916	30
2008-2009	$13,575.58	962	36
2009-2010	$12,861.42	904	51
2010-2011	$12,593.57	912	48
2011-2012	$13,507.00	907	64
Lehigh	**$62,863.25**	**6,430**	**1,479**
2006-2007	$13,249.46	1,367	240
2007-2008	$13,042.99	1,307	258
2008-2009	$10,471.18	1,076	276
2009-2010	$9,243.08	941	230
2010-2011	$8,674.47	909	233
2011-2012	$8,182.07	830	242
Luzerne	**$48,256.38**	**5,793**	**682**
2006-2007	$8,667.80	812	100
2007-2008	$8,822.26	964	101
2008-2009	$7,611.85	910	138
2009-2010	$7,780.98	1,014	139
2010-2011	$7,768.46	1,058	107
2011-2012	$7,605.03	1,035	97
Lycoming	**$56,977.19**	**6,740**	**421**
2006-2007	$11,726.38	1,052	60
2007-2008	$13,144.04	1,265	90
2008-2009	$10,440.91	1,232	67
2009-2010	$8,668.77	1,122	63
2010-2011	$6,962.82	1,065	72
2011-2012	$6,034.27	1,004	69
McKean	**$27,642.33**	**1,986**	**46**
2006-2007	$3,544.01	237	5
2007-2008	$4,749.80	342	9
2008-2009	$4,234.14	343	11
2009-2010	$5,250.63	365	6
2010-2011	$5,199.09	360	8
2011-2012	$4,664.66	339	7
Mercer	**$26,610.60**	**3,409**	**298**
2006-2007	$4,396.43	447	48
2007-2008	$4,440.44	517	45
2008-2009	$4,469.55	557	45
2009-2010	$4,220.63	591	54
2010-2011	$4,666.58	647	53
2011-2012	$4,416.97	650	53
Mifflin	**$8,324.76**	**1,041**	**62**
2006-2007	$1,141.03	128	4
2007-2008	$1,457.04	168	8
2008-2009	$1,495.93	165	18
2009-2010	$1,551.18	184	13
2010-2011	$1,363.18	189	8
2011-2012	$1,316.40	207	11

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Monroe	**$44,884.67**	**5,225**	**315**
2006-2007	$5,275.74	597	33
2007-2008	$5,383.29	631	45
2008-2009	$6,147.86	728	45
2009-2010	$6,764.92	810	36
2010-2011	$9,051.90	1,041	92
2011-2012	$12,260.96	1,418	64
Montgomery	**$115,532.24**	**8,826**	**5,164**
2006-2007	$20,195.93	1,349	901
2007-2008	$18,382.77	1,375	808
2008-2009	$17,303.27	1,425	742
2009-2010	$18,708.09	1,491	815
2010-2011	$20,862.42	1,641	930
2011-2012	$20,079.76	1,545	968
Montour	**$1,932.08**	**258**	**37**
2006-2007	$201.16	23	3
2007-2008	$244.53	25	6
2008-2009	$298.56	40	10
2009-2010	$443.43	50	10
2010-2011	$406.77	63	7
2011-2012	$337.63	57	1
Northampton	**$67,569.76**	**5,651**	**938**
2006-2007	$12,547.00	949	127
2007-2008	$12,374.88	983	146
2008-2009	$10,468.71	911	147
2009-2010	$10,954.92	950	184
2010-2011	$10,631.03	958	127
2011-2012	$10,593.22	900	207
Northumberland	**$11,330.83**	**1,283**	**113**
2006-2007	$1,674.08	182	14
2007-2008	$1,531.44	177	21
2008-2009	$1,868.89	191	21
2009-2010	$1,841.89	213	17
2010-2011	$2,346.33	254	23
2011-2012	$2,068.20	266	17
Perry	**$12,523.45**	**1,075**	**72**
2006-2007	$1,962.39	142	13
2007-2008	$2,086.00	174	12
2008-2009	$2,347.20	189	7
2009-2010	$2,146.43	197	13
2010-2011	$1,978.81	196	15
2011-2012	$2,002.62	177	12
Philadelphia	**$32,895.09**	**7,116**	**59**
2006-2007	$2,010.43	319	13
2007-2008	$4,813.04	808	13
2008-2009	$4,392.43	902	17
2009-2010	$4,909.84	1,115	8
2010-2011	$7,972.49	1,883	3
2011-2012	$8,796.86	2,089	5
Pike	**$9,738.96**	**1,130**	**167**
2006-2007	$1,130.54	126	17
2007-2008	$1,747.55	169	47
2008-2009	$1,353.60	160	16
2009-2010	$1,840.81	206	44
2010-2011	$1,783.80	234	18
2011-2012	$1,882.66	235	25
Potter	**$8,488.66**	**545**	**56**
2006-2007	$1,135.12	90	3
2007-2008	$1,200.39	85	6
2008-2009	$1,434.13	95	15
2009-2010	$1,382.18	88	11
2010-2011	$1,905.35	99	12
2011-2012	$1,431.49	88	9

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Schuylkill	**$43,181.86**	**3,859**	**510**
2006-2007	$6,344.08	472	88
2007-2008	$7,760.60	587	100
2008-2009	$7,545.31	655	87
2009-2010	$7,559.46	695	81
2010-2011	$7,348.84	704	88
2011-2012	$6,623.57	746	66
Snyder	**$10,728.49**	**972**	**131**
2006-2007	$1,381.43	120	20
2007-2008	$1,860.01	161	22
2008-2009	$2,103.48	173	16
2009-2010	$1,758.06	164	10
2010-2011	$1,871.99	180	31
2011-2012	$1,753.52	174	32
Somerset	**$13,879.24**	**1,422**	**384**
2006-2007	$2,286.78	232	59
2007-2008	$3,074.21	256	111
2008-2009	$2,401.43	228	77
2009-2010	$1,997.62	226	61
2010-2011	$2,077.33	253	34
2011-2012	$2,041.87	227	42
Sullivan	**$875.22**	**103**	**13**
2006-2007	$240.26	20	6
2007-2008	$105.02	15	3
2008-2009	$84.22	12	1
2009-2010	$127.70	17	1
2010-2011	$141.39	15	
2011-2012	$176.63	24	2
Susquehanna	**$7,917.78**	**946**	**79**
2006-2007	$1,426.10	113	13
2007-2008	$1,776.74	146	6
2008-2009	$1,309.83	153	9
2009-2010	$1,066.03	154	16
2010-2011	$1,180.31	188	18
2011-2012	$1,158.77	192	17
Tioga	**$3,304.29**	**470**	**88**
2006-2007	$379.26	50	7
2007-2008	$476.87	66	12
2008-2009	$445.30	59	15
2009-2010	$639.51	89	17
2010-2011	$706.88	99	22
2011-2012	$656.47	107	15
Union	**$6,717.88**	**683**	**53**
2006-2007	$848.13	82	11
2007-2008	$1,442.47	133	11
2008-2009	$928.56	100	7
2009-2010	$1,240.86	115	5
2010-2011	$1,044.15	132	6
2011-2012	$1,213.71	121	13
Venango	**$18,713.50**	**2,576**	**258**
2006-2007	$2,833.13	309	46
2007-2008	$3,340.68	387	38
2008-2009	$3,257.64	427	45
2009-2010	$2,989.84	446	41
2010-2011	$3,070.38	491	33
2011-2012	$3,221.83	516	55
Warren	**$21,787.50**	**1,370**	**94**
2006-2007	$3,279.42	201	25
2007-2008	$3,573.75	213	11
2008-2009	$3,009.66	212	10
2009-2010	$4,400.95	269	10
2010-2011	$3,886.92	244	22
2011-2012	$3,636.80	231	16

Appendix C (Continued)

Fiscal Year	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Washington	**$39,364.07**	**3,726**	**856**
2006-2007	$5,905.61	538	132
2007-2008	$5,563.60	506	127
2008-2009	$6,847.87	615	163
2009-2010	$6,930.07	644	153
2010-2011	$6,915.28	705	139
2011-2012	$7,201.64	718	142
Wayne	**$14,530.32**	**1,359**	**101**
2006-2007	$2,298.20	194	6
2007-2008	$3,374.65	249	22
2008-2009	$3,004.72	264	24
2009-2010	$2,699.95	245	15
2010-2011	$1,958.76	212	20
2011-2012	$1,194.04	195	14
Westmoreland	**$43,365.53**	**4,072**	**1,725**
2006-2007	$6,584.34	602	226
2007-2008	$7,663.86	687	264
2008-2009	$7,436.48	610	343
2009-2010	$7,297.53	641	287
2010-2011	$7,207.41	753	308
2011-2012	$7,175.91	779	297
Wyoming	**$5,076.88**	**628**	**102**
2006-2007	$858.68	73	25
2007-2008	$674.78	81	14
2008-2009	$620.16	99	18
2009-2010	$927.14	113	13
2010-2011	$963.66	133	10
2011-2012	$1,032.46	129	22
York	**$133,507.39**	**15,440**	**2,196**
2006-2007	$19,736.75	1,889	285
2007-2008	$24,008.71	2,344	417
2008-2009	$23,780.34	2,672	372
2009-2010	$23,460.25	2,856	401
2010-2011	$22,260.62	2,926	392
2011-2012	$20,260.72	2,753	329

Note: If a case had monies disbursed for the for the Emergency Medical Services assessment in different fiscal years. The case was counted in both fiscal years.

Source:

APPENDIX D

The Amount of Money Disbursed and the Number of Cases With Disbursements for the Emergency Medical Services (Act 1985-45) Assessment Between 7/1/2006 and 6/30/2012 in MDJS

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Adams	**$568,291.45**	**2**	**59,986**
2006-2007	$88,469.99	1	9,421
2007-2008	$100,086.34		10,507
2008-2009	$93,851.24	1	9,926
2009-2010	$88,114.52		9,325
2010-2011	$95,167.53		10,002
2011-2012	$102,601.83		10,805
Allegheny	**$5,757,962.13**		**633,424**
2006-2007	$910,023.08		99,560
2007-2008	$1,022,451.37		111,810
2008-2009	$1,025,405.33		113,008
2009-2010	$921,280.15		101,441
2010-2011	$956,783.58		105,367
2011-2012	$922,018.62		102,238
Armstrong	**$295,118.86**	**15**	**32,592**
2006-2007	$40,326.62	3	4,485
2007-2008	$48,431.85	2	5,375
2008-2009	$56,502.38	5	6,229
2009-2010	$47,605.57	1	5,313
2010-2011	$50,408.82	2	5,528
2011-2012	$51,843.62	2	5,662
Beaver	**$1,044,095.66**	**3**	**119,343**
2006-2007	$144,054.99		16,586
2007-2008	$174,756.73		19,850
2008-2009	$203,191.76	1	22,928
2009-2010	$185,168.29	1	21,215
2010-2011	$171,407.98	1	19,751
2011-2012	$165,515.91		19,013
Bedford	**$945,856.47**	**2**	**98,139**
2006-2007	$142,514.20	2	14,838
2007-2008	$152,893.85		15,845
2008-2009	$173,732.77		17,988
2009-2010	$183,488.49		19,000
2010-2011	$156,083.25		16,229
2011-2012	$137,143.91		14,239
Berks	**$2,415,167.52**	**10**	**262,084**
2006-2007	$409,149.56		44,279
2007-2008	$459,675.32	3	49,496
2008-2009	$417,869.17	2	45,314
2009-2010	$401,805.30	2	43,630
2010-2011	$373,610.82	1	40,731
2011-2012	$353,057.35	2	38,634
Blair	**$623,485.33**	**32**	**70,814**
2006-2007	$102,260.62	8	11,560
2007-2008	$107,140.97	9	12,164
2008-2009	$114,403.16	6	13,037
2009-2010	$112,757.94	3	12,805
2010-2011	$98,647.00	5	11,326
2011-2012	$88,275.64	1	9,922
Bradford	**$322,044.19**	**9**	**34,655**
2006-2007	$55,464.22	4	6,001
2007-2008	$50,187.07		5,483
2008-2009	$44,857.87		4,891
2009-2010	$43,716.45	3	4,769
2010-2011	$68,853.47	1	7,259
2011-2012	$58,965.11	1	6,252

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Bucks	**$3,966,975.67**		**432,304**
2006-2007	$637,738.34		69,739
2007-2008	$742,137.88		80,249
2008-2009	$679,768.18		74,123
2009-2010	$672,369.32		73,304
2010-2011	$613,880.40		67,414
2011-2012	$621,081.55		67,475
Butler	**$901,826.46**	**61**	**97,151**
2006-2007	$158,287.29	16	17,074
2007-2008	$178,949.88	18	19,063
2008-2009	$171,691.84	14	18,364
2009-2010	$141,567.93	9	15,320
2010-2011	$131,046.35	3	14,194
2011-2012	$120,283.17	1	13,136
Cambria	**$816,101.01**	**7**	**89,516**
2006-2007	$130,865.09		14,410
2007-2008	$160,547.33	1	17,495
2008-2009	$148,531.74	2	16,284
2009-2010	$129,903.37		14,311
2010-2011	$118,028.29	2	13,020
2011-2012	$128,225.19	2	13,996
Cameron	**$54,725.38**		**5,720**
2006-2007	$10,460.01		1,086
2007-2008	$8,751.56		920
2008-2009	$8,318.05		876
2009-2010	$9,500.42		990
2010-2011	$7,835.06		825
2011-2012	$9,860.28		1,023
Carbon	**$801,438.69**		**85,251**
2006-2007	$134,400.11		14,253
2007-2008	$162,497.42		17,147
2008-2009	$130,420.15		13,937
2009-2010	$119,894.43		12,893
2010-2011	$115,245.03		12,324
2011-2012	$138,981.55		14,697
Centre	**$1,137,289.23**	**2**	**117,511**
2006-2007	$172,012.21		17,782
2007-2008	$182,866.57		18,883
2008-2009	$211,738.07		21,901
2009-2010	$203,241.52		21,003
2010-2011	$184,556.20	1	19,053
2011-2012	$182,874.66	1	18,889
Chester	**$3,788,488.71**	**1**	**401,919**
2006-2007	$663,364.24	1	70,551
2007-2008	$700,964.94		74,102
2008-2009	$664,288.01		70,364
2009-2010	$618,108.66		65,679
2010-2011	$564,099.96		59,974
2011-2012	$577,662.90		61,249
Clarion	**$429,358.87**	**16**	**44,788**
2006-2007	$83,018.26	2	8,662
2007-2008	$83,595.63	5	8,734
2008-2009	$71,119.30	1	7,454
2009-2010	$64,496.40	2	6,717
2010-2011	$62,002.30	2	6,447
2011-2012	$65,126.98	4	6,774
Clearfield	**$536,044.03**	**14**	**57,335**
2006-2007	$82,244.39	2	8,878
2007-2008	$87,579.77	3	9,347
2008-2009	$101,152.18	2	10,767
2009-2010	$101,993.25	3	10,879
2010-2011	$78,681.14	2	8,463
2011-2012	$84,393.30	2	9,001

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Clinton	**$338,298.99**		**35,064**
2006-2007	$48,998.31		5,100
2007-2008	$45,183.80		4,706
2008-2009	$53,815.08		5,579
2009-2010	$66,784.43		6,912
2010-2011	$60,199.35		6,223
2011-2012	$63,318.02		6,544
Columbia	**$570,793.92**	**1**	**60,936**
2006-2007	$95,210.28		10,192
2007-2008	$100,945.51	1	10,715
2008-2009	$89,347.66		9,549
2009-2010	$91,460.43		9,784
2010-2011	$86,513.55		9,259
2011-2012	$107,316.49		11,437
Crawford	**$489,100.20**	**2**	**51,643**
2006-2007	$79,785.91	1	8,391
2007-2008	$81,744.45		8,609
2008-2009	$84,444.31		8,946
2009-2010	$92,377.95	1	9,790
2010-2011	$75,685.21		8,013
2011-2012	$75,062.37		7,894
Cumberland	**$2,267,379.56**	**104**	**236,906**
2006-2007	$360,670.61	24	37,550
2007-2008	$417,661.73	22	43,377
2008-2009	$430,024.50	17	44,755
2009-2010	$384,692.08	16	40,248
2010-2011	$356,202.78	19	37,420
2011-2012	$318,127.86	6	33,556
Dauphin	**$2,205,296.28**	**321**	**238,668**
2006-2007	$423,289.10	60	45,459
2007-2008	$428,662.19	74	45,958
2008-2009	$408,719.41	44	43,920
2009-2010	$349,047.12	32	38,005
2010-2011	$313,203.91	60	34,164
2011-2012	$282,374.55	51	31,162
Delaware	**$3,106,377.19**	**2**	**350,919**
2006-2007	$503,886.50		57,202
2007-2008	$587,870.99		66,080
2008-2009	$570,623.26		63,898
2009-2010	$540,609.95	1	61,145
2010-2011	$445,638.09		50,752
2011-2012	$457,748.40	1	51,842
Elk	**$193,928.07**		**20,394**
2006-2007	$34,366.75		3,615
2007-2008	$35,302.21		3,701
2008-2009	$30,633.31		3,259
2009-2010	$35,873.97		3,762
2010-2011	$27,368.56		2,878
2011-2012	$30,383.27		3,179
Erie	**$1,217,991.53**	**8**	**138,328**
2006-2007	$206,440.47	2	23,649
2007-2008	$209,802.96		23,703
2008-2009	$204,376.05	1	23,186
2009-2010	$200,885.53	1	22,821
2010-2011	$197,260.94	2	22,398
2011-2012	$199,225.58	2	22,571
Fayette	**$696,154.08**		**82,942**
2006-2007	$98,485.66		11,769
2007-2008	$104,678.83		12,589
2008-2009	$100,526.45		12,112
2009-2010	$132,750.64		15,620
2010-2011	$136,782.55		16,201
2011-2012	$122,929.95		14,651

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Forest	**$43,217.68**	**3**	**4,637**
2006-2007	$7,766.62	1	843
2007-2008	$6,508.68		718
2008-2009	$6,330.12		684
2009-2010	$6,578.07		702
2010-2011	$7,886.20		826
2011-2012	$8,147.99	2	864
Franklin	**$788,840.66**	**1**	**84,403**
2006-2007	$139,956.12		14,829
2007-2008	$124,563.11	1	13,337
2008-2009	$123,195.96		13,263
2009-2010	$116,784.02		12,564
2010-2011	$115,034.23		12,445
2011-2012	$169,307.22		17,965
Fulton	**$397,242.98**		**40,666**
2006-2007	$64,777.04		6,636
2007-2008	$52,558.25		5,392
2008-2009	$63,023.66		6,441
2009-2010	$74,594.09		7,623
2010-2011	$70,613.77		7,252
2011-2012	$71,676.17		7,322
Greene	**$243,955.88**		**27,531**
2006-2007	$35,318.16		4,042
2007-2008	$43,151.86		4,854
2008-2009	$42,127.63		4,809
2009-2010	$37,919.58		4,347
2010-2011	$47,787.50		5,246
2011-2012	$37,651.15		4,233
Huntingdon	**$210,615.79**		**21,992**
2006-2007	$25,347.79		2,673
2007-2008	$29,287.51		3,058
2008-2009	$38,754.26		4,026
2009-2010	$42,003.59		4,389
2010-2011	$37,862.31		3,958
2011-2012	$37,360.33		3,888
Indiana	**$552,619.77**		**59,296**
2006-2007	$89,609.13		9,655
2007-2008	$94,406.16		10,115
2008-2009	$96,333.27		10,375
2009-2010	$90,831.37		9,794
2010-2011	$87,954.13		9,413
2011-2012	$93,485.71		9,944
Jefferson	**$424,306.84**	**11**	**44,336**
2006-2007	$64,274.31	3	6,788
2007-2008	$77,615.50		8,121
2008-2009	$74,092.76	3	7,735
2009-2010	$73,474.00		7,635
2010-2011	$66,948.62	3	6,968
2011-2012	$67,901.65	2	7,089
Juniata	**$223,282.94**		**23,684**
2006-2007	$20,193.02		2,184
2007-2008	$38,674.89		4,074
2008-2009	$52,860.28		5,558
2009-2010	$43,614.17		4,619
2010-2011	$37,148.94		3,952
2011-2012	$30,791.64		3,297
Lackawanna	**$875,124.90**		**97,941**
2006-2007	$171,042.35		19,007
2007-2008	$174,512.58		19,342
2008-2009	$136,908.00		15,298
2009-2010	$134,731.75		15,165
2010-2011	$124,579.21		14,232
2011-2012	$133,351.01		14,897

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Lancaster	**$2,851,739.93**	**134**	**306,196**
2006-2007	$434,849.22	37	46,613
2007-2008	$531,482.28	36	56,525
2008-2009	$490,116.41	21	52,775
2009-2010	$461,852.36	16	49,821
2010-2011	$471,349.70	11	50,610
2011-2012	$462,089.96	13	49,852
Lawrence	**$563,368.80**	**1**	**63,412**
2006-2007	$78,539.41		8,913
2007-2008	$96,214.80		10,817
2008-2009	$99,904.98		11,250
2009-2010	$94,250.18		10,669
2010-2011	$96,765.32	1	10,865
2011-2012	$97,694.11		10,898
Lebanon	**$896,712.16**		**95,946**
2006-2007	$138,756.86		14,926
2007-2008	$139,636.81		14,962
2008-2009	$154,739.46		16,559
2009-2010	$165,011.23		17,655
2010-2011	$154,406.63		16,515
2011-2012	$144,161.17		15,329
Lehigh	**$1,776,794.41**	**2**	**195,175**
2006-2007	$282,964.08		31,300
2007-2008	$307,511.91	2	33,615
2008-2009	$283,070.16		30,989
2009-2010	$290,033.55		31,998
2010-2011	$315,137.60		34,603
2011-2012	$298,077.11		32,670
Luzerne	**$1,662,821.44**	**45**	**183,993**
2006-2007	$283,624.13	3	31,256
2007-2008	$312,956.32	4	34,315
2008-2009	$278,408.66	12	30,827
2009-2010	$267,133.36	9	29,710
2010-2011	$261,215.17	9	29,019
2011-2012	$259,483.80	8	28,866
Lycoming	**$695,364.32**	**4**	**78,271**
2006-2007	$92,834.17	1	10,653
2007-2008	$120,184.21	1	13,409
2008-2009	$119,975.59		13,488
2009-2010	$125,532.54	1	14,144
2010-2011	$110,365.78	1	12,526
2011-2012	$126,472.03		14,051
McKean	**$220,216.07**	**20**	**24,759**
2006-2007	$32,116.10	1	3,600
2007-2008	$41,789.82	7	4,607
2008-2009	$35,953.16	5	4,052
2009-2010	$34,345.62	5	3,908
2010-2011	$34,967.54	1	3,971
2011-2012	$41,043.83	1	4,621
Mercer	**$628,164.21**	**25**	**68,480**
2006-2007	$90,868.91	5	10,164
2007-2008	$102,670.57	2	11,241
2008-2009	$119,703.48	4	12,934
2009-2010	$107,536.25	6	11,706
2010-2011	$97,299.93	4	10,594
2011-2012	$110,085.07	4	11,841
Mifflin	**$252,991.34**	**1**	**26,959**
2006-2007	$36,356.00	1	3,886
2007-2008	$47,389.07		5,012
2008-2009	$48,021.66		5,103
2009-2010	$40,706.56		4,366
2010-2011	$38,236.56		4,088
2011-2012	$42,281.49		4,504

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Monroe	**$1,228,200.61**	**43**	**130,320**
2006-2007	$204,955.57	9	21,634
2007-2008	$224,787.73	7	23,650
2008-2009	$193,545.38	6	20,674
2009-2010	$215,017.51	3	22,981
2010-2011	$197,238.61	8	20,975
2011-2012	$192,655.81	10	20,406
Montgomery	**$5,643,325.27**	**17**	**615,981**
2006-2007	$875,542.54	1	95,672
2007-2008	$1,025,190.38	1	111,199
2008-2009	$1,041,546.02	7	113,760
2009-2010	$959,516.01	3	104,790
2010-2011	$892,423.07	2	97,543
2011-2012	$849,107.25	3	93,017
Montour	**$184,450.40**	**1**	**19,451**
2006-2007	$20,824.75		2,206
2007-2008	$34,834.06	1	3,686
2008-2009	$45,972.09		4,785
2009-2010	$36,139.81		3,772
2010-2011	$26,472.69		2,826
2011-2012	$20,207.00		2,176
Northampton	**$1,738,410.02**	**34**	**187,484**
2006-2007	$263,056.39	8	28,498
2007-2008	$303,466.96	4	32,754
2008-2009	$306,626.17	3	33,146
2009-2010	$305,706.87	4	32,983
2010-2011	$279,098.64	8	30,122
2011-2012	$280,454.99	7	29,981
Northumberland	**$452,093.96**	**13**	**48,724**
2006-2007	$69,074.59	4	7,477
2007-2008	$76,077.09	2	8,179
2008-2009	$79,504.60	1	8,533
2009-2010	$83,756.32	3	8,971
2010-2011	$70,600.28	2	7,713
2011-2012	$73,081.08	1	7,851
Perry	**$287,929.37**	**1**	**29,725**
2006-2007	$42,811.31		4,390
2007-2008	$40,269.55	1	4,132
2008-2009	$45,194.26		4,646
2009-2010	$38,715.09		4,013
2010-2011	$50,616.27		5,257
2011-2012	$70,322.89		7,287
Philadelphia	**$9,056,785.20**		**1,330,467**[a]
2006-2007	1,466,537.32		245,169[a]
2007-2008	1,486,780.37		239,270[a]
2008-2009	1,640,702.53		270,355[a]
2009-2010	1,650,491.56		228,119[a]
2010-2011	1,495,069.57		186,998[a]
2011-2012	1,317,203.85		160,556[a]
Pike	**$380,432.41**	**5**	**39,729**
2006-2007	$67,838.24		7,007
2007-2008	$63,613.21	2	6,639
2008-2009	$70,984.95		7,429
2009-2010	$63,067.50	1	6,608
2010-2011	$60,139.03	2	6,297
2011-2012	$54,789.48		5,749
Potter	**$141,614.70**	**1**	**15,659**
2006-2007	$23,539.42		2,616
2007-2008	$22,484.48	1	2,487
2008-2009	$20,693.83		2,303
2009-2010	$24,081.88		2,658
2010-2011	$25,711.04		2,823
2011-2012	$25,104.05		2,772

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Schuylkill	**$927,816.35**		**99,672**
2006-2007	$156,156.65		16,836
2007-2008	$184,411.96		19,706
2008-2009	$166,492.35		17,892
2009-2010	$154,474.74		16,561
2010-2011	$129,174.76		13,965
2011-2012	$137,105.89		14,712
Snyder	**$433,229.31**	**1**	**46,554**
2006-2007	$71,819.21	1	7,674
2007-2008	$71,433.89		7,663
2008-2009	$69,463.02		7,474
2009-2010	$76,484.80		8,205
2010-2011	$70,752.90		7,580
2011-2012	$73,275.49		7,958
Somerset	**$909,178.12**	**2**	**96,577**
2006-2007	$133,894.09		14,194
2007-2008	$167,816.41	2	17,700
2008-2009	$151,600.12		16,259
2009-2010	$141,819.77		15,156
2010-2011	$150,739.25		15,970
2011-2012	$163,308.48		17,298
Sullivan	**$109,325.65**		**11,370**
2006-2007	$14,339.90		1,512
2007-2008	$15,309.92		1,605
2008-2009	$16,534.88		1,730
2009-2010	$15,125.65		1,579
2010-2011	$22,373.83		2,308
2011-2012	$25,641.47		2,636
Susquehanna	**$245,798.20**	**2**	**25,895**
2006-2007	$30,528.94		3,222
2007-2008	$36,759.53		3,860
2008-2009	$40,220.46	1	4,218
2009-2010	$46,479.41		4,880
2010-2011	$44,573.25	1	4,730
2011-2012	$47,236.61		4,985
Tioga	**$298,536.78**	**2**	**31,605**
2006-2007	$47,374.20		5,028
2007-2008	$36,270.76		3,892
2008-2009	$41,146.23		4,417
2009-2010	$45,787.11	2	4,873
2010-2011	$53,361.60		5,638
2011-2012	$74,596.88		7,757
Union	**$301,945.13**	**7**	**31,977**
2006-2007	$47,009.41	2	5,026
2007-2008	$47,498.74		5,067
2008-2009	$53,683.01		5,686
2009-2010	$55,378.20	1	5,852
2010-2011	$48,330.05	4	5,082
2011-2012	$50,045.72		5,264
Venango	**$299,494.55**	**4**	**33,865**
2006-2007	$44,928.40	1	5,071
2007-2008	$49,132.40	1	5,560
2008-2009	$59,326.63		6,651
2009-2010	$50,332.50	1	5,710
2010-2011	$45,689.34	1	5,198
2011-2012	$50,085.28		5,675
Warren	**$171,176.20**	**7**	**18,974**
2006-2007	$26,105.17	3	2,895
2007-2008	$31,054.99		3,426
2008-2009	$29,773.36	3	3,287
2009-2010	$27,573.45	1	3,074
2010-2011	$25,889.11		2,918
2011-2012	$30,780.12		3,374

Appendix D (Continued)

	Disbursed Amount	Criminal/ARD Cases	Summary Cases
Washington	**$1,458,014.67**	**13**	**162,525**
2006-2007	$191,541.06	3	21,687
2007-2008	$242,095.40	5	27,002
2008-2009	$255,235.00	4	28,465
2009-2010	$272,042.96	1	30,402
2010-2011	$249,576.74		27,804
2011-2012	$247,523.51		27,165
Wayne	**$237,049.22**	**24**	**26,276**
2006-2007	$42,669.76	6	4,784
2007-2008	$40,876.69	7	4,549
2008-2009	$40,499.66	2	4,552
2009-2010	$41,883.25	4	4,616
2010-2011	$35,462.84	4	3,917
2011-2012	$35,657.02	1	3,858
Westmoreland	**$2,492,821.24**	**3**	**267,602**
2006-2007	$415,075.70		44,491
2007-2008	$422,878.64		45,297
2008-2009	$420,762.53	1	45,348
2009-2010	$427,308.42		46,020
2010-2011	$423,047.46	1	45,234
2011-2012	$383,748.49	1	41,212
Wyoming	**$258,362.42**	**2**	**27,203**
2006-2007	$52,935.30		5,651
2007-2008	$48,840.21		5,151
2008-2009	$47,260.65	1	4,953
2009-2010	$35,421.88		3,730
2010-2011	$32,301.32		3,398
2011-2012	$41,603.06	1	4,320
York	**$2,947,143.92**	**23**	**319,115**
2006-2007	$500,963.81	2	53,990
2007-2008	$508,191.05	4	54,742
2008-2009	$522,951.56	6	56,373
2009-2010	$510,133.41	5	55,332
2010-2011	$458,364.06	4	49,949
2011-2012	$446,540.03	2	48,729

Note: If a case had monies disbursed for the for the Emergency Medical Services assessment in different fiscal years. The case was counted in both fiscal years.

[a] Summary Cases for Philadelphia County include Criminal/ARD Cases also since no breakout was provided.

Source:

APPENDIX E

PRIOR PRINTER'S NOS. 1985, 2831 PRINTER'S NO. 3729

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 315 Session of 2011

INTRODUCED BY CAUSER, BARRAR, SAINATO, BAKER, CALTAGIRONE, COHEN, DAY, DENLINGER, EVERETT, FARRY, FLECK, GABLER, GINGRICH, GOODMAN, GRELL, HENNESSEY, HORNAMAN, KULA, O'NEILL, PICKETT, QUINN, RAPP, ROCK, SONNEY, STERN, SWANGER, TALLMAN, THOMAS, VULAKOVICH AND MURT, JUNE 2, 2011

AS AMENDED, HOUSE OF REPRESENTATIVES, JUNE 12, 2012

A RESOLUTION

Directing the Legislative Budget and Finance Committee and the Joint State Government Commission to study the financial and administrative effectiveness of the emergency medical services system.

WHEREAS, The Emergency Medical Services System Act was enacted as 35 Pa.C.S. Ch. 81 (relating to emergency medical services system) to replace the former act of July 3, 1985 (P.L.164, No.45), known as the Emergency Medical Services Act; and

WHEREAS, The enactment of the Emergency Medical Services System Act was the culmination of years of research and preparation to update the emergency medical services delivery system in this Commonwealth; and

WHEREAS, The Emergency Medical Services System Act changed the emergency medical services delivery system from a system based on national standards to a system based on curriculum; and

WHEREAS, The Commonwealth should continually assess and revise the statutes and regulations which govern the functions of emergency medical services agencies and providers and other components of the emergency medical services system; and

WHEREAS, It is the public policy of the General Assembly to ensure that the emergency medical services system adapts to changing needs of the residents of this Commonwealth and promotes the recruitment and retention of persons willing and

qualified to serve as emergency medical services providers in this Commonwealth; and

WHEREAS, The General Assembly finds it to be in the public interest to ensure readily available and coordinated emergency medical services of the highest quality to the citizens of this great Commonwealth; and

WHEREAS, There have been many changes in technology and organizational administration since the inception of the former Emergency Medical Services Act, such as the advent of the community college system, online computer courses, national associations and local area programs for emergency medical services training; and

WHEREAS, Changes in technology, systems management, infrastructure and communications capabilities allow for the Commonwealth to explore more beneficial approaches for the provision of the highest quality system for the delivery of emergency medical services, training and planning, as well as all-hazard emergency preparedness and disaster response training and planning; and

WHEREAS, The approximate $11,800,000 in annual funding for these emergency medical services under the Emergency Medical Services Operating Fund may be more effectively used under a more streamlined system which uses existing training, planning and infrastructure resources; and

WHEREAS, The Commonwealth's Regional Counter-Terrorism Task Force infrastructure is a model for the country and may serve as a model for streamlining the current emergency medical services system in this Commonwealth; therefore be it

RESOLVED, That the House of Representatives direct the Legislative Budget and Finance Committee to conduct a performance review of the financial administration of the emergency medical services system under the Emergency Medical Services Operating Fund. The performance review shall include an analysis of the Bureau of Emergency Medical Services, the Pennsylvania Emergency Health Service Council and the 16 regional emergency medical services councils; and be it further

RESOLVED, That the Joint State Government Commission explore enhancing the current system for the delivery of the Commonwealth's emergency medical system through the use of existing government and private sector programs, institutions, facilities and infrastructure resources and nationally recognized associations and organizations and that the

commission especially explore the feasibility of using the Commonwealth's many colleges and universities and community colleges, taking into account the availability of online services and courses and the use of adjunct professors; and be it further

RESOLVED, That the Joint State Government Commission examine the possibility of streamlining and restructuring the regional emergency medical services system and examine the feasibility of matching the regional emergency medical services councils to the current regional counter-terrorism zones within this Commonwealth to minimize the duplication of services and overlapping jurisdictions; and be it further

RESOLVED, That the Legislative Budget and Finance Committee prepare a comprehensive listing of both the expenditures of the Emergency Medical Services Operating Fund and a comprehensive listing of all compensation packages of all employees of the regional emergency medical services councils including the Pennsylvania Emergency Health Services Council; and be it further

RESOLVED, That both the committee and commission make recommendations for a more streamlined delivery model based on their findings; and be it further

RESOLVED, That the Joint State Government Commission develop legislation based on their findings; and be it further

RESOLVED, That both the committee and commission issue a joint report of their findings and recommendations to the Chief Clerk of the House of Representatives by ~~November 30, 2012~~ JUNE 30, 2013.

APPENDIX F

Response to This Report

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

September 19, 2013

Mr. Philip Durgin
Executive Director
Legislative Budget and Finance Committee
Room 400 Finance Building
613 North Street
Harrisburg, Pennsylvania 17105-8737

Dear Mr. Durgin,

Thank you for the draft copy of your report, *A Performance Audit of the Emergency Medical Services Operating Fund,* that was sent to Secretary of Health Michael Wolf, and also to me as the Deputy Secretary overseeing the Bureau of Emergency Medical Services.

We have reviewed the report and offer the responses below.

1. Establish parameters on the use of EMSOF funds for salaries and benefits.

While the Department agrees that it has a responsibility to monitor EMSOF funds, the Department does so through its grant process with each regional EMS council. Regional EMS councils are under grants from the Department to perform specific services as specified in their grant agreements. The authority for the Department to enter into grant agreements with regional EMS councils is derived from § 8112 of the EMS System Act, 35 Pa.C.S. § 8112. The regional EMS councils are designated as grantees mainly due to the fact that they provide services to the citizens of the Commonwealth as opposed to direct services to the state government. As such, the Department has entered into grants with 15 entities to serve as regional EMS councils. The grants specify the services that each council must perform as well as the budget that the councils have to perform those services. While regional EMS councils were created under the prior EMS Act and the current EMS System Act, regional EMS councils are governed by independent governing bodies that determine salaries, benefits, and other employee-related issues. So long as the regional EMS council is able to meet its obligations under the grant within the budget it is allocated, the Department does not dictate to any of its regional EMS councils parameters for salaries and benefits, as § 8112 of the EMS System Act permits regional EMS councils to use EMSOF funds for the payment of salaries without a limit as to what those salaries may be. The Department will note that it can refuse a budget item, but only if it is determined that it is beyond normal acceptable ranges. Were the Department to begin dictating salaries and benefits, then the

Department runs the risk of treating regional EMS councils as employees of the Commonwealth as opposed to grantees.

2. **DOH and PEHSC add greater specificity to the state EMS plan and incorporate the regional EMS plans into the statewide plan.**

The Department agrees with this recommendation and will note that the Department already requires this incorporation as part of the new regulations at § 1021.6(c). The Department plans to convene a workgroup of regional EMS council personnel, PEHSC representatives, and Bureau of EMS staff to review the current content and format of the state EMS plan, including incorporating regional EMS plans into the statewide EMS plan.

As part of the Department's new regulations, the Department has set forth parameters for the development and delivery of a statewide EMS plan. Within that regulation, § 1021.6, the Department will work with PEHSC to develop a statewide EMS plan. The plan will contain:

> (1) An inventory of EMS resources available in this Commonwealth.
>
> (2) An assessment of the effectiveness of the existing Statewide EMS system and a determination of the need for changes to the Statewide EMS system.
>
> (3) Performance measures for delivery of EMS to persons in this Commonwealth.
>
> (4) Methods to be used in achieving stated performance measures.
>
> (5) A schedule for achievement of the stated performance measures.
>
> (6) A method for monitoring and evaluating whether the stated statewide performance measures are being achieved.
>
> (7) Estimated costs for achieving the stated performance measures.

3. **DOH, in consultation with the Pennsylvania Emergency Health Services Council, incorporate additional factors into the regional EMS funding allocation decisions, including funds set aside for special projects.**

The Department has no issue with publicizing the process that it uses in distributing EMSOF funds with the assistance of PEHSC as deemed appropriate by the Department under PEHSC's statutorily created duties.

The Department is unclear as to the additional factors that the Committee proposes the Department consider.* Under the EMS System Act and the Department's regulations, and

*LB&FC Note: We recommended the Department consider the allocation factors enumerated in Act 37 and the Department's regulations (see p. S-9).

specifically § 1021.24(a), regional EMS councils are limited to using EMSOF funds for the following purposes:

(1) Providing public education, information, health promotion and prevention programs regarding EMS, including:

(i) Public education programs, instruction regarding call-taking and dispatching and how to access EMS systems.

(ii) Public information programs, including passenger and driver safety and EMS system awareness programs.

(iii) Health promotion programs, including wellness of EMS workforce and EMS safety programs that promote a culture of safe practices among EMS providers.

(iv) Prevention programs, including passenger restraint systems, prudent heart living and general health awareness, and safety practices to prevent errors in patient care and injuries to EMS providers.

(2) Purchasing ambulances, other EMS vehicles, medical equipment and rescue equipment which enables or enhances the delivery of EMS.

(i) Ambulances and other EMS vehicles will be considered for funding if the funds will be used for the initial acquisition of vehicles or parts, or the addition or replacement of existing vehicles or parts, by an EMS agency or an entity that qualifies for initial licensure as an EMS agency.

(ii) Medical equipment will be considered for funding if the funds will be used to purchase medical equipment for EMS agencies.

(iii) Rescue equipment will be considered for funding if the funds will be used to purchase rescue equipment for EMS agencies or rescue services recognized by the Department or the State Fire Commissioner.

(3) Conducting and ensuring the reasonable availability of training and testing programs for EMS providers. Priority consideration with respect to training will be given to training programs leading to the certification of EMS providers and the continuing education of EMS providers.

(4) Inspecting and investigating EMS agencies, educational institutes and medical facilities, and conducting other inspections and investigations to assist the Department in carrying out its regulatory responsibilities under the act.

(5) Purchasing communications equipment and services, including medical command communications equipment, and alerting equipment for EMS purposes.

(6) Purchasing equipment for emergency departments, if the equipment is used or intended to be used in equipment exchange programs with EMS agencies. The equipment purchased shall be of a type used by EMS agencies in the EMS provided to patients in a prehospital or interhospital setting. It shall be the type of equipment that can be easily or safely removed from the patient upon arrival or during treatment at a receiving facility.

(7) Maintaining and operating a regional EMS council. Items eligible for funding include:

(i) Salaries, wages and benefits of staff.

(ii) Travel.

(iii) Equipment and supplies.

(iv) Leasing office space.

(v) Other costs incidental to the conduct of the business of a regional EMS council which are found by the Department to be necessary and appropriate.

(8) Collecting and analyzing data necessary to evaluate the effectiveness of EMS systems in providing EMS and to administer quality improvement programs. These costs may include the processing of both prehospital and hospital data and include:

(i) Data collection.

(ii) Data entry.

(iii) Data processing of information.

(iv) Data analysis and evaluation.

(v) Data interpretation and dissemination.

(9) Facilitating the merger of EMS agencies or assisting an EMS agency to acquire another EMS agency when the Department determines circumstances exist to the extent that the transaction and financial assistance are needed to serve the public interest.

(10) Recruitment and retention of EMS providers by EMS agencies.

(11) Other costs determined by the Department to be appropriate and necessary for the implementation of a comprehensive regional EMS system.

In addition, pursuant to § 8112(d) of the Act and 28 Pa. Code § 1021.24(c), regional EMS councils are prohibited from using EMSOF funds for:

(1) Acquisition, construction or rehabilitation of facilities or buildings, except renovation as may be necessary for the implementation or modification of 911 and EMS communication systems.

(2) Purchase of hospital equipment, other than communications equipment for medical command and receiving facilities, unless the equipment is used or intended to be used in an equipment exchange program with EMS agencies.

(3) Maintenance of ambulances, other EMS vehicles and equipment.

(4) Costs deemed by the Department as inappropriate for carrying out the purposes of the act.

(5) Costs which are normally borne by patients, except for extraordinary costs as determined by the Department.

In providing transparency to the EMSOF allocation process, the Department publishes in the *Pennsylvania Bulletin* a list of EMSOF priorities for the coming fiscal year. The notice in the *Pennsylvania Bulletin*, listing funding priorities, is informational in nature. Notice in the *Pennsylvania Bulletin* of funding priorities alerts the regional EMS councils to areas of the Commonwealth's EMS system targeted for improvement through the process described below.

Each year, regional EMS councils are required to submit reports to the Department per the terms of their grant agreements with the Department. As part of these reports, the regional EMS councils are required to inform the Department of any new or existing issues that may require the Department's attention. Through these reports, the Department gains an understanding of possible shortcomings in the Commonwealth's EMS system. The Department uses notices in the *Pennsylvania Bulletin* to inform the EMS community, and the public at-large, of the Department's funding priorities for limited EMSOF funds. Notwithstanding notice of

funding priorities, use of EMSOF funds is limited to the criteria set forth in the EMS System Act, specifically 35 Pa.C.S. §§ 8112 and 8153, and the Department's regulations.

The Commonwealth's EMS system is very large in scope, with approximately 60,000 EMS providers and 1,650 EMS agencies. An ongoing concern of the Department is to make sure that rural areas are properly equipped to serve the needs of its citizens and to ensure that EMS providers respond in an appropriate amount of time to a patient in need. While rural areas may not have as many people as urban areas, geography and the number of calls received in rural areas play a factor in the allocation of EMSOF funds. The Department must ensure that these areas are adequately covered by qualified EMS personnel so that citizens know that their needs will be met in a timely manner. One of the Department's goals is to ensure that response times in rural areas are short even if geography plays a role in the number of EMS agencies in a given area.

4. The Department of Health commit to writing the process and decision factors used to allocate funds to the Pennsylvania Emergency Health Services Council.

The Department agrees with this overall recommendation. The Department will be evaluating all of its grantees and contractors and reviewing work statements in comparison to requested funding.

Concerning PEHSC, § 8108 of the EMS System defines the duties of the State Advisory Board to:

> (1) Elect officers.
>
> (2) Advise the department concerning manpower and training, communications, EMS agencies, content of regulations, standards and policies promulgated by the department under this chapter and other subjects deemed appropriate by the department.
>
> (3) Serve as the forum for discussion on the content of the Statewide EMS system plan, or any proposed revisions thereto, and advise the department as to the content of the plan.

In addition, § 8108 requires the Department to enter into a contract or grant with the State Advisory Board for performance of the above-cited responsibilities. The Department's contract with the State Advisory Board is a public document pursuant to § 8112(k)(1) and can be viewed at any time. This contract sets forth the agreement between the Department and PEHSC. Concerning funding, § 8108 provides that members of the board shall serve without compensation, except the Pennsylvania Emergency Health Services Council, through its contract with the Department, may pay necessary and reasonable expenses incurred by members of the Board while performing their official duties. The Department will review its contract with

PEHSC to ensure that the Department is providing for the payment of necessary and reasonable expenses as required under the EMS System Act.

5. **BEMS work to computerize records.**

The Department agrees with this recommendation. The Bureau of EMS will be assigning a staff person to be the lead person in working with the Change IT initiative from the Governor's office to upgrade and improve processes within the office. A portion of that project will be devoted to computerizing access to records.

6. **BEMS review the performance of regional councils, perhaps on a rotating basis as part of its contracting process.**

The Department agrees that it is important to provide frequent, useful, and on-going feedback as part of its duty in overseeing regional EMS councils. The Department already incorporates, through its regulations, a comprehensive annual oversight of regional EMS councils. To cite specific examples in the Department's regulations, § 1021.62 requires regional EMS councils to conduct an audit of the regional EMS systems per the terms of the grants that are entered into between the Department and the individual regional EMS councils. Currently, regional quality improvement committees must meet every 90 days and then have 30 days to submit a report to the Department.

In § 1021.103, the Department also requires that a regional EMS council's governing body post its annual report on the regional EMS council's website no later than 30 days after the end of the fiscal year, which is the same timeframe imposed by the grant agreement for regional EMS councils to submit annual reports to the Department. The annual reports must contain:

(1) Activities and accomplishments of the preceding year.

(2) A financial statement of income and expenses.

(3) A statement disclosing the names of officers and directors.

Further, the Department does review regional EMS councils' invoices and overall budgets to ensure that they are abiding by the terms of their grant agreement with the Department.

7. **BEMS prescribe a standard auditing format, including separate identification of EMSOF funded expenditures.**

The Department will work with its Comptroller and other subject matter experts to help define, as possible, a standard reporting format which will also be computerized. The Department would note that is follows Comptroller procedures, including auditing formats prescribed by the Comptroller, so the Department uses the format as given to it by the Comptroller. In addition, the Department would note that regional EMS councils either have

their own audits performed by virtue of their 501(c)(3) status or because they are part of a county government.

8. **DOH reconsider, with PEHSC's input, imposing restrictions on the use of income from the regional councils' secondary activities.**

The Department generally agrees with this recommendation and will request the advice of PEHSC within their statutorily specified duties under the EMS System Act. The Department would note that it is limited in its ability to proscribe secondary activity that is separate from regional EMS council duties, as that would be akin to treating regional EMS councils as employees of the Commonwealth instead of grantees as specified in § 8112. The grants entered into with the regional EMS councils require the councils to perform certain duties for the Department within a specified budget. Beyond that, the Department oversees regional EMS councils to make sure that any secondary activities do not conflict with their duties as regional EMS councils or otherwise creates the impression that EMSOF funds are being co-mingled with secondary activities. The Department already has plans to meet with regional EMS councils to ensure, and require them to provide, proof of separation of secondary activities, whether it be from separate accounts or through use of employees whose time is tracked and paid through the use of those secondary accounts. The Department hopes to have these procedures in place during the coming fiscal year.

9. **The General Assembly consider options to bolster EMSOF revenues.**

EMSOF fund sources are statutorily created under § 8153 of the EMS System Act. As such, the Department will continue to look to those sources of funding unless and until those sources are modified by the General Assembly.

Thank you for the opportunity to review the audit and make comments. Please do not hesitate to contact me if you have any questions. I can be reached at 717-783-8804.

Sincerely,

Martin Raniowski, MA
Deputy Secretary for
Health Planning and Assessment