



COMMONWEALTH OF PENNSYLVANIA  
PENNSYLVANIA PUBLIC UTILITY COMMISSION  
P.O. BOX 3265, HARRISBURG, PA 17105-3265

October 15, 1997

JOHN A PILLAR  
ATTORNEY AT LAW  
1106 FRICK BUILDING  
PITTSBURGH PA 15219

REFER TO OUR FILE

DOCKETED APPLICATION DOCKET  OCT 15 1997  ENTRY No. <u>72</u>
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In re: A-00114249 -Application of Non Profit Emergency Service of  
Beaver County, Inc., t/d/b/a Medic Rescue.

Dear Sir:

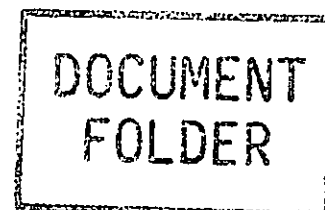
The above referenced application has been assigned for review without oral hearing. In order to reach a determination on the application, you are being required to file verified statements in accordance with 52 Pa. Code Section §3.381(e)(1). You will be required to file:

- A. VERIFIED STATEMENT OF APPLICANT
- B. VERIFIED STATEMENT(S) IN SUPPORT OF THE APPLICATION.

The verified statements should be in paragraph form. Each heading contained in the attached minimum outline should be a separate section or paragraph.

You should be aware of the fact that the verified statements will be reviewed based on the Commission's decision in the Application of Blue Bird Coach Lines, Inc., (A-00088807, F. 2, Am-K) 72 Pa. P.U.C. 262 (1990), which indicates: (1) the supporting witnesses must give evidence which is probative and relevant to the application proceeding; (2) the supporting witnesses must identify Pennsylvania origin and destination points between which they require transportation and those points must correspond with the scope of the operating territory specified in the application, including requests for vice versa authority; and (3) the number of witnesses which will represent a cross section of the public on the issue of need will vary with the breadth of the intended territory and commodity description.

You are being granted an initial thirty (30) days to file verified statements. They will be due on or before November 14, 1997.



If additional time is required, it may be requested by telephone but must be followed in writing with the reasons for the extension stated. Questions about the application should be directed to Tim Zeigler at 717-783-5946.

Very truly yours,

Tim Zeigler  
Technical Unit  
Bureau of Transportation & Safety



PILLAR · MULROY & FERBER

November 14, 1997

Re: Non Profit Emergency Service of  
Beaver County, Inc., t/d/b/a  
Medic Rescue  
Docket No. A-00114249  
File No. 2543

RECEIVED

NOV 14 1997

Hon. James J. McNulty, Acting Secretary  
Pennsylvania Public Utility Commission  
P. O. Box 3265  
Harrisburg, PA 17105-3265

PA PUBLIC UTILITY COMMISSION DOCKET  
PROTHONOTARY'S OFFICE

DOCKETED

NOV 19 1997

ENTRY No. 72

Dear Mr. McNulty:

We enclose for filing the original and one copy of **Verified Statements on Behalf of Applicant** in connection with the above docketed proceeding.

Please acknowledge receipt of the enclosures on the duplicate of this letter of transmittal and return it in the stamped, self-addressed envelope provided.

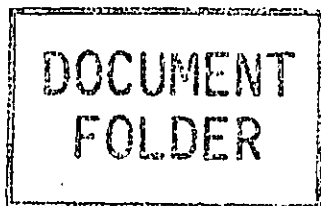
Very truly yours,

*John A. Pillar sw*

JOHN A. PILLAR

SW  
Enclosures  
cc: Medic Rescue (w/encl.)

U. S. POSTAL SERVICE CERTIFICATE OF MAILING ENCLOSED



846 NW 81 10115

PROFESSIONAL CORPORATION · ATTORNEYS  
1106 FRICK BUILDING · PITTSBURGH, PA 15219  
(412) 471-3300 - FAX: (412) 471-6068

107

Before the  
PENNSYLVANIA PUBLIC UTILITY COMMISSION

Application of  
NON PROFIT EMERGENCY SERVICE OF BEAVER COUNTY, INC.,  
t/d/b/a MEDIC RESCUE

Docket No. A-00114249

RECEIVED

NOV 14 1997

VERIFIED STATEMENTS ON BEHALF OF APPLICANT  
PROTHONOTARY'S OFFICE

DOCKETED  
APPLICATION DOCKET

NOV 19 1997

ENTRY No. 72

JOHN A. PILLAR, ESQ.  
Attorney for  
NON PROFIT EMERGENCY  
SERVICE OF BEAVER  
COUNTY, INC., t/d/b/a  
MEDIC RESCUE  
Applicant

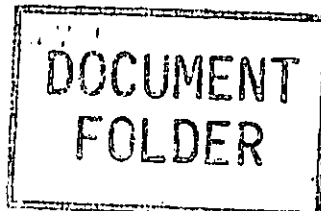
Pillar . Mulroy & Ferber, P.C.  
1106 Frick Building  
Pittsburgh, PA 15219  
412/471-3300

Due Date: November 14, 1997

NOV 16 8 1 AM '97

ADMINISTRATIVE

CLERK



Before the  
PENNSYLVANIA PUBLIC UTILITY COMMISSION

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Application of  
NON PROFIT EMERGENCY SERVICE OF BEAVER COUNTY, INC.,  
t/d/b/a MEDIC RESCUE

Docket No. A-00114249

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**INTRODUCTORY STATEMENT**

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By this application, Non Profit Emergency Service of Beaver County, Inc., t/d/b/a Medic Rescue, seeks authority as follows:

To transport, as a common carrier, persons, in paratransit service, between points in the County of Beaver, and from points in said County to points in the Counties of Allegheny, Butler, Lawrence and Washington, and return;

subject to the following conditions:

(1) that service is limited to the use of vehicles modified to handle wheelchairs, and is equipped and manned to provide certain medical procedures whether ongoing or emergency in nature;

(2) service is limited to the transportation of persons who are nonambulatory, or persons who, due to chronic or acute physical or mental conditions, require assistance in boarding or disembarking the vehicle, or medical monitoring, or the use of medical appliances or equipment, or an escort, including a driver certified to provide CPR and provide care at the level of a First Responder; and

(3) service is limited to persons who make advance reservations.

No protests were filed to this application and it stands unopposed. Applicant now submits its verified statements in support of its application.

**VERIFIED STATEMENT OF PATRICK M. SHERIN  
ON BEHALF OF NON PROFIT EMERGENCY SERVICE  
OF BEAVER COUNTY, INC., t/d/b/a  
MEDIC RESCUE**

**1. Legal Name and Domicile of Applicant**

Applicant is Non Profit Emergency Service of Beaver County, Inc., t/d/b/a Medic Rescue. The applicant has its principal place of business and domicile at 1019 Riverside Drive, Bridgewater, PA 15009. The applicant is a domestic, non-profit corporation organized under the laws of the Commonwealth of Pennsylvania.

**2. Identity and Qualifications of Person Making Statement**

My name and business address are Patrick M. Sherin, 1019 Riverside Drive, Bridgewater, PA 15009. I am the General Manager of Medic Rescue and I am also one of five members of the Board of Directors. I am responsible for the day-to-day operations and management of Medic Rescue. I am familiar with its equipment, facilities and personnel, and I am authorized to make this statement on behalf of Medic Rescue before the Pennsylvania Public Utility Commission.

**3. Applicant's Affiliations**

Neither the applicant nor any of its officers, directors or members, have any ownership or management interest in any other motor carrier.

**4. Authority Sought**

By this application, Medic Rescue seeks the following operating authority as published in the *Pennsylvania Bulletin*:

To transport, as a common carrier, persons, in paratransit service, between points in the County of Beaver, and from points in said County to points in the Counties of Allegheny, Butler, Lawrence and Washington, and return;

subject to the following conditions:

(1) that service is limited to the use of vehicles modified to handle wheelchairs, and is equipped and manned to provide certain medical procedures whether ongoing or emergency in nature;

(2) service is limited to the transportation of persons who are nonambulatory, or persons who, due to chronic or acute physical or mental conditions, require assistance in boarding or disembarking the vehicle, or medical monitoring, or the use of medical appliances or equipment, or an escort, including a driver certified to provide CPR and provide care at the level of a First Responder; and

(3) service is limited to persons who make advance reservations.

#### **5. General Scope of Currently Authorized Operations**

Medic Rescue presently holds no operating rights from the Pennsylvania Public Utility Commission nor from any other regulatory agency regulating transportation of passengers or property.

#### **6. Duplicating Authority Which Will Result From Grant of Authority**

No duplicating authority will result from the grant of the authority sought.

#### **7. Terminal Facilities and Communications Network**

Medic Rescue operates out of the following facilities and performs the functions indicated as to each facility below:

0415 11 21 11/15

- a. 313 Bridge Street (Borough of Bridgewater) Beaver, PA 15009. A brick building containing 6,000 square feet of one story garage space with 3,000 square feet of office space. The office space is 2 stories. **Functions:** Administration, supervision, accounts receivable, dispatch center for ambulances and wheelchair vans, housing of ambulances and wheelchair vans, training facility, decontamination facility, laundry facility and wash bay.
- b. 1019 Riverside Drive (Borough of Bridgewater) Beaver, PA 15009. A one story frame structure office containing 2,000 square feet. **Function:** Corporate activities, payroll and accounts payable.
- c. 1424 7th Avenue (City of Beaver Falls) Beaver Falls, PA 15010. A one store masonry structure with basement containing 6,000 square feet. The top floor is leased and the basement is self occupied. **Function:** Ambulance sub-station used solely for ambulance responses, either emergency or non-emergency.
- d. 936 Midland Avenue (Borough of Midland), Midland, PA 15059. A one story brick structure housing the Borough of Midland's offices, police department and fire department. Medic Rescue leases 1200 square feet on the west side of the building. **Function:** Ambulance sub-station used solely for ambulance responses, either emergency or non-emergency.

- e. 24th and Beaver Road (Harmony Township), Ambridge, PA 15003. A one story brick structure housing the Harmony Township Volunteer Fire Department. Medic Rescue leases 1600 square feet on the south side of the building. **Function:** Ambulance sub-station used solely for ambulance responses, either emergency or non-emergency.

The vehicles operated by Medic Rescue are dispatched through our central dispatch center by use of a 400 MX radio system. The equipment is owned by Medic Rescue and the frequency is leased from Crown Communications.

#### **8. Equipment**

There is attached to my statement as Appendix "A" a list of the equipment to be operated by Medic Rescue upon approval of this application. Appendix "A" consists of two pages. Page 1 is a list of all vehicles, including wheelchair vans. Page 2 is a list of Medic Rescue wheelchair vans which emphasize the particular type of equipment that will be used in connection with the proposed service. Each vehicle will be equipped with a wheelchair van lift, oxygen, and first-aid equipment. All of the equipment is owned by Medic Rescue. Medic Rescue employs 24 wheelchair van drivers. These drivers are either certified by the state of Pennsylvania as emergency medical technicians, or are in the process of being certified by the state of Pennsylvania as First Responders. Both certifications require classroom studies with demonstration of acquired skills and passing of a test. The courses are taught by certified instructors. These individuals are trained to perform

basic life support skills which include, but are not limited to, CPR, administration of oxygen, and first aid.

#### **9. Safety Program**

Medic Rescue has initiated many safety programs. The following is a brief analysis of these programs. All of the programs are in book form.

- a. Drivers Education - Each vehicle driver is required to take a 4 hour classroom instruction, a computerized test, driving with a certified instructor and passing an obstacle course test. In addition, a driver's manual has been prepared and each driver receives one.
- b. The company and the union have a Health & Safety Committee which discusses problems and resolves problems on a bi-monthly basis.
- c. Each employee is required to take lifting classes upon employment and annually thereafter.
- d. Each employee is required to take blood-borne and air-borne pathogen classes upon employment and annually thereafter.
- e. A number of standard operating procedures have been implemented to insure the protection of the employees.
- f. Vehicle maintenance is completed on each vehicle every 3,000 miles. The vehicle maintenance includes a PA state inspection plus oil and filter, checking all moving exterior parts for wear, and an interior inspection of gauges, safety equipment and wheelchair lift maintenance.

g. Although Medic Rescue does not have a PUC license, all aspects of DOT compliance are complied with.

**10. Service Currently Provided to Supporting Witnesses**

Medic Rescue has been providing wheelchair van service for a number of years to and from medical facilities only. We have had requests for transportation to other than medical facilities and we have had to deny them because we do not have a PUC license. Our county has almost 200,000 people, and approximately 38% of these people are senior citizens. Beaver County has over 2,000 beds allocated to personal and skilled care. Most of these people are feeble and require wheelchair van transportation. Their lives should not end when admitted to a nursing home. They should have the means to visit their families on holidays, go to weddings, funeral visits, and other functions or activities that are not medically related. At this time, there is no provider of these services in Beaver County which are sorely needed. Medic Rescue would like to fill this need.

**11. Type of Service Offered**

As explained in the preceding paragraph, Medic Rescue desires to provide service in specially equipped vehicles for the transportation of persons that require such service between points in Beaver County, and from points in Beaver County, to points in the Counties of Allegheny, Butler, Lawrence and Washington, and return. Medic Rescue has determined that there is a need for this service based on requests that we have received and our perception of the needs for this service and the lack of available


transportation. Medic Rescue has been in business continually since 1978. The business conducted has been solely the transportation of the sick and injured by ambulance and the transportation of the sick to and from medical facilities by wheelchair van. We have the equipment and personnel available to expand this service to provide a more comprehensive service to the public for those who require specialized equipment and special services.

**12. Financial Data**

There is attached to my statement as Appendix "B", a copy of the financial statements of the applicant, including a balance sheet as of September 30, 1996, and an income statement for the 12 month period ending September 30, 1996. These statements are also compared to a balance sheet and income statement for a comparable period of 1995.

The undersigned deposes and says that he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Date: Nov 10, 1997

  
\_\_\_\_\_  
Patrick M. Sherin

MEDIC RESCUE VEHICLE LIST

<u>UNIT NO.</u>	<u>YEAR</u>	<u>MAKE</u>	<u>TYPE</u>	<u>MODEL</u>	<u>VIN NO.</u>	<u>INS.</u>
1	1992	FORD	II	HORTON	1FDJS34M1NHA51198	YES
2	1994	FORD	III	HORTON	1FDJE30M6RHB41983	YES
3	1992	FORD	II	HORTON	1FDJS34MXNHA51197	YES
4	1992	FORD	II	HORTON	1FDJS34M3NHA51199	YES
5	1997	FORD	II	MED TECH	1FDJE30F7VHB22841	YES
6	1992	FORD	II	HORTON	1FDJS34M6NHA51200	YES
7	1997	FORD	II	MED TECH	1FDJE30F9VHB22842	YES
8	1993	FORD	III	HORTON	1FDJE30M8PHB07542	YES
9	1992	FORD	II	HORTON	1FDJS34M1NHA51203	YES
10	1990	FORD	II	WC	1FDHS34MXLHB48153	YES
11	1994	FORD	III	HORTON	1FDJE30M8RHB41984	YES
12	1994	FORD	III	HORTON	1FDJE30MXRHB41985	YES
14	1996	FORD	III	MED TECH	1FDJE30FXTHA78217	YES
15	1996	FORD	III	MED TECH	1FDJE30F1THA78218	YES
19	1988	FORD	II	WC	1FDHS34M7JHA83775	YES
20	1979	FORD	III	GRUMMIN	E37AHDE2246	NO
24	1991	CHEV	SUB.	JB RESCUE	1GCGV26K3MF110709	YES
27	1989	FORD	II	WC	1FDHS34M6KHC12851	YES
28	1989	FORD	II	WC	1FDHS34M6KHC39144	YES
29	1989	FORD	II	WC	1FDHS34M4KHC39143	YES
30	1991	FORD	VAN	WHEEL CHAIR	1FBJS31H9MHB08410	YES
31	1992	FORD	VAN	WHEEL CHAIR	1FBJS31HXNHA97127	YES
32	1994	FORD	VAN	WHEEL CHAIR	1FDEE14N5KHB88558	YES
33	1995	CHEV	VAN	WHEEL CHAIR	1GAGG35K3SF132295	YES
34	1995	CHEV	VAN	WHEEL CHAIR	1GNEG25K1SF148821	YES
35	1997	FORD	VAN	WHEEL CHAIR	1FTHE2420VHA69341	YES
CAR 1	1992	FORD	SEDAN	SKIP	2FACP74W8NX175496	YES
CAR 3	1988	FORD	SEDAN	FLEET	2FABP74F8JX143632	YES
CAR 4	1989	CHEV	SEDAN	FLEET	1G1BN51EOKR159979	YES
EMOC	1985	SHIOLENE	TRAILER	HORTON	67128520421	YES
TRUCK	1992	GMC	TRACTOR	MR	1GDJ6H1J2NJ521713	YES

## MEDIC RESCUE WHEEL-CHAIR VAN LIST

<u>UNIT #</u>	<u>YEAR</u>	<u>MAKE</u>	<u>TYPE</u>	<u>MODEL</u>	<u>VIN #</u>	<u>PLATE #</u>
30	1991	FORD	VAN	WHEEL CHAIR	1FBJS31H9MHB08410	ABP4878
31	1992	FORD	VAN	WHEEL CHAIR	1FBJS31HXNHA97127	ALT8064
32	1994	FORD	VAN	WHEEL CHAIR	1FDEE14N5KHB88558	ATN9955
33	1995	CHEV	VAN	WHEEL CHAIR	1GAGG35K3SF132295	BBW8972
34	1995	CHEV	VAN	WHEEL CHAIR	1GNEG25K1SF148821	BDS1633
35	1997	FORD	VAN	WHEEL CHAIR	1FTHE2420VHA69341	BHA8960

MEDIC RESCUE  
BEAVER FALLS, PENNSYLVANIA

FINANCIAL STATEMENTS  
SEPTEMBER 30, 1997

MEDIC RESCUE  
BALANCE SHEETS  
SEPTEMBER 30, 1997

ASSETS

	THIS YEAR -----	LAST YEAR -----
CURRENT ASSETS		
CASH ON HAND	136.71	136.71
CASH IN SAVINGS	116,105.72	65,012.01
CASH - CERTIFICATE OF DEPOSIT	500,000.00	300,000.00
CASH - PAYROLL	63.52	369.81
CASH - GENERAL	44,185.31	23,204.76
CASH APPROPRIATED	732.60	0.00
	-----	-----
BILLINGS	4,433,816.05	1,318,499.45
LESS DOUBTFUL ACCOUNTS	3,983,555.09	632,879.74
	-----	-----
NET ACCOUNTS RECEIVABLE	450,260.96	685,619.71
ACCOUNTS RECEIVABLE - OTHER	333.00	18,208.00
ACCOUNTS RECEIVABLE - EMPLOYEES	2,023.02	1,580.48
INTEREST RECEIVABLE	0.00	3,614.75
PREPAID EXPENSES	41,613.58	35,031.70
SUPPLIES ON HAND	16,136.82	16,136.82
	-----	-----
TOTAL CURRENT ASSETS	1,173,591.25	1,148,911.75
	-----	-----

(continued)

PROPERTY, PLANT AND EQUIPMENT

VEHICLES

LESS ACCUMULATED DEPRECIATION

THIS YEAR      LAST YEAR

-----  
965,942.21      967,242.21  
685,104.35      569,468.94

-----  
280,837.86      397,773.27

COMMUNICATION EQUIPMENT

LESS ACCUMULATED DEPRECIATION

-----  
317,989.60      317,989.60  
305,256.09      282,957.92

-----  
12,733.51      35,031.68

OTHER FIXED ASSETS

LESS ACCUMULATED DEPRECIATION

-----  
1,290,405.91      1,059,757.55  
879,573.63      587,167.51

-----  
610,832.28      472,590.04

TOTAL PROPERTY, PLANT & EQUIPMENT

-----  
904,403.65      905,394.99  
-----

OTHER ASSETS

LAND

LOANS RECEIVABLE

UTILITY DEPOSIT

INVESTMENT - MRHC/FLEET

GOODWILL

LESS AMORTIZATION

10,836.23      10,836.23

364,397.37      342,372.52

2,400.00      2,400.00

67,288.00      67,288.00

28,431.00      28,431.00

28,431.00      28,431.00

TOTAL OTHER ASSETS

-----  
444,921.60      422,896.76  
-----

TOTAL ASSETS

-----  
2,522,916.50      2,477,206.50  
-----

(continued)

LIABILITIES

THIS YEAR  
-----  
LAST YEAR  
-----

CURRENT LIABILITIES

NOTES PAYABLE - CURRENT	73,773.72	42,270.20
MORTGAGE - CURRENT PORTION	19,648.91	19,648.91
ACCOUNTS PAYABLE	157,151.49	81,873.87
UNION DUES PAYABLE	17.75	1,484.82
EMPLOYEE 401K PAYABLE	55.00	709.54
WAGES PAYABLE	43,885.50	33,570.18
TAXES PAYABLE:		
FICA AND FEDERAL INCOME	34,785.63	16,757.61
STATE INCOME	1,609.81	1,398.92
LOCAL	1,379.49	3,536.84
PA UNEMPLOYMENT COMPENSATION	6,426.40	2,323.68
OPT	130.00	0.00
TOTAL TAXES PAYABLE	47,421.36	24,017.05
OTHER PAYROLL DEDUCTIONS	19.39	19.39

TOTAL CURRENT LIABILITIES

341,937.62  
-----  
202,174.88  
-----

LONG-TERM DEBT

NOTES PAYABLE	155,921.03	72,264.35
MORTGAGE PAYABLE	174,438.64	192,443.31

TOTAL LONG-TERM DEBT

330,359.67  
-----  
264,707.66  
-----

DEFERRED CHARGES TO INCOME

DEFERRED SUBSCRIPTIONS	107,636.92	109,380.37
------------------------	------------	------------

TOTAL DEFERRED CHARGES TO INCOME

107,636.92  
-----  
109,380.37  
-----

TOTAL LIABILITIES & DEFERRED CHARGES TO INCOME

779,934.21  
-----  
576,262.91  
-----

EQUITY

RETAINED EARNINGS - BEGINNING		
UNAPPROPRIATED	1,900,943.59	1,900,943.59
NET INCOME/LOSS TO DATE	157,961.30	349,752.76

RETAINED EARNINGS - ENDING

1,742,982.29  
-----  
2,250,697.35  
-----

TOTAL LIABILITIES AND EQUITY

2,522,916.50  
-----  
2,826,960.26  
-----

MEDIC RESCUE  
STATEMENTS OF INCOME  
12 MONTHS ENDED SEPTEMBER 30, 1997

	CURR MON. THIS YEAR	SAME MON. LAST YEAR	Y.T.D. THIS YEAR	Y.T.D. LAST YEAR
	-----	-----	-----	-----
REVENUE				
SERVICE REVENUE:				
DIRECT BILLINGS	595,187.18	564,925.86	7,115,529.87	6,920,918.57
DONATIONS	200.00	200.00	645.00	545.00
TOTAL SERVICE REVENUE	595,387.18	565,125.86	7,116,174.87	6,921,463.57
SUBSCRIPTION FEES	35,188.18	37,053.69	413,966.46	441,348.50
REBATE - SUBSCRIPTION FEES	0.00	0.00	382.50	332.50
RENTAL INCOME	910.67	910.67	10,928.04	10,928.04
INTEREST INCOME	5,376.84	29,692.67	16,675.10	39,746.62
SALES OF EQUIPMENT	38,400.00	9,707.92	44,100.00	8,843.92
OTHER	2,589.85	26,100.54	11,107.29	30,552.30
TOTAL REVENUE	677,852.72	649,175.51	7,612,569.26	7,434,862.62
BILLING LOSSES				
LOSSES - DIRECT BILLINGS	372,306.19	121,746.25	3,238,574.86	2,997,716.02
REBATES - DIRECT BILLINGS	2,404.13	1,958.31	14,067.19	11,829.08
TOTAL BILLING LOSSES	274,710.32	123,704.56	3,252,642.05	3,009,545.10
NET REVENUE	403,142.40	525,470.95	4,359,927.21	4,425,317.52
COST OF OPERATIONS				
ADVERTISING	13,893.05	14,023.17	136,565.37	89,592.56
ADVERTISING - YELLOW PAGES	775.25	693.25	8,860.00	7,189.00
ADVERTISING - MEMBERSHIPS	0.00	0.00	0.00	1,216.00
AMORTIZATION	0.00	462.37	0.00	462.37
BANK CHARGES	97.28	35.11	1,466.98	962.24
COLLECTION FEES	1,601.29	2,762.96	25,100.34	26,623.14
DEPRECIATION	19,245.76	20,118.06	230,359.70	232,547.42
DIRECTOR FEES	2,064.64	1,825.60	24,089.04	19,628.17
DUES & SUBSCRIPTIONS	339.97	23.97	3,448.32	3,469.38
EDUCATION & SEMINARS	500.00	665.51	10,001.87	14,516.76
GENERAL REPAIRS & MAINTENANCE	6,020.35	1,961.37	51,057.11	40,942.73
COMPUTER REPAIRS & MAINTENANCE	1,786.55	1,995.35	20,623.15	18,634.78
INSURANCE	7,960.92	1,147.96	90,322.12	111,836.65
INTEREST EXPENSE	4,514.67	5,074.99	32,581.53	28,211.04
LAUNDRY	85.48	0.00	780.35	508.94

(continued)

	CITY MON. THIS YEAR	SAME MON. LAST YEAR	T.T.D. THIS YEAR	T.T.D. LAST YEAR
LEASING - OFFICE EQUIPMENT	508.00	0.00	1,319.50	0.00
MISCELLANEOUS	13,596.90	3,897.38	66,800.97	53,995.98
PENALTIES	0.00	0.00	0.00	1,114.40
PETTY CASH	200.00	100.63	2,538.58	2,421.61
POSTAGE	917.23	1,518.20	17,451.79	13,619.40
POSTAGE - MEMBERSHIP	11,260.00	1,000.00	27,416.13	12,354.19
PRINTING	459.40	890.50	12,523.46	8,943.60
PRINTING - MEMBERSHIP	0.00	0.00	39,040.26	26,511.05
PROFESSIONAL SVCS. - ATTORNEY	4,320.54	0.00	20,402.60	1,891.04
PROFESSIONAL SERVICES - ACCTG.	0.00	0.00	24,074.69	23,095.00
PROFESSIONAL SVCS. - COMPUTER	0.00	646.00	16,661.00	8,852.00
PROFESSIONAL SERVICES - OTHER	68,249.06	67,507.16	988,674.35	967,271.29
PROFESSIONAL SVCS.-BUS. DEVL.	9,732.11	9,191.78	79,547.46	74,502.15
RADIO EQUIPMENT	1,570.09	279.00	16,774.18	7,623.37
RADIO REPAIRS	561.90	252.00	4,918.49	5,408.89
RENT EXPENSE	1,178.00	1,723.00	16,385.52	20,676.00
SUPPLIES - MEDICAL	10,900.78	20,956.82	126,465.03	87,621.86
SUPPLIES - OFFICE	957.89	409.51	19,565.27	15,636.62
TAXES - PROPERTY	0.00	0.00	13,870.93	12,772.07
TELEPHONE	3,377.03	3,065.94	37,096.98	34,744.41
TRAVEL	1,681.85	3,012.83	12,126.01	14,378.18
TRAVEL - MILEAGE	0.00	32.82	117.54	746.89
UTILITIES	2,189.81	2,327.13	26,691.55	29,188.75
VEHICLE EXPENSE:				
FUEL AND OIL	9,824.18	11,524.55	90,022.87	65,475.68
OTHER	1,100.00	12,388.00	6,975.67	7,587.90
REPAIRS & MAINTENANCE	29,707.40	15,408.41	246,630.58	217,449.96
TIRES	0.00	1,822.00	11,862.00	14,636.29
TOTAL VEHICLE EXPENSE	40,631.58	16,366.96	355,491.12	305,149.83
EMPLOYEE COSTS:				
WAGES	132,306.08	108,798.47	1,485,012.13	1,280,818.75
EMPLOYEE BENEFITS - CLOTHING	4,123.19	1,073.27	33,325.43	19,836.84
EMPLOYEE BENEFITS - HEALTH	20,643.24	21,560.02	150,775.91	184,328.34
EMPLOYEE BENEFITS - DEDUCTIBLE	1,412.08	347.87	16,645.34	14,475.98
EMPLOYER PAID MEDICAL	4,070.00	0.00	10,247.50	2,258.00
401K EMPLOYER PAID CONTRIBUTION	2,094.58	2,895.03	18,518.88	25,431.73
PARAMEDIC TUITION REIMB.	0.00	0.00	700.00	0.00
INSURANCE - WORKMEN'S COMP	9,100.00	9,949.00	91,813.00	98,749.00
TAXES - OTHER	0.00	0.00	788.63	96.39
TAXES - PAYROLL	11,354.98	8,980.90	148,872.41	124,689.97
TOTAL COST OF EMPLOYEES	184,504.15	153,894.56	1,956,699.23	1,750,685.00
TOTAL COST OF OPERATIONS	415,681.53	335,662.97	4,517,888.51	4,075,563.76
NET INCOME/LOSS (-)	12,539.13	189,807.98	157,961.30	349,753.76

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF HARRIET POPOWICH

1. Name and residence address: 750 HOENIG RD  
BADEA, PA, 15005

2. Name of employer and/or occupation and business address:  
RETIRED

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? YES If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance.
- b. Confined to wheelchair.
- c. Need medical monitoring during transit.
- d. Need use of medical appliances or equipment during transit.
- e. Need service of or escort during transit.
- f. Need driver certified to provide CPR or First Responder care level during transit.
- g. State any other reason relating to a chronic or acute physical or mental condition. OXYGEN  
24 HRS

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. WHEELCHAIR OXYGEN

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) ECONOMY BORO

6. State the destinations to which service is needed? (Please state city or town.) SEWICKLEY MOON TWP

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 3 X A MONTHS
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: WHEEL CHAIR VAN WITH LIFT.
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
DOCTOR SOCIAL SHOPPING
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). NO  
PROVIDED GOOD VAN SERVICE,
12. State any other factor that is important to you.  
IF VAN WAS NOT AVAILABLE I WOULD  
NEEDED AN AMBULANCE.

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Harriet J Popowich  
(Signature)

HARRIET POPOWICH  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF DENISE Y. HOSEY

1. Name and residence address: Denise Y. Hosey  
230 Midland Ave. #10 Midland, Pa. 15059

2. Name of employer and/or occupation and business address:  
NA.

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? yes If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. ✓
- b. Confined to wheelchair. \_\_\_\_\_
- c. Need medical monitoring during transit. \_\_\_\_\_
- d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
- e. Need service of or escort during transit. \_\_\_\_\_
- f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
- g. State any other reason relating to a chronic or acute physical or mental condition. Total hip replacement that has not healed

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_  
NA

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) \_\_\_\_\_  
Midland PA

6. State the destinations to which service is needed? (Please state city or town.) Alleghany General Hospital  
Pittsburgh.

7. State the number of times (per week, month) that you will need the service of Medic Rescue. About Twice a month
8. Describe public transport service now available comparable to the proposed service, if any: No public transportation in Midland. There's a door to door shuttle service that will take passengers only to appointments in the Beaver Co. area.
9. Describe type of vehicle you need to transport you, including special features required: ~~Van~~ Van with wheelchair lift
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other). At the present I only use it for my doctor visits in Pittsburgh. But in the future I would like to ~~be~~ be able to use it for family, shopping, and social visits.
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). I use Medic Rescue because there is no other <sup>transport</sup> service that will accommodate me to Pittsburgh.
12. State any other factor that is important to you. I would like to know that the Medic Rescue Wheelchair Van service will provide transportation to ~~emergency~~ other places other than my doctor's appts.

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Ms Denise Y. Hosey  
(Signature)

Denise Y. Hosey  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Pamela Yoho

1. Name and residence address: Baden Pa 246 Oak Street
2. Name of employer and/or occupation and business address:  
Disabled
3. Do you require paratransit transportation service such as is proposed by Medic Rescue? Yes If yes, indicate the reasons you need this service by checking the applicable items below:
  - a. Cannot walk or board or disembark vehicle without assistance. ✓
  - b. Confined to wheelchair. ✓
  - c. Need medical monitoring during transit. \_\_\_\_\_
  - d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
  - e. Need service of or escort during transit. \_\_\_\_\_
  - f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
  - g. State any other reason relating to a chronic or acute physical or mental condition. Seizure disorder
4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_
5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) Baden
6. State the destinations to which service is needed? (Please state city or town.) Sewickley, Beaver Med Center.

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 1-2 month
8. Describe public transport service now available comparable to the proposed service, if any: Taxi - if able
9. Describe type of vehicle you need to transport you, including special features required: Ambulance / w/c. van
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
Hospital visits / PR visits  
Doctor visits  
shopping
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). yes - member
12. State any other factor that is important to you.  
Someone who could do shopping for

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Pamela Yoko  
 (Signature)

Pamela Yoko  
 (Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Jane Ross - Nursing Unit Coordinator

1. Name and residence address: Beaver Valley Nursing & Rehab Center  
257 Georgetown Road, Beaver Falls, PA

2. Name of employer and/or occupation and business address:

same as ↑

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? yes If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. ✓
- b. Confined to wheelchair. ✓
- c. Need medical monitoring during transit. ✓
- d. Need use of medical appliances or equipment during transit. ✓
- e. Need service of or escort during transit. ✓
- f. Need driver certified to provide CPR or First Responder care level during transit. ✓
- g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_

wheelchair, O<sub>2</sub> (Oxygen)

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) \_\_\_\_\_

South Beaver

6. State the destinations to which service is needed? (Please state city or town.) \_\_\_\_\_

at times Beaver County also Allegheny County

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 31

8. Describe public transport service now available comparable to the proposed service, if any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Describe type of vehicle you need to transport you, including special features required: WC van w/ lift

10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
All of above also wedding, funerals

11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). we use Medic Rescue WC van + stretcher (ambulance services) quite often

12. State any other factor that is important to you. \_\_\_\_\_  
Peace of mind that patients are safe during transfers. for needs stated above!

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Jane Ross  
(Signature)

Jane Ross  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Lucille A. Jonas

1. Name and residence address: 116 1st AVE.  
HIGHLAND ACRES, MIDLAND, PA 15059

2. Name of employer and/or occupation and business address:  
RETIRED

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? YES If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. \_\_\_\_\_
- b. Confined to wheelchair. \_\_\_\_\_
- c. Need medical monitoring during transit.
- d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
- e. Need service of or escort during transit.
- f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
- g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) \_\_\_\_\_  
OHIOVILLE

6. State the destinations to which service is needed? (Please state city or town.) \_\_\_\_\_  
CHIPPewa

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 12 times a month
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: WHEELCHAIR VAN LIFT
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other). SHOPPING - DOCTOR VISITS
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). YES
12. State any other factor that is important to you. IMPORTANT TO ME BECAUSE I LIVE ALONE

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Lucille A. Jonas  
(Signature)

Lucille A. JONAS  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF

Eric W. Flanagan

1. Name and residence address: 2001 Washington St West  
Aly. Pa. 15001 Aly

2. Name of employer and/or occupation and business address:  
Retired

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? Yes If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. \_\_\_\_\_
- b. Confined to wheelchair. \_\_\_\_\_
- c. Need medical monitoring during transit. \_\_\_\_\_
- d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
- e. Need service of or escort during transit. \_\_\_\_\_
- f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
- g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_  
HOPEWELL ALIQUIPPA

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) \_\_\_\_\_  
HOPEWELL ALIQUIPPA

6. State the destinations to which service is needed? (Please state city or town.) SEWICKLEY

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 3
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: Wheel Chair VAN LIFT
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). 911 emergencies
12. State any other factor that is important to you.

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Steve Harvan  
(Signature)

STEVE HARVAN  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Trinity Oaks Care Center  
1. Name and residence address: Nancy Simmons - Owner Chapel Rd Box 585  
Beaver - Pa. 15009

2. Name of employer and/or occupation and business address:

Same as 1

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? YES If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. yes
- b. Confined to wheelchair. yes
- c. Need medical monitoring during transit. yes
- d. Need use of medical appliances or equipment during transit. yes
- e. Need service of or escort during transit. yes
- f. Need driver certified to provide CPR or First Responder care level during transit. yes
- g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_

Oxygen -

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) \_\_\_\_\_

Beaumont Twp.

6. State the destinations to which service is needed? (Please state city or town.) \_\_\_\_\_

Beaver County

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 10 per month
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: W/C VAN
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other). DOCTOR VISITS
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). we use their service frequently
12. State any other factor that is important to you.

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Nancy Simmons  
 (Signature)  
NANCY SIMMONS  
 (Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF EMOGENE WALTERS

1. Name and residence address: 343-WAYNE STREET  
BADEN PA. 15005

2. Name of employer and/or occupation and business address:

NONE

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? YES If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance.
- b. Confined to wheelchair.
- c. Need medical monitoring during transit.
- d. Need use of medical appliances or equipment during transit.
- e. Need service of or escort during transit.
- f. Need driver certified to provide CPR or First Responder care level during transit.
- g. State any other reason relating to a chronic or acute physical or mental condition. UNABLE TO WALK

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) \_\_\_\_\_

BADEN

6. State the destinations to which service is needed? (Please state city or town.) Ambridge Swickley

7. State the number of times (per week, month) that you will need the service of Medic Rescue. \_\_\_\_\_
8. Describe public transport service now available comparable to the proposed service, if any: NONE  
\_\_\_\_\_  
\_\_\_\_\_
9. Describe type of vehicle you need to transport you, including special features required:  
~~Wheel Chair~~ Wheel Chair VAN  
\_\_\_\_\_
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
Unable To Transport IN CAR.  
\_\_\_\_\_  
\_\_\_\_\_
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). ~~USE~~  
Emergency Provider.  
\_\_\_\_\_
12. State any other factor that is important to you. \_\_\_\_\_  
Need The AVAILABILITY of This  
Transport Vehicles.  
\_\_\_\_\_  
\_\_\_\_\_

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Erin Jones  
(Signature)

Judy Jones POA  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF BERTHA HUUD

1. Name and residence address: BERTHA HUUD  
2007 FORGE DRIVE ALIQUIPPA PA 15001
2. Name of employer and/or occupation and business address:  
RETIRED
3. Do you require paratransit transportation service such as is proposed by Medic Rescue? \_\_\_\_\_ If yes, indicate the reasons you need this service by checking the applicable items below:
  - a. Cannot walk or board or disembark vehicle without assistance. \_\_\_\_\_
  - b. Confined to wheelchair. \_\_\_\_\_
  - c. Need medical monitoring during transit. \_\_\_\_\_
  - d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
  - e. Need service of or escort during transit. \_\_\_\_\_
  - f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
  - g. State any other reason relating to a chronic or acute physical or mental condition. Problem  
with the left leg & left arm
4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. \_\_\_\_\_
5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) Hopewell Twp.
6. State the destinations to which service is needed? (Please state city or town.) Doctors office in Hopewell  
And Hospital in Aliquippa

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 3 TIMES A MONTH
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: WHEEL CHAIR
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
DOCTOR VISIT
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). yes
12. State any other factor that is important to you. \_\_\_\_\_

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Bertha Huud  
(Signature)

BERTHA HUUD  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Charles Magestro

1. Name and residence address: 1515-3rd Ave. - Apx 5-C  
New Brighton, Pa. 15866

2. Name of employer and/or occupation and business address:  
Retired

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? yes If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. \_\_\_\_\_
- b. Confined to wheelchair. \_\_\_\_\_
- c. Need medical monitoring during transit. \_\_\_\_\_
- d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
- e. Need service of or escort during transit. \_\_\_\_\_
- f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
- g. State any other reason relating to a chronic or acute physical or mental condition \_\_\_\_\_  
Congestive heart failure  
General weakness

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. nd

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.)  
New Brighton, Pa.

6. State the destinations to which service is needed? (Please state city or town.) Brighton, Pa  
Medical Center,

7. State the number of times (per week, month) that you will need the service of Medic Rescue. once a wk
8. Describe public transport service now available comparable to the proposed service, if any: None
9. Describe type of vehicle you need to transport you, including special features required: Wheelchair Van
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
Doctor Visits, & Medical Center
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). We do need it for Emergencies.
12. State any other factor that is important to you.  
Service of this type is wauld be needed in Beaker County

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Charles Magestro  
(Signature)

CHARLES MAGESTRO  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF PATRICIA PFEITZER

1. Name and residence address: New Sheffield Manor  
1916 Main St Aliquippa Pa 15001

2. Name of employer and/or occupation and business address:  
Personal Care Home  
1916 Main St  
Aliquippa Pa 15001

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? Yes If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. ✓
- b. Confined to wheelchair. ✓
- c. Need medical monitoring during transit. ✓
- d. Need use of medical appliances or equipment during transit. ✓
- e. Need service of or escort during transit. ✓
- f. Need driver certified to provide CPR or First Responder care level during transit. ✓
- g. State any other reason relating to a chronic or acute physical or mental condition. Blind or can't walk or move w/o by them self

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. Oxygen

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) Aliquippa

6. State the destinations to which service is needed? (Please state city or town.) Beaver County

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 6 x month
8. Describe public transport service now available comparable to the proposed service, if any: None
9. Describe type of vehicle you need to transport you, including special features required: W/C lift, Gen. Chair
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
Doctor visit, transport to Hospital
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). yes (only)
12. State any other factor that is important to you.  
Trained & Careful Staff

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Patricia Pfeiffer  
(Signature)

Patricia Pfeiffer  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Rochester Manor

1. Name and residence address: JILL MILLER, ADM. DIRECTOR  
174 VIRGINIA AVE., ROCHESTER, PA 15074
2. Name of employer and/or occupation and business address:  
Rochester Manor  
174 Virginia Ave  
Rochester, PA 15074
3. Do you require paratransit transportation service such as is proposed by Medic Rescue? yes If yes, indicate the reasons you need this service by checking the applicable items below:
  - a. Cannot walk or board or disembark vehicle without assistance. ✓
  - b. Confined to wheelchair. ✓
  - c. Need medical monitoring during transit. ✓
  - d. Need use of medical appliances or equipment during transit. ✓
  - e. Need service of or escort during transit. ✓
  - f. Need driver certified to provide CPR or First Responder care level during transit. ✓
  - g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_
4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require.  
oxygen, walkers, canes, leg braces,  
residents & hip precautions
5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.)  
The medical center-Beaver upmc-Beaver Valley  
Local Dr. Offices thruout the county
6. State the destinations to which service is needed? (Please state city or town.)  
Dr. office appointment  
(specialists), hospital, xraus, extensive  
studies (doppler, CT scan.) BEAVER COUNTY

7. State the number of times (per week, month) that you will need the service of Medic Rescue. - 15 X 5 a week
8. Describe public transport service now available comparable to the proposed service, if any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Describe type of vehicle you need to transport you, including special features required: - Van with wheelchair lift.  
\_\_\_\_\_  
\_\_\_\_\_
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
family unable to take them, due to work schedule, inability to get them in & out of car)  
DOCTOR VISITS
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). YES - Hospital.  
Emergencies, 911 calls
12. State any other factor that is important to you. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Jill Miller  
(Signature)

Jill Miller  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Autumn Lane of Aliquippa

1. Name and residence address: Diana Oblinger, RN  
1521 Kennedy Blvd. Alio PA 15001
2. Name of employer and/or occupation and business address:  
Dotter Family Corporation
3. Do you require paratransit transportation service such as is proposed by Medic Rescue? Yes If yes, indicate the reasons you need this service by checking the applicable items below:
  - a. Cannot walk or board or disembark vehicle without assistance.
  - b. Confined to wheelchair.
  - c. Need medical monitoring during transit.
  - d. Need use of medical appliances or equipment during transit.
  - e. Need service of or escort during transit.
  - f. Need driver certified to provide CPR or First Responder care level during transit.
  - g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_
4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. Oxygen
5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) Aliquippa
6. State the destinations to which service is needed? (Please state city or town.) Beaver County, ALIQUIPPA

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 15 times / month (5) patients
8. Describe public transport service now available comparable to the proposed service, if any: NA
9. Describe type of vehicle you need to transport you, including special features required: Wheel chair van lift.
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
DR VISITS
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). Yes
12. State any other factor that is important to you.  
IT IS IMPORTANT TO HAVE PROFESSIONAL + knowledgeable staff during transport of our RESIDENTS.

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Diana Oblinger RN  
(Signature)

DIANA OBLINGER, RN  
(Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF Blair Personal Care, RAY McMURDY, MGR.

1. Name and residence address: 1031 MERCUR RD  
BEAVER FALLS, PA 15010

2. Name of employer and/or occupation and business address:  
\_\_\_\_\_  
\_\_\_\_\_

3. Do you require paratransit transportation service such as is proposed by Medic Rescue? YES If yes, indicate the reasons you need this service by checking the applicable items below:

- a. Cannot walk or board or disembark vehicle without assistance. \_\_\_\_\_
- b. Confined to wheelchair. \_\_\_\_\_
- c. Need medical monitoring during transit. \_\_\_\_\_
- d. Need use of medical appliances or equipment during transit. \_\_\_\_\_
- e. Need service of or escort during transit. \_\_\_\_\_
- f. Need driver certified to provide CPR or First Responder care level during transit. \_\_\_\_\_
- g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_  
\_\_\_\_\_

4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. Oxygen

5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.)  
Beaver Falls North Sewickley

6. State the destinations to which service is needed? (Please state city or town.)  
Beaver County  
BEAVER FALLS, BEAVER,  
NEW BRIGHTON

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 20X MONTHS - 4 PATIENTS
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: Wheel Chair Van lift
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other). DOCTOR VISIT
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). yes
12. State any other factor that is important to you.

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

*Ray McMurdy*  
 (Signature)

RAY McMURDY  
 (Print Name)

Re: APPLICATION OF MEDIC RESCUE  
Docket No. A-00114249

STATEMENT OF BEAVER VALLEY GERIATRIC CENTER

1. Name and residence address: SALLY MOORE RN / PHYSICIAN SERVICE,  
246 Friendship Circle, BEAVER, PA. 15007
2. Name of employer and/or occupation and business address:  
SAME AS 1.
3. Do you require paratransit transportation service such as is proposed by Medic Rescue? YES If yes, indicate the reasons you need this service by checking the applicable items below:
  - a. Cannot walk or board or disembark vehicle without assistance. ✓
  - b. Confined to wheelchair. ✓
  - c. Need medical monitoring during transit. ✓
  - d. Need use of medical appliances or equipment during transit. ✓
  - e. Need service of or escort during transit. ✓
  - f. Need driver certified to provide CPR or First Responder care level during transit. ✓
  - g. State any other reason relating to a chronic or acute physical or mental condition. \_\_\_\_\_
4. If you checked items c and/or d above, state what type of monitoring, appliance or equipment you require. Oxygen
5. State what origins in Beaver County from which service is needed. (Please state origins by city or town.) BEAVER
6. State the destinations to which service is needed? (Please state city or town.) BEAVER CO. BEAVER, ROCHESTER, NEW BRIGHTON  
ALLEGHENY CO.

7. State the number of times (per week, month) that you will need the service of Medic Rescue. 30 / month & PATIENTS
8. Describe public transport service now available comparable to the proposed service, if any: NONE
9. Describe type of vehicle you need to transport you, including special features required: WHEELCHAIR VAN + SPECIAL CHAIR.
10. State why you need transportation from Medic Rescue (ie. for doctor visit, social, shopping, family visit, other).  
NON-AMBULATORY / WHEELCHAIR SOUND DOCTOR VISITS
11. State your knowledge of Medic Rescue (ie. do you use the service currently for emergencies). YES
12. State any other factor that is important to you. \_\_\_\_\_

The undersigned deposes and says that (s)he is authorized to make this verification, that the facts set forth herein are true and correct to the best of his/her knowledge, information and belief. The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Sally Moore  
(Signature)

SALLY MOORE  
(Print Name)

**CONCLUSION**

On the basis of the foregoing verified statements, applicant submits that the evidence warrants the following conclusions:

(a) applicant is fit, willing and able to provide the service proposed; and (b) there is a public need or demand for the proposed service in the application area to the extent authority is requested.

Respectfully submitted,

PILLAR • MULROY & FERBER, P.C.

By: 

\_\_\_\_\_  
JOHN A. PILLAR  
Attorney for  
NON PROFIT EMERGENCY  
SERVICE OF BEAVER  
COUNTY, INC., t/d/b/a  
MEDIC RESCUE, Applicant

PILLAR AND MULROY, P.C.  
Suite 700  
312 Boulevard of the Allies  
Pittsburgh, PA 15222

Due Date: November 14, 1997



COMMONWEALTH OF PENNSYLVANIA  
PENNSYLVANIA PUBLIC UTILITY COMMISSION  
P.O. BOX 3265, HARRISBURG, PA 17105-3265

REFER TO OUR FILE

November 19, 1997

JOHN A PILLAR  
ATTORNEY AT LAW  
1106 FRICK BUILDING  
PITTSBURGH PA 15219

In re: A-00114249 - Application of Non Profit Emergency  
Service of Beaver County, Inc., t/d/a/b Medic Rescue

Dear Sir:

We have received the verified statement(s) and/or other information filed in connection with the above referenced application proceeding.

The record will be reviewed and a recommendation will be made for Commission consideration at public meeting. You will be advised by the Secretary as to the action taken by the Commission.

Very truly yours,

Tim Zeigler  
Bureau of Transportation & Safety

DOCKETED APPLICATION DOCKET  NOV 19 1997  ENTRY No. <u>72</u>
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