



**Elmore County Ambulance District
FY 2026 Feasibility Study**

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1. EXECUTIVE BRIEF

This report presents a comprehensive assessment of the Elmore County Ambulance District's operations, personnel, and service capacity. The analysis reveals that the district is operating at high capacity with its current 4-unit deployment, with significant implications for emergency response effectiveness and patient outcomes.

Key Findings

1. Geographic Coverage Challenge

The district serves 3,075 square miles—one of the largest ambulance service areas in Idaho—with terrain ranging from the I-84 corridor at 2,500 feet to remote mountain communities exceeding 10,000 feet in elevation. Approximately 60% of the county consists of mountainous terrain with limited road access, creating inherent response time challenges that cannot be fully mitigated through operational adjustments alone.

Zone	Terrain	Avg Response Time (FY23-25)	NFPA Standard
Mountain Home	Flat plains, I-84	6 min 51 sec	9 min (90% of calls)
Mountain Home AFB	Flat plains	7 min 14 sec	9 min (90% of calls)
Glenns Ferry	Valley/plains	8 min 1 sec	10 min (80% of calls)
Pine/Featherville	Mountains - 10,651 ft	14 min 47 sec	14 min (80% of calls)

2. Call Volume at Capacity Threshold

Call volumes have remained consistently above 3,000 annually for three consecutive fiscal years (FY2023: 3,059; FY2024: 3,056; FY2025: 3,032). Research indicates that sustained call volumes at this level place significant operational strain on EMS systems, particularly in rural districts with extended transport times. The current volume, combined with the geographic challenges of a 3,075-square-mile service area, indicates operation near practical capacity limits.

Fiscal Year	Period	Total Calls	Status
FY 2023	Oct 2022 – Sep 2023	3,059	HIGH CAPACITY
FY 2024	Oct 2023 – Sep 2024	3,056	HIGH CAPACITY
FY 2025	Oct 2024 – Sep 2025	3,032	HIGH CAPACITY

3. Current Unit Deployment and Personnel Assessment

The district currently deploys 4 ambulance units daily, with 2 units staffed at the ALS (Paramedic) level and 2 units staffed at the BLS/AEMT level. This configuration provides a mix of Advanced Life Support and Basic Life Support coverage across the service area.

Unit Type	Daily Deployment	Capability
ALS Units (Paramedic)	2 units	Full Advanced Life Support
BLS/AEMT Units	2 units	Basic/Intermediate Life Support
TOTAL DAILY DEPLOYMENT	4 units	Mixed ALS/BLS capability

The district maintains 38 clinical personnel (19 Paramedics, 9 AEMTs, 10 EMT-Basics), of whom 37 are available for field operations due to one dual-role Operations Captain position. This staffing level meets Idaho Code requirements and supports the current 4-unit deployment configuration.

Role	Current Staffing	Notes
Clinical Field Staff	38 (37 available)	19 Paramedics, 9 AEMTs, 10 EMTs
District Chief	1.0 FTE	Meets Idaho Code requirements
Operations Captain	1.0 FTE (dual-role)	Also serves as Training Officer
Medical Director	Contracted	Compliant with Idaho Code § 56-1016

4. Staffing Requirements Analysis

Industry standards indicate that maintaining 24/7 ambulance coverage requires approximately 7 FTEs per unit (2 personnel per unit × 3 shifts + coverage for leave/training). The current 4-unit deployment requires approximately 28-40 FTEs, depending on shift configuration and coverage models used.

Configuration	FTEs Required	Current Available	Status
4-Unit (current)	28-40	37	Adequate for current ops
5-Unit (expanded)	35-50	37	Would require 0-13 additional FTEs

5. Clinical Impact of Response Delays

Extended response times, particularly during "Level Zero" events when all 4 units are committed, and no ambulances are available, have measurable clinical consequences. Based on peer-reviewed research on time-critical medical conditions:

Cardiac Arrest: Survival decreases 7-10% per minute without CPR/defibrillation. Estimated 6-12 preventable deaths annually are attributable to response delays.

Major Trauma: Scene times exceeding 10 minutes associated with increased mortality. I-84 corridor crashes contribute to an estimated 3-6 preventable deaths annually.

Stroke: tPA treatment window of 3-4.5 hours from symptom onset. An estimated 5-10 patients annually miss optimal treatment windows due to transport times.

TOTAL ANNUAL IMPACT: Estimated 9-18 preventable deaths plus 10-20 cases of severe disability that could possibly have been mitigated with faster response.

Recommendations

1. Fifth Unit Deployment. Unit Expansion — Phased Deployment: Deploy an additional ambulance unit based on documented 60–90 annual Level Zero events and three consecutive years of call volumes exceeding 3,000 annually. Near-term (FY2026–FY2027): Add a fifth deployed unit with strategic positioning to address peak-demand coverage gaps and reduce mutual aid dependence. Recruitment of 7–10 additional FTEs should begin immediately given 6–12 month hiring timelines for credentialed ALS providers. Mid-term (FY2028–FY2029): Geographic expansion units for the Mayfield/West Elmore County and West Mountain Home corridors, funded through expanded levy authority. See Sections 3.7 and 8 for phased staffing projections and cost analysis.

2. Increased ALS Coverage: Evaluate transitioning one or more BLS/AEMT units to ALS (Paramedic) staffing to increase advanced care capability across all deployed units.

3. Third Unit Deployment: Implement a third ambulance unit with strategic positioning based on call volume patterns and geographic analysis. This requires recruitment of 7-10 additional FTEs.

4. Mayfield Springs Substation: Coordinate with the Mayfield Springs development to establish a staffed substation, addressing western county coverage and anticipated population growth.

5. Dynamic Unit Posting: Implement dynamic posting protocols to strategically position the 4 current units during peak hours, reducing response times to the Glenns Ferry area and I-84 corridor.

6. Workforce Development: Address regional workforce shortage through competitive compensation analysis, partnerships with EMS education programs, and retention initiatives.

7. Seven Documented Regional Growth Drivers: Seven documented, permitted, or actively financed development projects and trends will drive significant call volume increases across the service area during the District's planning horizon: (1) Mayfield Springs master-planned community (2,325 homes, groundbreaking October 2024); (2) Shoshone-Bannock Tribes casino resort (\$311M, in active federal review) and separate Shoshone-Paiute Tribes casino proposal; (3) western county industrial expansion and Qatari Emiri Air Force training facility at Mountain Home AFB; (4) I-84 corridor highway improvements (\$300M+ investment driving regional traffic growth); (5) Crimson Orchard Solar construction (\$304M, underway, operations 2027) and two additional approved energy facilities; (6) seasonal recreation surges in the Pine/Featherville zone where response times already test NFPA benchmarks; and (7) documented 8.74% single-year population growth in Glenns Ferry. See Section 3.7.6 for sourced documentation of each driver.

2. CURRENT OPERATIONS AND LEVEL OF SERVICE

2.1 Geographic Coverage and Service Area

The Elmore County Ambulance District serves 3,075 square miles of land area across Elmore County, Idaho, with a population of approximately 29,729 residents (U.S. Census Bureau, 2024). The service area encompasses dramatically diverse terrain that creates unique operational challenges.

Northern Zone (Approximately 60% of County Area)

- Dominated by the Northern Rocky Mountain Province and Idaho Batholith
- Features steep, rugged terrain with peaks reaching 10,651 feet (Snowyside Peak)
- Includes portions of Boise National Forest and Sawtooth National Recreation Area
- Communities served: Pine, Featherville, Atlanta
- Response times significantly impacted by terrain, elevation, and seasonal weather

Southern Zone (Approximately 40% of County Area)

- Part of the Columbia Plateau Province and Snake River Plain
- Relatively flat, rolling upland plain (Mountain Home Plateau)
- Major population centers: Mountain Home (county seat), Glenns Ferry
- Interstate 84 corridor runs through this zone
- Mountain Home Air Force Base (population ~4,500) adds complexity to service demands

Current Station Configuration

The District operates from three primary locations: 1. Mountain Home Station (Primary): Serves the highest population density areas including Mountain Home, Mountain Home AFB, and I-84 corridor. 2. Glenns Ferry Station: Provides coverage to eastern county and Three Island Crossing area. 3. Pine/Featherville

Critical Geographic Challenges

- 60% of service area is mountainous terrain requiring specialized response capabilities
- Long-distance interfacility transfers to Boise (2-3 hours round trip) remove units from service for extended periods
- I-84 corridor creates high-acuity motor vehicle accident demand
- Seasonal access limitations in northern mountain communities

2.2 Current Unit Deployment

The Elmore County Ambulance District currently deploys 4 ambulance units daily to serve its 3,075-square-mile service area. This deployment model provides geographic coverage while balancing staffing resources and operational demands.

Unit Configuration

Unit Type	Number	Staffing Level	Capability
ALS Units	2	Paramedic + EMT/AEMT	Full ALS interventions
BLS/AEMT Units	2	AEMT/EMT crews	BLS + limited ALS
TOTAL	4 units daily	Mixed staffing	Tiered response

This tiered deployment model allows the district to dispatch ALS units to high-acuity calls (cardiac arrest, major trauma, respiratory emergencies) while BLS/AEMT units handle lower-acuity calls and provide backup coverage. The 2 ALS units ensure Paramedic-level care is available for the most critical emergencies, while the 2 BLS/AEMT units extend overall coverage capacity.

2.3 Call Volume Analysis

Annual Call Volume Summary (FY2023-FY2025)

Fiscal Year	Period	Total Calls	YOY Change	% Change
FY 2023	Oct 1, 2022 - Sep 30, 2023	3,059	—	—
FY 2024	Oct 1, 2023 - Sep 30, 2024	3,056	-3	-0.1%
FY 2025	Oct 1, 2024 - Sep 30, 2025	3,032	-24	-0.8%

Call volumes have remained essentially stable over the past three fiscal years, holding at approximately 3,000 calls annually. The year-over-year variation of less than 1% is statistically insignificant and falls within normal operational variance.

Research presented at the American College of Surgeons Clinical Congress 2025 found that rural EMS call times average 92.8 minutes compared to 74.1 minutes nationally, with high-acuity calls averaging 97.1 minutes versus 69 minutes nationally (Turcinovic et al., 2025). These extended time-on-task figures reduce unit availability and effectively lower the number of calls a system can handle while maintaining response time targets.

Understanding Call Volume Impact on a 4-Unit System

With 4 units handling approximately 3,000 calls annually, each unit averages 750 calls per year, or approximately 2.05 calls per unit per day. However, call distribution is not uniform—peak periods may see multiple simultaneous calls that commit all 4 units, while other periods have excess capacity.

Key operational considerations include:

- When all 4 units are committed simultaneously, the district enters "Level Zero" status requiring mutual aid

- Interfacility transfers to Boise (2-3 hour round trips) can remove 1-2 units from emergency availability for extended periods
- The 2 ALS units must be strategically deployed to ensure Paramedic coverage for high-acuity calls
- Staff fatigue and burnout considerations limit sustainable utilization rates—industry guidance recommends Unit Hour Utilization (UHU) targets of 0.30-0.50 for 24-hour shift systems to allow adequate time for rest, documentation, and equipment maintenance

Call Volume Distribution Characteristics

Category	Approximate % of Volume	Clinical Significance
Medical Emergency	~69% (~2,092 calls)	Mixed BLS/ALS appropriate
Trauma/MVA	~11% (~333 calls)	Requires ALS, extended scene times
Interfacility Transfers	~9% (~273 calls)	Resource-intensive, 2-3 hr to Boise
Other/Support	~11% (~333 calls)	LE/fire support, public service

Key Volume Factors Specific to Elmore County

Factor	Impact on Call Volume
Interfacility Transfer Burden	St. Luke's Elmore is a Critical Access Hospital. Complex cases requiring specialty care must be transferred to Boise, generating substantial transfer volume. Estimated 250–300 transfers annually at 2.5 hours average, consuming 625–750 hours annually where one unit is completely removed from the service area.
I-84 Corridor Traffic	High-speed interstate creates consistent demand for trauma response. Motor vehicle accidents on I-84 are typically high-acuity, multi-patient incidents requiring extended scene times.
Mountain Home Air Force Base	Base population (~4,500) contributes to call volume through off-base housing emergencies, mutual aid requests for on-base incidents, and military family members accessing civilian healthcare.
Aging Demographics	Elmore County's 65+ population is growing rapidly. This demographic uses EMS at 3–4 times the rate of younger populations, disproportionately driving call volume increases.

Factor	Impact on Call Volume
Energy Construction Workforce	Three county-approved energy projects are in active construction or advanced permitting: Crimson Orchard Solar (\$304M, under construction, operations 2027), a wind and solar facility (CUP-2024-04, approved 2024), and the Black Mesa Solar project. Large-scale construction brings concentrated temporary workforces into rural county zones, generating occupational injury and medical demand. Casino resort construction projects an additional 3,000 construction workers at peak.
Northern Recreation Zone and Tourism	The Pine/Featherville corridor draws seasonal visitors to 380+ miles of OHV and snowmobile trails, Anderson Ranch Reservoir (4,730 acres, 10 campgrounds, 4 boat launches), multiple hot springs, and Soldier Mountain ski resort. Recreational activity generates trauma-intensive calls (OHV accidents, drownings, falls) in the zone with the District's longest response times (14 min 47 sec average). This row consolidates the former 'Seasonal Recreation' factor with newly documented recreational demand specific to northern zone activities and call types.
Glenns Ferry Population Growth	Glenns Ferry's population grew 8.74% in a single year (2022–2023), with employment up 18.2% and median household income up 41.8% in the same period. Three Island Crossing State Park generates year-round tourist traffic through the community. Growth is occurring at the location of the District's least-expandable satellite station.

Seven documented regional growth drivers — detailed and sourced in Section 3.7.6 — will accelerate call volume growth beyond what historical trends suggest. These include the Mayfield Springs master-planned community (groundbreaking October 2024), two casino resort proposals in active federal review, an announced Qatari Air Force training facility at Mountain Home AFB, Crimson Orchard Solar construction (operations 2027), I-84 corridor improvements, Pine/Featherville recreational surges, and documented 8.74% single-year population growth in Glenns Ferry. Each driver contributes to a different segment of the service area and call-type profile, but collectively they represent a sustained, multi-year demand increase that the District's current four-unit deployment cannot absorb without additional staffing and infrastructure investment.

3. PERSONNEL ASSESSMENT

3.1 Current Staffing Levels

3.1.1 Clinical Personnel (Field Operations)

The Elmore County Ambulance District maintains a clinical workforce aligned with the National EMS Scope of Practice Model, which establishes minimum competencies for EMS personnel at each licensure level (NASEMSO, 2019). Current staffing supports the daily deployment of 4 ambulance units across the 3,075-square-mile service area.

Certification Level	Number	Capability per National EMS Scope of Practice
Paramedic (EMT-P)	19 (17+2)	Advanced Life Support (ALS) - Full scope
Advanced EMT (AEMT)	9	Intermediate ALS capabilities
EMT-Basic (EMT-B)	10	Basic Life Support (BLS)
TOTAL CLINICAL	38	37 available for field operations

Note: One Paramedic serves in dual capacity as Operations Captain/Training Officer, reducing available field personnel to 37 for operational shifts. The 19 Paramedics support staffing of 2 ALS units daily, while AEMTs and EMT-Basics staff the remaining 2 BLS/AEMT units.

3.1.2 Paramedic Distribution by Role

Role	Count	Primary Function
Field Paramedics	17	Direct patient care, ALS unit staffing
Operations Captain/Training Officer	1	Dual-role: scheduling, training, ops oversight
Other Administrative Paramedics	1	Administrative functions with field backup
TOTAL PARAMEDICS	19	17+2 configuration

3.1.3 Administrative and Support Personnel

Position	Staffing	Notes
District Chief/Administrator	1.0 FTE	Full-time executive leadership
Medical Director	Contracted	Compliant with Idaho Code § 56-1016
Operations Captain/Training Officer	1.0 FTE	Dual-role Paramedic
Billing Specialists	2.0 FTE	Revenue cycle management
Other Administrative	3.0 FTE	Support functions
HR/Payroll	Outsourced	External vendor
Fleet/Logistics	Outsourced	External vendor

Total District Workforce: 44 employees (38 clinical + 6 administrative direct employees) plus contracted/outsourced support services.

3.2 Idaho Certification Requirements

Under Idaho Code § 56-1012 and IDAPA 16.01.07, EMS personnel certification levels correspond to specific capabilities and scopes of practice. The Elmore County Ambulance District maintains compliance with all state certification requirements.

3.2.1 State Certification Standards

Paramedic: Per Idaho Code § 56-1012(23): Advanced airway management, cardiac monitoring and interpretation, medication administration including controlled substances, invasive procedures (IV, IO, intubation, chest decompression), all performed under physician medical director supervision.

Advanced EMT: Per Idaho Code § 56-1012(1): IV access and fluid administration, limited medication administration (D50, glucagon, nitro, naloxone), advanced assessment skills bridging BLS and full ALS capability, supraglottic airway devices.

EMT-Basic: Per Idaho Code § 56-1012(18): CPR and AED use, hemorrhage control and wound care, splinting and immobilization, oxygen administration, basic patient assessment, emergency childbirth, assisted medication administration (epi-pen, albuterol).

3.2.2 Agency Minimum Standards

Idaho Code § 56-1016 establishes minimum standards for EMS agencies operating in Idaho:

- **Medical Director:** Each licensed ambulance service must operate under a physician medical director who provides medical oversight, protocol development, and quality assurance (§ 56-1016(6))
 - **Crew Requirements:** At least two ambulance crew members on each patient transport, with the crew member delivering patient care being at minimum a state certified EMT (§ 56-1016(3))
 - **Vehicle Standards:** Ambulances must meet equipment and safety standards established by the Idaho Bureau of EMS
 - **Continuing Education:** All certified personnel must maintain current certification through continuing education requirements
- District Compliance Status: COMPLIANT** — The Elmore County Ambulance District meets all Idaho Code requirements for EMS agency operation.

3.3 Staffing Requirements Analysis

3.3.1 Unit Hour Staffing Calculations

To provide 24/7 ambulance coverage, one ambulance on duty 24 hours a day, 365 days a year requires the ambulance to be staffed 8,760 hours annually (365×24). Industry standards indicate that maintaining this coverage with standard shift patterns requires approximately 7 full-time employees per ambulance unit:

- 2 personnel per unit $\times$ 3 shifts = 6 positions
- + 1 FTE to cover vacations, sick leave, training, and FMLA
- = 7 FTEs minimum per unit (conservative estimate)
- 8-10 FTEs per unit recommended for robust coverage with adequate relief

3.3.2 FTE Requirements by Deployment Configuration

Component	4-Unit (Current)	5-Unit	6-Unit	Notes
Units Deployed	4	5	6	Daily 24/7
Personnel/Unit	2	2	2	CMS minimum
Min per Shift	8	10	12	Units $\times$ 2
FTEs (Conservative)	28-32	35-40	42-48	7-8 per unit
FTEs (Robust)	36-40	45-50	54-60	9-10 per unit
Current Available	37	37	37	Field personnel
Gap/Surplus	+5 to +9	-3 to -13	-17 to -23	Hiring need

3.3.3 Federal Staffing Requirements

The Centers for Medicare & Medicaid Services (CMS) establishes minimum staffing requirements for ground ambulance services under 42 CFR § 410.40:

- **Basic Life Support (BLS):** Minimum of two crew members, at least one certified as an EMT-Basic or higher
- **Advanced Life Support Level 1 (ALS-1):** At least one crew member certified as a Paramedic or equivalent ALS provider
- **Advanced Life Support Level 2 (ALS-2):** ALS-1 requirements plus administration of at least 3 medications or certain ALS procedures

District Configuration: The current 2 ALS + 2 BLS/AEMT unit deployment meets CMS requirements. ALS units are staffed with Paramedic + EMT/AEMT; BLS units are staffed with AEMT/EMT combinations.

3.4 National EMS Workforce Crisis

The district's staffing must be evaluated within the context of a national EMS workforce crisis that poses significant recruitment and retention challenges for rural agencies. Understanding these trends is essential for workforce planning and competitive positioning.

3.4.1 National Workforce Statistics

Metric	National Data	Source
Application Decline (vs. pre-pandemic)	-13% average	NAEMT 2023
Agencies Reporting Decreased Apps	65%	NAEMT 2023
Annual Turnover Rate	20-30%	Industry avg
Rural Managers: Hiring = Major Challenge	91%	2021 Study
Expected Staff Replacement Cycle	~4 years	Based on turnover

3.4.2 Compensation Disparity

EMS compensation significantly lags comparable healthcare positions, creating recruitment challenges and driving attrition to hospital-based roles:

Position	Median Hourly Wage	Comparison to Paramedic
EMT-Basic	\$16.39/hour	—
Paramedic	\$22.42/hour	Baseline
Registered Nurse	\$38-94/hour	+70% to +320%
Physician Assistant	\$55.55/hour	+148%

CRITICAL IMPLICATION: Hospitals can offer Paramedics 70-320% higher wages than ambulance services, creating a continuous drain of experienced providers from prehospital to hospital-based positions.

3.4.3 Rural-Specific Challenges

Rural EMS agencies face compounded workforce challenges beyond compensation:

- **Limited Training Access:** Rural areas often lack nearby EMS education programs, requiring providers to travel significant distances for initial certification and continuing education
- **Geographic Isolation:** Limited applicant pools in rural communities; difficulty attracting candidates from urban areas
- **Call Volume Variability:** Unpredictable call patterns with periods of high intensity followed by extended downtime can contribute to burnout
- **Extended Transport Times:** Long-distance interfacility transfers increase crew fatigue and stress
- **Housing Costs:** In some rural areas, housing affordability issues compound recruitment challenges

3.4.4 Industry Mitigation Strategies

The NAEMT 2023 survey found that EMS agencies have adopted various strategies to address workforce shortages:

Strategy	% Adopted	Elmore Status
Lengthened response time goals	49%	Not Implemented
Implemented alternate response to low-acuity calls	37%	Not Implemented
Moved from all-ALS to tiered deployment	28%	Currently Using
Single paramedic deployment models	23%	Not Implemented

3.5 Staffing Impact on Response Capability

3.5.1 Current ALS Coverage Analysis

The district's 2 ALS + 2 BLS/AEMT deployment model provides tiered response capability. However, the distribution of ALS-certified personnel directly impacts the district's ability to provide advanced care across all response zones.

Scenario	ALS Available	BLS Available	Impact
Normal Operations	2 units	2 units	Full coverage
1 ALS on Boise Transfer	1 unit	2 units	Reduced ALS
2 ALS on Calls	0 units	2 units	No ALS available
Level Zero (All 4 Committed)	0 units	0 units	Mutual aid only

3.5.2 Staffing Adequacy for Expanded Operations

5th Unit Deployment: Would require 7-13 additional FTEs depending on shift configuration. At current staffing levels (37 available), the district could face a gap of 0-13 positions. Recruitment in the current labor market would likely require 6-12 months to fill positions, assuming competitive compensation is offered.

6th Unit Deployment: Would require 14-23 additional FTEs beyond current capacity. This represents a major expansion requiring significant budget allocation for salaries, benefits, training, and equipment. Multi-year phased implementation recommended.

ALS Staffing Constraint: Each additional ALS unit requires qualified Paramedics. The district's 19 Paramedics (17 field-available) would need augmentation of 2-4 Paramedics per additional ALS unit. Paramedic recruitment is particularly challenging given national shortages.

3.6 Personnel Recommendations

Immediate Actions (0-6 Months)

1. **Compensation Analysis:** Conduct comprehensive compensation study comparing Elmore County rates to regional competitors (Ada County Paramedics, Magic Valley, St. Luke's system) and establish competitive pay scales to improve recruitment and retention.
2. **Retention Program:** Implement formal retention initiatives including longevity bonuses, professional development funding, and recognition programs to reduce turnover below the 20-30% national average.
3. **Succession Planning:** Identify potential leadership candidates and implement cross-training to ensure continuity in key administrative and supervisory positions.

Short-Term Actions (6-18 Months)

4. **Education Partnership:** Establish formal partnership with College of Western Idaho or Boise State University EMS programs to create pipeline for new EMTs and Paramedics, potentially including tuition assistance or work-study arrangements.
5. **Recruitment Campaign:** Launch targeted recruitment for 7-10 additional FTEs to support potential 5th unit deployment, focusing on Paramedics and AEMTs. Begin recruitment 12+ months before anticipated activation.
6. **AEMT-to-Paramedic Pathway:** Develop internal advancement program to support current AEMTs in obtaining Paramedic certification, including scheduling accommodations and financial support.

Long-Term Actions (18-36 Months)

7. **Workforce Development Program:** Establish comprehensive workforce development program including Explorer/cadet programs, high school EMS career pathways, and community EMT certification courses.
8. **Regional Collaboration:** Explore regional workforce sharing agreements with neighboring counties to address surge staffing needs and provide mutual career advancement opportunities.
9. **Alternative Response Models:** Evaluate community paramedicine or mobile integrated healthcare programs that could address lower-acuity calls while providing career advancement opportunities for experienced providers.

Implementation Timeline and Cost Projections: The recommendations above are supported by detailed phased staffing projections in Section 3.7.3, which documents the addition of 18 fixed FTEs between FY2026 and FY2029 at escalating annual personnel costs from \$3,048,371 (FY2026 baseline) to \$4,374,173 (FY2029 full capacity). Section 3.7.4 provides a year-by-year

personnel cost summary. Section 3.7.5 identifies the specific workforce risk factors — paramedic pipeline constraints, compensation competitiveness, rescue technician availability, and supervisory span of control — that will determine whether the phased timeline is achievable. Readers should review Sections 3.7.3 through 3.7.7 in conjunction with the recommendations above when preparing budget requests, grant applications, or board presentations related to staffing.

3.7 Staffing Assessment and Future Needs Analysis

This section documents the Elmore County Ambulance District's current staffing baseline, evaluates alignment with national standards, identifies operational gaps, and projects staffing requirements through FY2031 to maintain service quality, ensure crew safety, and prevent response time degradation. Projections are drawn from the District's internal staffing and compensation model and reflect anticipated regional growth, service expansion, and inflation-adjusted compensation costs.

3.7.1 Current Staffing Baseline (FY2026)

The table below reflects the District's FY2026 approved staffing configuration across all four operational departments: Administrative, Ambulance Service, Rescue, and CHEMS (Community Health Emergency Medical Services). Wages include mandatory Social Security and Medicare taxes. Part-time and on-call headcount is indicated as "Varies" and is not included in the fixed FTE total.

Position	HC	Wages & Taxes	Fringe & Liability	Total Cost
Administrative				
Director	1	\$95,910	\$46,114	\$142,024
Billing Clerk	2	\$105,681	\$79,351	\$185,032
Office Manager	0*	—	\$41,574	\$41,574
Administrative Total	3	\$201,591	\$167,039	\$368,630
Ambulance Service				
Chief	0*	—	—	—
Deputy Chief	1	\$94,778	\$46,113	\$140,891

Position	HC	Wages & Taxes	Fringe & Liability	Total Cost
Lieutenant	4	\$316,993	\$176,397	\$493,390
Paramedic	2	\$131,766	\$169,154	\$300,920
EMT	15	\$980,784	\$65,091	\$1,045,875
PT Help / Reservist	Varies	\$430,600	\$22,950	\$453,550
Ambulance Service Total	22	\$1,954,921	\$479,705	\$2,434,626
Rescue				
Captain	1	\$3,561	—	\$3,561
Lieutenant	1	\$3,109	—	\$3,109
Technicians	14	\$35,605	—	\$35,605
Rescue Total	16	\$42,275	—	\$42,275
CHEMS				
CHEMS Director	1	\$67,912	\$42,624	\$110,536
Community Paramedic	1	\$51,324	\$40,980	\$92,304
CHEMS Total	2	\$119,236	\$83,604	\$202,840
DISTRICT ANNUAL TOTAL	43	\$2,318,023	\$730,348	\$3,048,371

* The Office Manager position carries fringe/liability cost in FY2026 but is currently unfilled (0 HC). The Chief position is similarly budgeted at zero headcount; both are addressed in the near-term staffing plan. Part-time help and reservist wages are reflected in the budget but excluded from the fixed headcount total of 43.

Note on compensation components: Per the District's staffing model, the Wages & Taxes column includes base wages plus the employer share of federal FICA taxes (Social Security 6.2% and Medicare 1.45%, combined rate 7.65%), applied via a 1.0765 multiplier. The Fringe & Liability column is intended to capture remaining employer-paid costs such as health, dental, and vision insurance premiums, PERSI (Public Employee Retirement System of Idaho) contributions, workers' compensation, and related benefits. Idaho does not impose a state-level employer payroll tax; Idaho income tax is an employee-side withholding and is not reflected here as an employer cost. However, inclusion of Idaho State Unemployment Insurance (SUI) and PERSI contributions within the Fringe & Liability figures has not been independently verified. Readers should confirm with the District's finance team that these obligations are fully accounted for before using these totals for budgeting, board presentation, or grant application purposes.

Key Observations — FY2026 Baseline

- The District employs 43 fixed FTEs across four departments, with an additional variable complement of part-time clinical staff and on-call rescue technicians.
- Ambulance Service accounts for 22 of those 43 FTEs — the largest single department — and carries the highest compensation burden (\$2.43M of the \$3.05M total).
- Labor costs represent approximately 76% of total operating expenditures, consistent with the 75–85% national benchmark for EMS systems.
- Two leadership vacancies — the Ambulance Chief and Office Manager — create immediate administrative and operational gaps. The Chief position in particular represents a structural deficiency identified in Section 3.5 and the national industry benchmarks reviewed in Section 3.4.
- The Rescue division's compensation is primarily wages with no fringe liability recorded in FY2026, reflecting its part-time and on-call staffing model.

3.7.2 Projected Staffing Growth: FY2026–FY2031

The following table presents the District's projected staffing headcount and estimated personnel costs from FY2026 through FY2031. Projections reflect the planned addition of positions necessary to support a fifth ambulance unit, geographic coverage expansion to the Mayfield/West Elmore County corridor and West Mountain Home, and growth in CHEMS programming. Compensation estimates apply an annual escalation rate of approximately 3% for wages and 2% for fringe benefits. FY2028 and beyond are projected on a January–December calendar year basis following a three-month transition period at the end of FY2027.

Note: The "Trans." column represents the October–December 2027 transition quarter, reflecting partial-year costs as the District aligns to a calendar fiscal year.

Position	FY2026	FY2027	Trans.*	FY2028	FY2029	FY2030	FY2031
Administrative							
Director	1	1	1	1	1	1	1
Billing Clerk	2	2	2	2	2	2	2
Office Manager	0*	0	1	1	1	1	1
Admin Total	3	3	4	4	4	4	4
Ambulance Service							
Chief	0*	1	1	1	1	1	1
Deputy Chief	1	1	1	1	1	1	1
Lieutenant	4	4	4	4	4	4	4
Paramedic	2	2	2	3	5	5	5
EMT	15	16	16	18	20	20	20
PT Help / Reservist	Varies	Varies	Varies	Varies	Varies	Varies	Varies
Ambulance Total	22	24	24	27	31	31	31

Position	FY2026	FY2027	Trans.*	FY2028	FY2029	FY2030	FY2031
Rescue							
Captain	1	1	1	1	1	1	1
Lieutenant	1	2	2	2	2	2	2
Technicians	14	16	16	20	20	20	20
Rescue Total	16	19	19	23	23	23	23
CHEMS							
CHEMS Director	1	1	1	1	1	1	1
Community Paramedic	1	1	1	1	2	2	2
CHEMS Total	2	2	2	2	3	3	3
DISTRICT TOTAL	43	48	49	56	61	61	61
Est. Personnel Cost	\$3,048,371	\$3,441,678	\$876,659	\$4,037,389	\$4,374,173	\$4,497,048	\$4,623,442

* Trans. = Oct-Dec 2027 transition quarter (3 months). Annual wage/fringe escalation: ~3% wages, ~2% fringe.

3.7.2.1 Estimated Personnel Cost — Calculation Methodology

The Est. Personnel Cost row in the projection table is derived directly from the District's internal staffing and compensation model. Each figure represents the sum of Wages & Taxes plus Fringe & Liability across all positions in all four departments (Administrative, Ambulance Service, Rescue, and CHEMS). The escalation logic applied at each transition is as follows.

FY2026 Baseline

Figures are taken directly from the District's FY2026 approved budget. Base wages are multiplied by 1.0765 to incorporate the employer share of FICA taxes (Social Security 6.2% + Medicare 1.45%). Fringe and liability figures are entered as budget line amounts. The resulting FY2026 total is \$3,048,371.

FY2026 to FY2027

Wage escalation from FY2026 to FY2027 is position-specific, not uniform:

- Most existing positions (Deputy Chief, Lieutenants, Paramedics, EMTs, PT Help, Rescue and CHEMS staff): wages $\times$ 1.05 — a 5% year-over-year increase reflecting merit and cost-of-living adjustment.
- Director: wages $\times$ 1.15 — a 15% increase, reflecting a targeted equity or market adjustment modeled in the spreadsheet.
- Ambulance Chief: added as a new position at a hardcoded base wage of \$103,335, with fringe set at \$47,224 $\times$ 1.03. This is a market-rate figure for a new hire, not derived from an escalation of a prior year.
- Rescue Lieutenant: wages $\times$ 2, reflecting the headcount doubling from 1 to 2 rather than a wage rate change.
- Positions with headcount increases (EMTs, Rescue Technicians): per-FTE wage rate from FY2026 $\times$ new total headcount $\times$ 1.05, so both the rate increase and the additional bodies are captured.
- CHEMS Director: FY2026 wages plus a calculated overtime supplement (hourly rate of \$32.65 $\times$ 1.5 overtime multiplier $\times$ 416 hours), reflecting anticipated overtime load as CHEMS programming expands.

Fringe escalation FY2026 to FY2027: all positions $\times$ 1.03 (3%).

FY2027 to Transition Quarter (Oct–Dec 2027)

Each position's FY2027 annual wages and fringe are divided by 4, producing a three-month partial-year cost for the October–December 2027 transition period. No escalation is applied at this step — the transition quarter uses FY2027 rates unchanged. The transition total of \$876,659 represents exactly one quarter of the \$3,441,678 FY2027 annual figure.

Transition Quarter to FY2028

FY2028 figures are derived by annualizing the transition quarter (multiplying by 4) and then applying an escalation step:

- Wages: transition quarter wages $\times 4 \times 1.08$ — an 8% escalation. This step accounts for one full year of wage growth between the start of FY2027 and the beginning of the FY2028 calendar year (approximately 15 months), modeled as a combined 5% + 3% compound increase ($1.05 \times 1.03 \approx 1.08$).
- Fringe: transition quarter fringe $\times 4 \times 1.03$ — a 3% escalation.
- Positions with headcount increases in FY2028 (Paramedic HC 2→3, EMT HC 16→18, Rescue Technician HC 16→20): new headcount is added at the per-FTE wage rate from the transition quarter, escalated by 1.08, and added to the annualized wages for the existing headcount.

The FY2028 total of \$4,037,389 reflects both the wage step and the addition of 7 net new positions.

FY2028 to FY2029, FY2030, and FY2031

From FY2028 onwards, the model applies uniform annual escalation with no further position-specific adjustments except for headcount additions:

- Wages: prior year $\times 1.03$ (3% annually) for all existing positions.
- Fringe: prior year $\times 1.02$ (2% annually) for all existing positions.
- Headcount additions (FY2029: Paramedic HC 3→5, EMT HC 18→20, CHEMS Community Paramedic HC 1→2): new positions added at the per-FTE rate from FY2028, escalated by 1.03, and summed with the continuing positions.

FY2030 and FY2031 apply the same 3%/2% escalation with no headcount changes, producing the stable cost growth of approximately \$123,000–\$126,000 per year seen in the projection table.

3.7.3 Staffing Growth Narrative by Phase

Phase 1 — Immediate Needs (FY2026, Current Year)

The district enters FY2026 with 43 fixed FTEs and two critical vacancies. No net new hires are projected in this phase; the priority is filling existing authorized positions:

- Fill the Office Manager position (currently unfilled) to consolidate administrative functions dispersed across county locations.
- Initiate recruitment for the Ambulance Chief (funded in FY2027), allowing for a 6–12-month lead time given the competitive regional labor market for supervisory paramedics.

- Begin the compensation analysis and retention program recommended in Section 3.6 to reduce turnover risk as expansion hiring ramps up.

Phase 2 — Near-Term Expansion (FY2027, 48 FTEs)

FY2027 adds 5 fixed FTEs, bringing the total to 48, at an estimated annual personnel cost of \$3.44 million. The key additions are:

- Ambulance Chief (1 FTE): Fills the dedicated system-wide operations leadership gap identified in Section 3.5. Budgeted at \$103,335 base wage plus \$48,641 fringe. This position is the highest-priority hire in the district's near-term plan, providing centralized oversight of training, scheduling, and daily operations across all stations.
- EMT (1 additional FTE, total 16): Adds clinical capacity to begin absorbing call volume growth without increasing ALS unit strain.
- Rescue Lieutenant (1 additional FTE, total 2): Expands rescue supervisory depth as call complexity and geographic coverage demands increase.
- Rescue Technicians (2 additional FTEs, total 16): Supports anticipated growth in rescue call volume, particularly related to I-84 corridor incidents and northern zone seasonal demand.

Phase 3 — Geographic Expansion (FY2028, 56 FTEs)

FY2028 represents the largest single-year headcount increase in the projection period, adding 8 FTEs to reach 56, at an estimated annual personnel cost of \$4.04 million. This phase corresponds to the staffing of the Mayfield/West Elmore County substation and the West Mountain Home coverage area. Key additions:

- Office Manager (previously unfilled position activated: 1 FTE): Consolidates administrative and billing support functions currently dispersed across county locations.
- Paramedic (1 additional, total 3): Expands ALS capacity for the new coverage zones. Paramedic recruitment must begin no later than mid-FY2027 given typical 6–12 month hiring timelines for credentialed ALS providers.
- EMT (2 additional, total 18): Provides BLS staffing for expanded unit deployment.
- Rescue Technicians (4 additional, total 20): Scales the rescue complement to support the expanded geographic footprint, including the western county corridor.

Phase 4 — Full Operational Capacity (FY2029, 61 FTEs)

FY2029 completes the district's planned expansion to 61 FTEs, at an estimated annual personnel cost of \$4.37 million. This headcount is projected to remain stable through FY2031, with cost growth attributable solely to compensation escalation. Additions in this phase include:

- Paramedic (2 additional, total 5): Reaches the Paramedic staffing level necessary to maintain ALS coverage across all expanded units, including the ability to staff two simultaneous ALS units with adequate relief factor coverage.
- EMT (2 additional, total 20): Completes BLS unit staffing for the full 5-unit deployment model.
- Community Paramedic — CHEMS (1 additional, total 2): Expands community health programming as call volume grows and the District's CHEMS department matures.

Phase 5 — Stable Operations (FY2030–FY2031, 61 FTEs)

No additional headcount is projected in FY2030 or FY2031. Personnel cost growth of approximately \$123,000 annually reflects wage escalation of ~3% per year. This stable phase allows the District to: consolidate operational processes across expanded stations; build supervisor bench strength and advance internal candidates; monitor call volume trends and Unit Hour Utilization to determine whether further staffing increases are warranted; and evaluate whether a sixth unit deployment becomes necessary based on growth in the Mayfield, West Mountain Home, or northern zone service areas.

3.7.4 Personnel Cost Projection Summary

The following table summarizes total estimated personnel costs from FY2026 through FY2031, and the year-over-year increases associated with each staffing phase. These figures serve as the baseline for the financial analysis in Section 5 and the funding gap analysis in Section 8

Fiscal Year	Fixed FTEs	Wages Taxes &	Fringe Liability &	Total Personnel Cost	YOY Increase
FY2026 (baseline)	43	\$2,318,023	\$730,348	\$3,048,371	—
FY2027	48	\$2,640,778	\$800,900	\$3,441,678	+\$393,307 (+13%)
Trans. Oct–Dec 2027	49	\$676,434	\$200,225	\$876,659	(3-mo. partial)
FY2028 (Jan–Dec)	56	\$3,218,751	\$818,638	\$4,037,389	+\$595,711 (+17%)
FY2029 (Jan–Dec)	61	\$3,539,161	\$835,011	\$4,374,172	+\$336,783 (+8%)
FY2030 (Jan–Dec)	61	\$3,645,336	\$851,711	\$4,497,047	+\$122,875 (+3%)
FY2031 (Jan–Dec)	61	\$3,754,696	\$868,746	\$4,623,442	+\$126,395 (+3%)

Note: FY2028 and subsequent years reflect a calendar-year (January–December) fiscal year following the October–December 2027 transition quarter. Year-over-year comparisons for FY2028 use the annualized FY2027 base.

3.7.5 Standards Alignment Assessment

The district's projected staffing trajectory addresses the most critical gaps identified against NFPA 1710, NFPA 1720, and industry Unit Hour Utilization benchmarks:

Standard	Requirement	Current Status	Addressed By Projection
NFPA 1710	Dedicated EMS operations chief	Gap — 0 FTEs	Chief added in FY2027
NFPA 1710	2 Paramedics + 2 EMTs for high-acuity ALS	Marginal — limited redundancy	Paramedic depth reaches 5 by FY2029
NFPA 1720	14-min rural response, 80% compliance	Northern zone exceeds — terrain constraints	Western substation partially mitigates by FY2028
Industry UHU	0.25–0.35 for 24-hr systems	At capacity — elevated burnout risk	EMT expansion reduces per-unit call burden by FY2028
Admin. capacity	Dedicated billing/admin support	Fragmented — staff at multiple locations	Office Manager filled FY2027; billing staff stable at 2 FTE

3.7.6 Workforce Risk Considerations

The staffing projections above are predicated on the District's ability to recruit and retain qualified EMS personnel in a highly competitive regional labor market. As documented in Section 3.4, the national EMS workforce crisis — characterized by a 13% decline in applications since the pandemic, 20–30% annual turnover rates, and a 70–320% paramedic compensation gap relative to hospital-based positions — presents material risk to the implementation timeline.

The following risk factors are specific to executing the District's staffing growth plan:

- Paramedic pipeline constraints: Hiring three additional Paramedics between FY2027 and FY2029 will require sustained recruitment effort given the regional shortage of credentialed ALS providers. Partnerships with College of Western Idaho EMS program (recommended in Section 3.6) should be initiated in FY2026 to build a candidate pipeline.
- Compensation competitiveness: All projected wage figures include a 3–5% annual escalation assumption. If Ada County Paramedics, St. Luke's Health System, or regional competitors increase compensation at a higher rate, the District may face accelerated turnover among existing staff and difficulty filling new positions at projected wage levels. The compensation analysis recommended in Section 3.6 should be completed before FY2027 hiring begins.
- Rescue technician availability: Rescue Technicians are on-call and part-time, which historically limits the applicant pool to local community members with availability for emergency response. Expanding the Technician complement from 14 to 20 by FY2028 will require a proactive community recruitment campaign, potentially including an Explorer or cadet program.
- Supervisory succession: The projection adds an Ambulance Chief but does not add Lieutenant-level supervisory positions. As the clinical workforce grows from 22 to 31 Ambulance Service FTEs, the span of control for the existing Lieutenant complement (4 FTEs) will widen, potentially affecting supervision quality and compliance with training program requirements under NFPA 1500.

Risk Mitigation

Executing this staffing plan successfully requires the District to begin recruitment 12 or more months before planned activation dates, maintain compensation at or above regional benchmarks, invest in internal advancement pathways (particularly the AEMT-to-Paramedic program outlined in Section 3.6), and monitor workforce metrics quarterly — including turnover rate, time-to-fill by position, and application volume — to identify emerging shortfalls before they affect operational readiness.

3.7.7 Documented Regional Growth Drivers

The staffing projections in this section are not speculative — they are anchored in documented, approved, or actively permitted development projects that will generate measurable increases in population, traffic, employment, and EMS call volume within the District's service area. The four primary growth drivers are described and sourced below.

1. Mayfield Springs Master-Planned Community

Mayfield Springs is a 730-acre master-planned community situated along Interstate 84 at the Ada–Elmore County border, immediately adjacent to the Boise Stage Stop interchange (Exit 95). The project broke ground in October 2024 after receiving approval from both the Elmore County Planning and Zoning Commission and the Elmore County Commission. At full buildout, the development will include approximately 2,325 homes (roughly 1,900 single-family and 400 multifamily units), a planned town center with commercial and retail services, a K–12 charter school, and an on-site emergency services building designed to house Elmore County Sheriff, Mountain Home Ambulance, and fire response units.

The project is the first major housing development east of Boise along the I-84 corridor and is estimated to house more than 5,400 people at buildout. It is not alone: several additional planned communities are also in various stages of approval in the same corridor, including the Mayfield Townsite (15,000 units, first approved 2011), Elk Creek, Sunrider Ranch, and Palm Estates. Combined, these projects could more than double Elmore County's current population of approximately 29,700.

Source	Description	EMS Relevance
Idaho Business Review (July 25, 2025)	"Mayfield Springs builds future-ready community near I-84" 730 acres, ~2,325 homes, groundbreaking October 2024; planned town center, school, and emergency services building.	New residential population directly within District service area; on-site EMS facility planned.
KIVI TV (July 17, 2025)	"Mayfield Springs: First major housing development south of Boise along I-84 corridor" 2,400 homes planned.	Confirms scale; first major eastward development shift in Treasure Valley.

Source	Description	EMS Relevance
Boise Dev (October 11, 2022)	Mayfield Springs county approval — 5,400+ population at buildout, commercial center, K–12 school; Mayfield Townsite (15,000 units, approved 2011) noted as additional pipeline.	Combined Mayfield projects could more than double county population over 20 years.
Idaho Business Review (January 31, 2023)	Mountain Home and Elmore County are preparing for developments that could double local population; Micron hiring increase driving housing demand just over Ada County border.	Population growth directly increases EMS call volume; Micron commuter population adds off-peak demand.

2. Casino Resort Development — Mountain Home

Two federally recognized Idaho tribes are pursuing separate casino resort projects in the Mountain Home area, both requiring approval from the U.S. Department of Interior, the Governor of Idaho, and local government entities.

The Shoshone-Bannock Tribes (headquartered at Fort Hall) purchased 157 acres along Interstate 84 near Exit 95 in January 2020 and submitted federal land-in-trust and gaming applications to the Department of Interior in June 2023. The proposed \$311 million resort-casino complex would include 2,000 electronic gaming machines, a 250-room hotel, six food and beverage venues, a 15,000-square-foot event center, an amphitheater, bowling alley, movie theater, and horse racing track — totaling approximately 500,000 square feet. An economic feasibility study projects that the facility would generate \$187.2 million in annual economic impact and employ 1,200 people permanently, with nearly 3,000 construction workers during the building phase.

The Shoshone-Paiute Tribes (headquartered on the Duck Valley Reservation) are separately pursuing a resort casino on a 40-acre parcel near the Ada–Elmore County line, also requiring federal trust approval. The tribe anticipates an 18–24 month construction timeline following approvals.

Both projects are in active federal review and neither has received final approval. However, the Shoshone-Bannock Tribes have confirmed ongoing negotiations with Elmore County and the City of Mountain Home on memoranda of agreement covering law enforcement, fire protection, and emergency management services — indicating the county is actively planning for the operational impacts of the facility.

Source	Description	EMS Relevance
Shoshone-Bannock Tribes (February 23, 2024)	Official update confirming applications submitted to Dept. of Interior; ongoing negotiations with Elmore County and Mountain Home on emergency services agreements.	Tribe actively negotiating EMS/fire/law enforcement MOAs with county.
KTVB News (February 23, 2024)	Tribes submitted applications for land-in-trust transfer and gaming authorization; \$311M complex, 157 acres at I-84 Exit 95.	24/7 casino operations generate consistent overnight EMS demand; hotel guests, large events.
Idaho Business Review (March 28, 2023)	~3,000 construction workers during build phase; 1,200 permanent jobs; \$187.2M projected annual economic impact; 80% of construction jobs taken by Mountain Home-area residents.	Construction-phase worker population increases trauma and occupational injury call volume.
Shoshone-Paiute Tribes (shopaitribes.org)	Separate casino proposal on 40-acre parcel near Ada–Elmore County line; 18–24 month construction timeline following approvals.	Second potential casino compounds call volume growth if both projects advance.

3. Western County Industrial and Economic Expansion

Western Elmore County is experiencing a convergence of industrial and military-related economic growth that will increase both the resident workforce population and daytime occupational activity in areas currently underserved by the district's station footprint.

The Elmore County Land Use and Building Department's active permit queue as of late 2025 and early 2026 includes a Mayfield Substation Project (CUP-2025-25) and Industrial Wastewater Evaporation Ponds (CUP-2025-13), reflecting industrial permitting activity in the western county corridor consistent with utility and energy sector growth. Additionally, the October 2025 Idaho Department of Labor regional economic report confirmed that U.S. Department of Defense officials announced Qatar military pilots will be trained at Mountain Home Air Force Base beginning around 2030, bringing 12 jets and requiring construction of a Qatari Emiri Air Force facility near the base. This international training mission represents a significant expansion of base-related activity and associated civilian population in Mountain Home.

The broader Treasure Valley economy, anchored by Micron Technology's ongoing hiring growth just across the Ada County border, is also driving an increase in the working-age population settling in Elmore County due to lower housing costs — directly contributing to both daytime commuter traffic on I-84 and growth in the district's residential call base.

Source	Description	EMS Relevance
Elmore County Land Use Dept. (2025–2026 Active Permits)	CUP-2025-25: Mayfield Substation Project. CUP-2025-13: Industrial Wastewater Evaporation Ponds. Both pending or recently approved in the western county corridor.	Industrial facilities generate occupational health and trauma call demand in areas west of current station coverage.
Idaho Dept. of Labor SW Idaho Economic Activity (October 2025)	Qatar military pilots to train at Mountain Home AFB ~2030; 12 jets; Qatari Emiri Air Force Facility construction planned near base.	Military construction and expanded base population increase call volume in Mountain Home core service area.
Idaho Business Review (January 31, 2023)	Mountain Home area is preparing for major population influx driven by Micron hiring and residential development; housing demand increasing.	Workforce growth drives residential call volume increases ahead of census-measured population changes.

4. I-84 Corridor Improvements and Traffic Growth

Interstate 84 runs directly through the district's highest-population service zone and is already the primary source of high-acuity motor vehicle accident calls. Multiple active Idaho Transportation Department (ITD) projects are expanding I-84 capacity and access in the Treasure Valley corridor, which will increase both traffic volume and development pressure along the Elmore County segment of the highway.

ITD has committed more than \$300 million to I-84 improvements in Canyon County alone, including widening to six lanes and rebuilding multiple interchanges. More directly relevant to Elmore County, the new State Highway 16 corridor — a limited-access freeway connecting I-84 to US-20/26 in the central Treasure Valley — is on track to open fully in 2027. This new north-south connection will redirect significant traffic volumes eastward through the Treasure Valley, increasing I-84 use in the Mountain Home area by improving access from growth areas north of Boise.

Increased highway capacity and interchange improvements at the Boise Stage Stop (Exit 95) — the primary access point for both the Mayfield Springs community and the proposed casino site — will accelerate development and traffic in that corridor. Higher traffic volumes on a high-speed rural interstate directly translate into higher-frequency and higher-acuity MVA call demand for the district.

Source	Description	EMS Relevance
ITD Projects (itdprojects.idaho.gov)	I-84 Corridor: \$300M+ in Canyon County improvements including widening and interchange reconstruction; ongoing through mid-2020s.	Increased highway capacity west of Elmore County drives traffic growth onto the Elmore County I-84 segment.
Idaho Transportation Dept. (itd.idaho.gov/project/sh16construction)	SH-16 new limited-access freeway, I-84 to US-20/26; full corridor expected to open 2027; funded under Governor Little's Leading Idaho initiative.	New north-south freeway redistributes Treasure Valley traffic patterns; increases I-84 volumes east of Boise through Elmore County.
ITD / Pacific Builder & Engineer (2021)	Idaho Transportation Board approved \$300M+ bond program; I-84, SH-16 and Chinden Blvd (US-20/26) widening projects accelerated.	Coordinated corridor investment signals sustained traffic growth on I-84 through the district's service area over the next decade.
Boise Dev (October 11, 2022)	Mayfield Springs development at Boise Stage Stop Exit 95 described as major development shift to the east; additional projects in same I-84 corridor noted.	Exit 95 and surrounding corridor will experience significant traffic growth from residential and commercial buildout.

5. Solar and Energy Development — Elmore County

Elmore County has become one of Idaho's most active utility-scale energy development corridors, with multiple large solar, wind, and battery storage projects in various stages of construction, permitting, or planning. The construction phases of these projects bring concentrated temporary workforces — in the hundreds to low thousands — into rural areas of the county, directly generating occupational injury and medical call demand in zones already operating at or beyond response time thresholds.

The most immediately significant project is Crimson Orchard Solar, developed by Clēnera (U.S. subsidiary of Enlight Renewable Energy). Elmore County approved the project's Conditional Use Permit (CUP-2024-18) in March 2025. Construction is underway as of 2025, with commercial operation planned for the first half of 2027. The project pairs 120 MW of solar generation with 400 megawatt-hours of battery energy storage, connecting to Idaho Power via a 20-year power purchase agreement. Clēnera secured \$304 million in construction financing from HSBC, ING Capital, KeyBanc Capital Markets, and MUFG Bank, with total project investment estimated at \$326–\$342 million.

A second project, CUP-2024-04, was also approved by Elmore County for a combined wind and solar facility featuring 47 turbines and solar arrays, interconnecting with Idaho Power at the Danskin substation. An existing 40 MW Black Mesa solar project with 40 MW battery storage already operates in the county. PowerWorks additionally operates the 22 MW Sawtooth Wind Farm in Elmore County and is developing the proposed 400 MW Desert Ridge wind-solar-storage project, though that project has no confirmed approval timeline.

The District already receives solar and wind farm revenue (\$60,000–\$95,000 annually per the financial section), confirming existing financial relationships with these projects. However, the construction-phase and operational-phase EMS implications have not previously been captured as call volume drivers. Multi-year construction projects sustained through 2027 and beyond represent a meaningful, near-term increase in workforce population within the county's rural western zones.

Source	Description	EMS Relevance
Elmore County Land Use & Building Dept. (CUP-2024-18, March 2025)	Crimson Orchard Solar CUP approved — 120 MW solar + 400 MWh battery storage; applicant required to coordinate with Elmore County EMS, Sheriff, and fire district.	CUP conditions explicitly involve EMS; construction workforce in western county rural zones.
Power Technology (March 2025)	Clēnera secures \$304M construction financing for Crimson Orchard; \$326–\$342M total investment; construction underway; commercial operation first half 2027.	Active construction workforce through 2027 in area west of current station coverage.
Elmore County Land Use & Building Dept. (CUP-2024-04, October 2024)	Wind and solar facility approved — 47 turbines + solar arrays connecting to Idaho Power Danskin substation; second large-scale energy project in county.	Additional construction workforce; occupational injury demand in rural zones.
Idaho Power (March 2023)	40 MW Black Mesa solar + 40 MW battery storage under construction in Elmore County; first major energy storage deployment in county.	Confirms Elmore County as established energy development corridor.

6. Pine/Featherville Recreation — Seasonal Population Surge in the Highest-Risk Zone

The Pine and Featherville area in northern Elmore County is one of southwest Idaho's most popular recreation destinations, drawing seasonal visitors for OHV riding, snowmobiling, fishing, boating, hot springs, hunting, and backcountry access to the Sawtooth National Recreation Area. This seasonal population surge occurs in the precise zone where the District's response times are already the longest and most clinically precarious.

The Pine-Featherville trail system encompasses 380 miles of off-highway vehicle trails, snowmobile routes, hiking paths, and mountain biking trails across four mountain ranges. Anderson Ranch Reservoir — a 4,730-acre reservoir on the South Fork of the Boise River with 50 miles of shoreline, ten campgrounds, and four large boat launches — draws boaters, water skiers, anglers, and campers throughout the summer season. Trinity Hot Springs and Baumgartner Hot Springs draw additional visitors year-round. Soldier Mountain ski resort and snowmobile trails extend demand into winter months. The Idaho Backcountry Discovery Route (IDBDR) passes directly through Pine, attracting multi-day off-road motorcycle travelers from across the region.

The EMS implications are specific to both activity type and geography. OHV accidents, boating injuries, drownings, falls in mountainous terrain, and altitude-related emergencies generate call types that are disproportionately trauma-intensive and time-critical — precisely the conditions where delayed response has the greatest clinical consequence. The existing report documents the Pine/Featherville zone at 14 min 47 sec average response time against a 14-minute NFPA standard, with remote mountain areas reaching 45–90 minutes under optimal conditions. Seasonal visitors may not be aware of these limitations when undertaking high-risk activities.

This recreation demand directly supports two investments already recommended in Section 4: the Pine Station helipad (the property has expansion capacity and helicopter utilization is frequent in this zone) and backup power installation at Pine Station, where extended rural power outages compound response delays.

Source	Description	EMS Relevance
Hayhurst B&B / Local Recreation Guides (hayhurstbnb.com)	380 miles of OHV, snowmobile, hiking, and mountain biking trails in the Pine-Featherville system across four mountain ranges; Idaho Backcountry Discovery Route (IDBDR) runs through Pine.	OHV accidents, falls, exhaustion, and remote trauma are primary call types; longest-response zone in the District.
Recreation.gov / Boise National Forest (n.d.)	Anderson Ranch Reservoir: 4,730-acre reservoir, 50 miles shoreline, 10 campgrounds, 4 boat launches; year-round recreation managed by Boise National Forest.	Water emergencies (drowning, boating trauma) require rapid response in area averaging 14+ min response times.
Southwest Idaho Travel Association (2024)	Featherville listed as major recreation destination offering rafting, ATVing, snowmobiling, hot springs, fishing, and boating; amenities include gas, medical center, grocery.	Tourism infrastructure confirms sustained seasonal visitation to northern zone.
Breaking AC / Idaho Commerce (March 2026)	Idaho direct travel spending reached \$3.7 billion in FY2025, supporting \$475M in state and local tax revenues; lodging tax collections up 5.2% year-over-year.	Statewide tourism growth context; Elmore County northern zone shares in recreational visitation trends.

7. Glenns Ferry — Population Growth at the District's Most Constrained Satellite Station

Glenns Ferry, Elmore County's second incorporated city, is experiencing measurable population and economic growth that is occurring at the location served by the District's most infrastructure-constrained satellite station. As documented in Section 4, the Glenns Ferry station cannot expand on its current property, has no backup power, no decontamination area, and accommodates only one ambulance and two crew members at maximum capacity.

According to U.S. Census data compiled by DataUSA, Glenns Ferry's population grew from 1,327 to 1,443 between 2022 and 2023 — an 8.74% single-year increase — while median household income grew from \$36,413 to \$51,625, a 41.8% increase in the same period. Both figures significantly exceed statewide averages for that year, suggesting economic activity beyond baseline demographic growth. Employment in Glenns Ferry grew 18.2% in the same period, from 534 to 631 workers.

Three Island Crossing State Park, located two miles off Interstate 84 at the Glenns Ferry exit, draws tourists from across the Pacific Northwest to the historic Oregon Trail river crossing site. The park includes campgrounds, eight cabins, picnic areas, and an interpretive center, generating year-round visitor traffic through the community. The broader Glenns Ferry economic development plan also envisions attracting light industry and expanding residential growth, with active community development committees pursuing these goals.

Growth at Glenns Ferry is particularly significant from an EMS planning perspective because it is occurring at the exact location where infrastructure constraints make service expansion most difficult and most expensive — requiring either relocation of the station or acquisition of adjacent property. Population growth that outpaces station capacity at this location cannot be absorbed through operational adjustments alone.

Source	Description	EMS Relevance
DataUSA (2023 Census data)	Glenns Ferry population grew 8.74% (2022–2023), from 1,327 to 1,443; median household income grew 41.8%; employment grew 18.2% in the same period.	Population growth at location of least-expandable satellite station; demand increases cannot be absorbed within existing facility constraints.
Idaho Department of Parks and Recreation (October 2025)	Three Island Crossing State Park at Glenns Ferry: campgrounds, 8 cabins, interpretive center, year-round operation. One of Idaho's significant Oregon Trail heritage sites.	Tourist traffic generates medical call demand (cardiac, trauma, medical emergencies) in community served by single-unit, non-expandable station.
Glenns Ferry Idaho (glennsferryidaho.org) (n.d.)	Downtown revitalization and economic development plans are active; community pursuing light industry, residential growth, and expanded tourism infrastructure.	Planned residential and commercial growth directly in the Glenns Ferry EMS service zone.

3.7.8 Staffing Assessment Conclusion

The Elmore County Ambulance District's staffing baseline of 43 FTEs is adequate to sustain current four-unit operations but provides insufficient depth for geographic expansion, surge demand, or leadership development. The projections in this section chart a phased path from 43 to 61 FTEs over four fiscal years at a total incremental personnel cost of approximately \$1.33 million annually by FY2029, representing a 43% increase over the FY2026 baseline.

This investment is not optional. The four growth drivers documented in Section 3.7.6 — Mayfield Springs (2,325+ homes, groundbreaking October 2024), two competing casino resort proposals (\$311 million Shoshone-Bannock project in active federal review, Shoshone-Paiute project separately pursuing approval), western county industrial and military expansion including a Qatari Air Force training facility at Mountain Home AFB, and accelerating I-84 corridor traffic from over \$300 million in regional highway improvements — represent documented, permitted, or federally active projects that will drive EMS call volume increases that current staffing cannot absorb.

The Compounding Cost of Delayed Hiring

Each year the District delays filling its leadership and clinical vacancies triggers a self-reinforcing cycle of operational degradation that becomes harder to reverse over time. The mechanism operates through four documented pathways:

- Overtime and fatigue accumulate immediately. When authorized positions go unfilled, the existing workforce absorbs the gap through mandatory overtime and extended shifts. The National Association of State EMS Officials has identified fatigue as one of the most serious hidden dangers in EMS, with irregular and back-to-back shifts directly contributing to provider error and compromised patient safety (NASEMSO, 2018). The District's 22 Ambulance Service FTEs are already operating a 4-unit, 24/7 deployment at stated capacity. Any further demand without additional staffing increases the overtime burden on those providers from day one.
- Burnout converts vacancies into attrition. The 2025 EMS1/Fitch & Associates What Paramedics Want survey found that inadequate staffing was ranked the most stressful aspect of the job by 25% of EMS providers — and that losing top performers to burnout creates a vicious cycle in which new employees who encounter a burnout culture are more likely to leave quickly rather than invest in their roles (EMS1/Fitch & Associates, 2025). Nationally, burnout estimates among EMS providers nearly doubled between 2015 and 2022 and are now directly associated with intention to leave the profession within one year (National Registry of EMTs, 2024). A delayed vacancy that generates burnout does not preserve the status quo — it converts one open position into two or three.
- Leadership vacancies suppress retention independently of workload. The 2025 EMS workforce survey found that 33% of EMS providers report dissatisfaction with their agency's leadership, and over 50% report that their supervisor rarely or never provides recognition, praise, or constructive feedback (EMS1, 2025). Poor leadership directly

increases turnover even when staffing levels are otherwise adequate. The District's Ambulance Chief position — unfilled in FY2026 — is the single position most responsible for providing that supervisory presence. Every month this role remains open, the District operates without a system-wide operations leader, training oversight, or the supervisory accountability structures that research consistently identifies as a primary driver of EMS retention.

- Replacement costs and timelines grow with each cycle. The American Ambulance Association's 2021 Employee Turnover Study found that the average cost to recruit, screen, and onboard a replacement paramedic is \$9,112 — and that turnover among EMS clinicians runs 20–30% annually, implying a full staff replacement cycle of roughly four years (AAA, 2021). Each departure triggered by understaffing and burnout restarts a 6–12 month recruitment and onboarding timeline at that cost, during which the operational gap persists and the cycle deepens. Nationally, staffing shortages have already left 39% of EMS positions and 55% of paramedic positions vacant, creating a regional labor pool that makes late-entry recruitment progressively harder (JEMS, 2024).

The operational consequence of this compounding cycle is measurable. Nationally, EMS staffing shortages have produced documented delays in dispatch, reductions in crew availability, and increased reliance on mutual aid — a response mode that the National EMS Advisory Council has confirmed produces longer response times and patient care delays in both the requesting and responding jurisdictions simultaneously (NEMS Advisory Council, 2022). For Elmore County, where mutual aid resources are already 50–90 minutes away (Section 6.3), any incremental reduction in the District's internal staffing capacity has a direct and immediate impact on response times for the District's most time-critical patients.

The District is not yet in a staffing crisis — it is at the threshold. The window to hire ahead of demand, build a stable leadership structure, and fill the clinical pipeline before growth arrives is open now. The staffing projections in this section are designed to keep it that way.

The projections presented here form the personnel cost basis for the revenue analysis in Section 7 and the needs cost model in Section 8.

Section Summary

The Elmore County Ambulance District currently operates at staffing capacity across all stations, serving 3,075 square miles and approximately 29,729 residents. While call volumes have remained stable at approximately 3,000 calls annually over the past three years, anticipated regional growth—including housing development, industrial expansion, casino construction, and freeway improvements—will drive increased demand that current staffing levels cannot sustain.

This assessment documents current staffing, evaluates alignment with national standards, identifies operational gaps, and projects near-term and future staffing requirements to maintain service quality, ensure crew safety, and prevent response time degradation.

Service Area Context

Geographic Challenges

Zone	Characteristics	Impact on Staffing
Northern Zone (~60% of county)	Rugged terrain, peaks to 10,651 ft, seasonal access limitations	Extended response times, specialized capabilities required, seasonal demand fluctuations
Southern Zone (~40% of county)	Snake River Plain, I-84 corridor, population centers	Higher call density, MVA demand, interfacility transfer burden
Mountain Home AFB	~4,500 population	Adds complexity to service demand

Operational Realities

- **60% of service area** is mountainous terrain requiring specialized response capabilities
- **Interfacility transfers to Boise** (2–3 hour round trips) removes units from emergency availability for extended periods
- **I-84 corridor** generates high-acuity motor vehicle accident demand
- **Seasonal access limitations** in northern mountain communities affect response and staffing deployment

Research presented at the American College of Surgeons Clinical Congress 2025 found that rural EMS call times average 92.8 minutes compared to 74.1 minutes nationally, with high-acuity calls averaging 97.1 minutes versus 69 minutes nationally. These extended time-on-task figures reduce unit availability and effectively lower the number of calls a system can handle while maintaining response time targets.

Current Staffing Levels

Personnel Summary

Category	Count	Notes
Full-Time Medical Staff	23	Includes 8 Paramedics; includes CHEMS staff
Part-Time Medical Staff	17	Mixed certification levels (EMT, AEMT, Paramedic)
Part-Time Rescue Technicians	19	On-call basis
Full-Time Director	1	Administrative oversight
Total Personnel	60	All stations combined

Current Capacity Status

All stations are currently operating at staffing capacity.

Station	Status
Mountain Home	At capacity
Glenns Ferry	At capacity
Pine	At capacity

National Standards and Industry Benchmarks

Response Time Standards

NFPA 1710 (Career Fire Departments) establishes:

- **Turnout time:** 60 seconds for EMS calls
- **First responder arrival:** 4 minutes travel time (240 seconds)
- **ALS unit arrival:** 8 minutes (480 seconds) for 90% of incidents
- **ALS scene staffing:** Minimum of 2 Paramedics and 2 EMTs for cardiac arrest and other high-acuity calls

NFPA 1720 (Volunteer/Combination Departments) establishes response benchmarks by demand zone:

Demand Zone	Population Density	Staffing	Response Time	Compliance Target
Urban	>1,000/sq mi	15 personnel	9 minutes	90%
Suburban	500–1,000/sq mi	10 personnel	10 minutes	80%
Rural	<500/sq mi	6 personnel	14 minutes	80%
Remote	Travel distance ≥8 mi	4 personnel	As established by AHJ	90%

Elmore County Context: With a population density of approximately 9.7 persons per square mile ($29,729 \div 3,075$), the county falls within the "Rural" and "Remote" categories under NFPA 1720, where 14-minute response times are the benchmark for 80% compliance—yet much of the northern service area may exceed even these extended targets due to terrain and distance.

Ambulance Staffing Requirements

NFPA 1710 Section 5.3 specifies:

- ALS ambulances shall be staffed with a minimum of two personnel, with at least one certified at the Paramedic level
- For high-acuity ALS calls, the effective response force should include a minimum of two Paramedics and two EMTs

Idaho State Requirements (IDAPA 16.01.03):

- EMS agencies are licensed at BLS, ILS, or ALS clinical levels based on highest personnel certification

- ALS agencies must deploy licensed personnel trained and equipped to provide Paramedic skills
- Personnel must practice under physician supervision with established protocols

Unit Hour Utilization (UHU) Standards

Unit Hour Utilization measures system workload by dividing transport (or total call time) by staffed unit hours.

Industry Benchmarks:

System Type	Recommended Range	UHU	Rationale
911 EMS systems	0.25–0.35		Ensures unit availability for emergencies
24-hour systems	shift	0.25–0.30	Accounts for fatigue, rest, documentation, training
12-hour systems	shift	0.35–0.50	Shorter shifts tolerate higher utilization

Key Findings from Research:

- EMS agencies responding solely to 911 calls typically target lower UHU (0.30–0.50) to ensure sufficient units remain available
- Agencies with 24-hour shifts aim for lower UHUs due to concerns over fatigue and safety
- UHU rates above 25–30% for 24-hour operations can lead to employee burnout and negatively affect station and unit reliability
- Work-related burnout is highest among providers responding to 20+ calls per week—nearly 2.5 times the odds of burnout compared to those handling fewer than 5 calls weekly
- High UHU can result in provider fatigue and medical errors, particularly in 24-hour shift systems

Call Volume Analysis: Historical Trends

Call volumes have remained essentially stable over the past three fiscal years. The year-over-year variation of less than 1% is statistically insignificant and falls within normal operational variance.

Metric	Value
Annual call volume	~3,000 calls
Year-over-year variance	<1% (stable)
Trend period	3 fiscal years

Current System Utilization: 4-Unit System Analysis:

Metric	Calculation	Result
Calls per unit per year	$3,000 \div 4 \text{ units}$	750 calls/unit
Calls per unit per day	$750 \div 365$	~2.05 calls/unit/day

Operational Considerations:

- Call distribution is not uniform—peak periods may commit all 4 units simultaneously
- When all units are committed, the district enters **"Level Zero" status** requiring mutual aid
- Interfacility transfers to Boise (2–3 hour round trips) can remove 1–2 units from emergency availability
- Only 2 ALS units must be strategically deployed to ensure Paramedic coverage for high-acuity calls
- Extended rural call times (averaging 92.8 minutes vs. 74.1 minutes nationally) further reduce effective capacity

Burnout and Fatigue Risk - Current Risk Factors:

- Staff fatigue and burnout considerations limit sustainable utilization rates
- Industry guidance recommends UHU targets of 0.30–0.50 for 24-hour systems to allow adequate time for rest, documentation, and equipment maintenance
- Research shows high UHU leads to increased turnover, decreased job satisfaction, and medical errors
- Crews at capacity now face elevated risk if call volume increases

Identified Staffing Gaps

Immediate Needs

Position	Justification	Priority
Full-Time EMS Chief	Coordination of all stations; oversight of training, staffing, scheduling, and daily operations. Currently no dedicated position for system-wide operational management.	Immediate
Seasonal Paramedic (Pine)	6-month position during tourism season. Northern zone experiences significant seasonal demand increase: current staffing cannot absorb surge without degrading coverage elsewhere.	Immediate

Administrative Gap

EMS leadership and support functions are currently fragmented:

- EMS Director
- Deputy Chief
- CEMS staff
- Billing staff

These positions are dispersed across multiple county locations, creating coordination inefficiencies. Additionally, payroll and certain administrative duties are currently handled by county staff rather than dedicated EMS personnel.

Position	Justification	Priority
Billing/Payroll Staff	Additional position to handle payroll and administrative duties currently performed by county staff; consolidates EMS administrative functions	Near-Term

Future Staffing Requirements

Projected Growth Drivers

Factor	Impact on Call Volume
Housing developments	Population growth increases medical call demand
Industrial expansions	Workplace injuries, occupational health calls
Casino developments	24/7 operations, increased traffic, visitor population
Freeway expansion	Construction-phase incidents; post-completion MVA changes
Tourism growth (northern zone)	Seasonal surge in recreation-related emergencies

Risk Assessment: Growth is coming to the area in housing, industrial, casinos, and expanded freeway infrastructure. These developments will drive call volume higher, taxing crews already at capacity. Without staffing increases, the District faces:

- Work overload and accelerated burnout
- Increased risk of on-duty injury
- Response times exceeding national standards
- Greater risk of adverse patient outcomes

Near-Term Staffing Plan (1–2 Years)

Mayfield / West Elmore County Coverage:

Position Type	Count	Rationale
Paramedics	4	ALS capability for western coverage area
EMTs	4	BLS staffing and transport support
Subtotal	8	New positions for geographic expansion

West Mountain Home Expansion:

Position Type	Count	Rationale
Paramedics	4	ALS capability for growing west-side demand
EMTs	4	BLS staffing and transport support
Subtotal	8	New positions for service area growth

Staffing Projection Summary

Category	Current	Immediate Adds	1–2 Year Adds	Projected Total
Full-Time Medical	23	—	+16	39
Part-Time Medical	17	—	TBD	17+
Rescue Technicians	19	—	TBD	19+
EMS Chief	0	+1	—	1
Seasonal Paramedic	0	+1	—	1
Billing/Admin	0	—	+1	1
Director	1	—	—	1

Standards Alignment Assessment

Current Gaps

Standard	Requirement	Current Status	Gap
NFPA 1710	2 Paramedics + 2 EMTs for high-acuity ALS	2 ALS units; 8 Paramedics total	Marginal compliance; limited redundancy
NFPA 1710	8-minute ALS response, 90%	Not measured/reported	Assessment needed
NFPA 1720	14-minute response (rural), 80%	Northern zone likely exceeds	Terrain/distance limitations
Industry	UHU 0.25–0.35 for 24-hr systems	At capacity	Elevated burnout risk
Industry	Dedicated EMS operations chief	None	Gap

Recommended Actions for Standards Compliance

1. **Implement response time tracking** aligned with NFPA 1710/1720 benchmarks
2. **Calculate and monitor UHU** to assess burnout risk and system capacity
3. **Add EMS Chief position** to provide dedicated operational oversight per industry best practice
4. **Increase Paramedic depth** to ensure consistent 2-Paramedic response capability for high-acuity calls
5. **Develop geographic coverage expansion** (Mayfield, West Mountain Home) before growth outpaces capacity

Financial Considerations

Position Cost Estimates

Note: Actual costs will vary based on benefits, overtime, and local wage scales.

Position	Estimated Annual Cost	Notes
Full-Time Paramedic	\$65,000–\$85,000	Includes benefits
Full-Time EMT	\$45,000–\$60,000	Includes benefits
EMS Chief	\$80,000–\$100,000	Supervisory/management position
Seasonal Paramedic (6 mo.)	\$35,000–\$45,000	Pro-rated; may include housing
Billing/Admin Staff	\$45,000–\$55,000	Includes benefits

Phased Implementation

Phase	Positions	Estimated Cost Impact
Immediate	EMS Chief + Seasonal Paramedic	\$115,000–\$145,000/year
Year 1–2	Mayfield coverage (4 Paramedic + 4 EMT)	\$440,000–\$580,000/year
Year 1–2	West Mountain Home (4 Paramedic + 4 EMT)	\$440,000–\$580,000/year
Near-Term	Billing/Admin position	\$45,000–\$55,000/year

Risk Analysis: Status Quo vs. Staffing Investment

Consequences of Maintaining Current Staffing

Risk	Impact
Response time degradation	Exceeds NFPA standards; increased patient mortality risk
Crew burnout	Turnover, recruitment challenges, medical errors
On-duty injuries	Fatigue-related incidents; workers' compensation costs
Level Zero events	Increased mutual aid dependence; coverage gaps
Regulatory exposure	Potential non-compliance with state/national standards
Community safety	Inability to meet service expectations during growth period

Benefits of Staffing Investment

Benefit	Outcome
Standards compliance	Meets NFPA 1710/1720 response benchmarks
Crew welfare	Sustainable UHU; reduced burnout and turnover
Service capacity	Absorbs growth without degrading response times
Geographic coverage	Addresses underserved western areas
Operational coordination	EMS Chief provides system-wide oversight
Administrative efficiency	Consolidated billing/payroll functions

Recommendations

Immediate (Current Fiscal Year)

1. **Hire full-time EMS Chief** to coordinate all stations, manage training, staffing, scheduling, and daily operations
2. **Establish seasonal Paramedic position for Pine** (6-month tourism season coverage)
3. **Implement UHU tracking** to monitor system capacity and burnout risk
4. **Begin response time data collection** aligned with NFPA 1710/1720 benchmarks

Near-Term (1–2 Years)

5. **Staff Mayfield/West Elmore County coverage** with 4 Paramedics and 4 EMTs
6. **Staff West Mountain Home expansion** with 4 Paramedics and 4 EMTs
7. **Add billing/administrative position** to consolidate payroll and administrative functions
8. **Conduct formal Standards of Coverage study** to validate staffing model against projected growth

Ongoing

9. **Monitor call volume trends** quarterly to identify demand changes before capacity is exceeded
10. **Track recruitment and retention metrics** to identify workforce sustainability issues early
11. **Coordinate staffing plan with facility improvements** (capacity constraints at current stations may limit staffing expansion without concurrent facility investment)

Conclusion

The Elmore County Ambulance District has maintained stable service delivery with current staffing levels, but the system operates at capacity with no reserve for growth or surge demand. Anticipated development across the county will increase call volume beyond what current staffing can sustainably support.

Investment in additional personnel—beginning with an EMS Chief and seasonal Pine coverage, followed by geographic expansion staffing—is necessary to:

- Maintain response times within national standards
- Prevent crew burnout and associated turnover
- Ensure adequate ALS coverage across the service area
- Position the District to absorb growth without service degradation

The alternative—maintaining current staffing while demand increases—creates unacceptable risks to crew welfare, patient outcomes, and system sustainability.

Assessment based on NFPA 1710, NFPA 1720, Idaho Administrative Code (IDAPA 16.01.03), American College of Surgeons research, and industry best practices for EMS system design.

4. EQUIPMENT AND FACILITIES ASSESSMENT

4.1 Introduction and Purpose

This section evaluates the current state of the Elmore County Ambulance District's physical assets—vehicles, medical equipment, and facilities—and their direct impact on service delivery and response times. The assessment establishes whether current equipment and infrastructure can support the call volume and geographic coverage requirements of the District.

Key Finding: Equipment and facility constraints directly contribute to response time delays through mechanical failures, inadequate unit availability, and suboptimal station placement. National data indicates that vehicle mechanical issues account for a measurable percentage of EMS response delays.

4.2 Ambulance Fleet Inventory

4.2.1 National Standards and Benchmarks

NFPA 1917 (Standard for Automotive Ambulances): Establishes minimum requirements for the design, performance, and testing of new automotive ambulances. Developed to address ambulance crash mortality and provide standardized safety specifications.

CAAS Ground Vehicle Standard (GVS): The Commission on Accreditation of Ambulance Services establishes the 'gold standard' for ambulance specifications, covering Type I (cab-chassis with modular body), Type II (van with integrated cab-body), and Type III (cutaway van with modular body) configurations.

Industry Replacement Benchmarks:

- Light-duty chassis ambulances: Typically replaced at 250,000 miles OR 5 years (whichever comes first) under standard replacement schedules
- With world-class maintenance: Can extend to 350,000 miles OR 7 years with rigorous preventive maintenance programs
- Engine hours vs. odometer: One hour of idle time equals approximately 30 miles of driving wear; maintenance should be triggered by engine hours, not just mileage
- Remount consideration: Modular bodies (Type I and Type III) can be remounted on new chassis, providing cost savings of 40-50% compared to full replacement

4.2.2 Fleet Inventory

<i>Unit #</i>	<i>Year</i>	<i>Make</i>	<i>Model</i>	<i>Age (Yrs)</i>	<i>Mileage</i>	<i>Condition</i>	<i>Primary Station</i>
3	2016	Chevrolet	Type 3	10 Yrs	170,000	P	
6	2019	Ford	Type 1	7 Yrs	162,000	P	
7	2019	Ford	Type 1	7 Yrs	132,000	F	
8	2019	Ford	Type 1	7 Yrs	90,000	F	
9	2023	Ford	Type 1	3 Yrs	26,000	G	
10	2024	Ford	Type 1	2 Yrs	12,000	G	
2517	2017	Chevrolet 4x4	Type 1	8 Yrs	30,000	G	
	2011	Expedition		15 Yrs	135,000	P	
	2014	Ford	F550	12 Yrs	167,000	F	Pine Rescue
	2000		3500	26 Yrs	unknown	P	Atlanta Rescue
	2010	(Ambulance)		16 Yrs	unknown	F	Atlanta
	2003	Chevrolet	(Ambulance)	23 Yrs	unknown	P	Prairie
	2002	Ford	F350	24 Yrs	unknown	P	Prairie Rescue
2690	2016	FreightLiner		10 Yrs	22,160	G	
2691	2020	Dodge	3500	6 Yrs	12,632	G	
2692	1994	International	4500	32 Yrs	50,292	F	

Unit #	Year	Make	Model	Age (Yrs)	Mileage	Condition	Primary Station
2693	2002	GMC	2500	24 Yrs	165,880	P	
Rescue 1	2025	Chevrolet	3500	1 Yrs	6,000	G	

Condition Rating Key: G = Good (meets all standards), F = Fair (minor issues, operational), P = Poor (significant concerns, needs replacement)

4.2.3 Fleet Analysis Questions

1. How many units exceed the 5-year/250,000-mile industry replacement benchmark?
5 of 7
2. What is the average fleet age? What is the average mileage?
6.2 years 114,000 miles
3. How many units are available per shift (primary, reserve, out of service)?
2 primary, 1 reserve
4. What is the current ratio of front-line units to reserve units? (Recommended: 1.5:1)
3.5:1
5. How many mechanical failure incidents occurred in the past 12 months that affected response capability?
No failures in line of duty. All found with daily checks and an aggressive maintenance program

Fleet Replacement Program Assessment

Current Program Status

The department operates on a 5-year ambulance replacement cycle with a 150,000-mile threshold, replacing one unit annually. This program stalled for two years during COVID-19, creating a replacement backlog that has allowed several units to age beyond recommended service life.

Current budget constraints limit the department to remounting existing modular bodies onto new chassis rather than purchasing complete replacement units. While remounting provides cost savings of 40–50% compared to full replacement, this approach has significant limitations:

- **No fleet expansion capability** – Budget supports only remounts, not additional units
- **Single remount lifespan** – Each modular body can only be remounted once before requiring full replacement at substantially higher cost
- **Deferred expense, not avoided expense** – Remounting delays but does not eliminate the need for eventual full replacement

Vehicle Replacement Costs

Vehicle Type	Configuration	Cost
Ambulance	Complete with equipment	\$450,000
Ambulance	Bare (chassis and body only)	\$300,000
Rescue Truck	Large/heavy duty (no equipment)	\$400,000
Rescue Truck	Medium duty (no equipment)	\$250,000

Note: Rescue trucks have an extended service life of up to 20 years compared to 5–7 years for ambulances.

Fleet Condition Analysis

Ambulance Fleet Summary

Based on the 5-year/250,000-mile industry replacement benchmark (NFPA 1917, CAAS GVS):

Primary Station – Ambulance Fleet

Based on the 5-year/250,000-mile industry replacement benchmark (NFPA 1917, CAAS GVS):

Metric	Finding	Benchmark
Units exceeding replacement benchmark	5 of 7 units (71%)	—
Average fleet age	6.2 years	5 years
Average mileage	114,000 miles	250,000 miles
Units available per shift	2 primary, 1 reserve	—
Front-line to reserve ratio	3.5:1	1.5:1 recommended
Mechanical failures affecting response (12 mo.)	0	—

Reserve Ratio Deficiency: The current 3.5:1 front-line to reserve ratio significantly exceeds the recommended 1.5:1 standard. This means the department has insufficient reserve capacity to cover units during scheduled maintenance, unplanned repairs, or surge demand. Industry best practice calls for approximately one reserve unit for every 1.5 front-line units; the current ratio provides less than half the recommended reserve depth.

Maintenance Program Success: An aggressive preventive maintenance program and daily vehicle checks have resulted in zero mechanical failures affecting response capability over the past 12 months. All issues have been identified during routine inspections before impacting operations. This proactive approach supports the viability of extending service life on well-maintained units but does not eliminate the need for timely replacement of aging chassis and equipment.

Overall Ambulance Fleet

Based on the 5-year/250,000-mile industry replacement benchmark (NFPA 1917, CAAS GVS):

Metric	Finding
Units exceeding 5-year benchmark	8 of 13 units (62%)
Units in Poor condition	5 units
Units in Fair condition	4 units
Units in Good condition	4 units
Average ambulance age	10.6 years
Oldest unit	26 years (Atlanta Rescue, 2000)

Critical Concerns – Ambulance Fleet

Unit	Year	Age	Mileage	Condition	Location
Unit 3	2016	10 yrs	170,000	Poor	—
Unit 6	2019	7 yrs	162,000	Poor	—
2011 Expedition	2011	15 yrs	135,000	Poor	—
Atlanta Rescue	2000	26 yrs	Unknown	Poor	Atlanta
Prairie Ambulance	2003	23 yrs	Unknown	Poor	Prairie
Prairie Rescue	2002	24 yrs	Unknown	Poor	Prairie

Rescue/Support Fleet Summary

Metric	Finding
Units exceeding 20-year benchmark	2 of 5 units (40%)
Average rescue fleet age	14.6 years
Oldest unit	32 years (1994 International)

Outlying Stations – Critical Deficiency

Outlying stations (Pine, Atlanta, Prairie) have received **no new unit purchases** and currently rely on donated vehicles from the Idaho Power Program. These aging, donated units present significant reliability and safety concerns:

Location	Unit	Year	Age	Mileage	Condition
Pine	F550 Rescue	2014	12 yrs	167,000	Fair
Atlanta	Rescue	2000	26 yrs	Unknown	Poor
Atlanta	Ambulance	2010	16 yrs	Unknown	Fair
Prairie	Ambulance	2003	23 yrs	Unknown	Poor
Prairie	F350 Rescue	2002	24 yrs	Unknown	Poor

Average age of outlying station units: 20.2 years

Four of five outlying station units are in Poor or Fair condition, with three units exceeding 20 years of service. These communities depend on equipment that would not meet current NFPA 1917 or CAAS standards and may present crew safety concerns in the event of a collision.

Outlying Station Deficiency

Outlying stations (Pine, Atlanta, Prairie) have received **no new unit purchases** and currently rely on donated vehicles from the Idaho Power Program. These ageing, donated units present reliability and safety concerns:

- Atlanta: Operating a 26-year-old rescue vehicle and 16-year-old ambulance
- Prairie: Operating a 23-year-old ambulance and 24-year-old rescue truck
- Pine: Operating a 12-year-old rescue truck in Fair condition

Industry Standards Reference

Per NFPA 1917 and CAAS Ground Vehicle Standards:

- **Standard replacement:** 250,000 miles OR 5 years (whichever comes first)
- **Extended service (world-class maintenance):** 350,000 miles OR 7 years maximum
- **Engine hour consideration:** One hour of idle time equals approximately 30 miles of driving wear; maintenance intervals should be triggered by engine hours, not odometer alone
- **Remount viability:** Type I and Type III modular bodies can be remounted once, providing 40–50% cost savings over full replacement

Recommended Actions

1. **Address reserve ratio deficiency:** Current 3.5:1 ratio provides inadequate backup capacity; prioritize adding reserve units to approach the 1.5:1 industry standard
2. **Replace units in Poor condition:** Unit 3 (2016) and Unit 6 (2019) at primary station require immediate attention
3. **Outlying stations:** Establish dedicated replacement funding rather than continuing reliance on donated equipment that does not meet current safety standards
4. **Program recovery:** Develop a 3–5 year accelerated replacement schedule to address the two-year COVID-related backlog
5. **Continue maintenance excellence:** The current preventive maintenance program has proven effective; sustained investment supports extended service life where appropriate
6. **Budget planning:** Account for post-remount full replacements in out-year projections (each remounted unit will require full replacement at \$450,000 after one additional service cycle)

**Assessment based on fleet inventory data and NFPA 1917/CAAS GVS industry benchmarks.*

4.3 Medical Equipment Assessment

4.3.1 Critical Equipment Standards

Cardiac Monitor/Defibrillators

- **Expected service life:** 8 years (per manufacturer specifications, e.g., Stryker LIFEPAK)
- **Battery replacement:** Every 2-4 years depending on usage
- **Electrode pads:** Replace per manufacturer expiration dates (typically 2 years)
- **Annual calibration/certification:** Required for biomedical compliance

Ventilators/Airway Management

- **Transport ventilators:** 5-10 year service life; annual preventive maintenance required
- **CPAP/BiPAP devices:** Annual inspection and calibration

Communications Equipment

- **Mobile radios:** 7-10 year service life; must be compatible with regional interoperability standards
- **Portable radios:** 5-7 year service life; battery replacement every 18-24 months
- **MDT/CAD terminals:** 3-5 year replacement cycle for hardware; software updates per dispatch center requirements

4.3.2 Equipment Inventory Template

<i>Equipment Type</i>	<i>Make/Model</i>	<i>Qty</i>	<i>Avg Age</i>	<i>Last Service</i>	<i>Status</i>
<i>Cardiac Monitor/Defib W/12-lead ECG</i>	<i>Zoll X series</i>	<i>7</i>	<i>[2.5 yrs]</i>	<i>[02/2025]</i>	<i>G</i>
<i>Video Laryngoscope</i>	<i>Mgrath MAC Laryngoscope</i>	<i>video [2]</i>	<i>[12 yrs]</i>	<i>[12 + yrs]</i>	<i>F</i>
<i>Transport Ventilator</i>	<i>Auto Vent 4000</i>	<i>[5]</i>	<i>[5 yrs]</i>	<i>[01/26]</i>	<i>[F]</i>
<i>Transport Ventilator</i>	<i>LTV 1200</i>	<i>1</i>	<i>20+ yrs</i>	<i>01/26</i>	<i>F</i>
<i>IV Pump</i>	<i>Sapphire Infusion pump</i>	<i>6</i>	<i>5 yrs</i>	<i>[02/25]</i>	<i>[F]</i>
<i>Suction Unit</i>	<i>Devilbiss Home Care suction unit</i>	<i>7</i>	<i>15+ yrs</i>	<i>02/25</i>	<i>P</i>

<i>Equipment Type</i>	<i>Make/Model</i>	<i>Qty</i>	<i>Avg Age</i>	<i>Last Service</i>	<i>Status</i>
<i>Power Stretcher/Cot</i>	<i>Stryker Power Pro</i>	6	10 yrs	12/25	<i>F</i>
<i>Power Stretcher/Cot</i>	<i>Stryker Power Pro 2</i>	1	2 yrs	12/25	<i>G</i>
<i>Stair Chair</i>	<i>Stryker StairPro 6252</i>	5	10+ yrs	10+	<i>P</i>
<i>Mobile Radio</i>	<i>Motorola 5550e</i>	6	2 yrs	n/a	<i>F</i>
<i>Mobile Radio</i>	<i>Motorola PBR 2500</i>	6	7 yrs	n/a	<i>F</i>
<i>Portable Radio</i>	<i>Motorola XPR3500E</i>	8	10+ yrs	10+	<i>F</i>
<i>Portable Radio</i>	<i>Motorola HT 1250/ PR860</i>	6	10+ yrs	10+	<i>P</i>
<i>Portable Radio</i>	<i>Mag 1</i>	6	10+ yrs	10 +	<i>F</i>
<i>MDT/Laptop</i>	<i>DELL 1YBLTG2</i>	6	7 yrs	n/a	<i>F</i>
<i>Tablets</i>	<i>Microsoft surface Pro</i>	4	7 yrs	n/a	<i>F</i>
<i>Tablets</i>	<i>X-tablet</i>	2	2 yrs	n/a	<i>F</i>

Status Key: G = Good (current, operational), F = Fair (approaching end of life), P = Poor (needs immediate replacement)

4.3.3 Rescue Equipment

<i>Equipment Type</i>	<i>Replacement Cost</i>	<i>Purchase Date</i>	<i>Age</i>	<i>Recommended Lifespan</i>
<i>Hurst Tool Set (Jaws of Life)</i>	<i>\$50,000-\$60,000</i>	<i>2022</i>		<i>10-15 years</i>
<i>Hurst Tool Set (Jaws of Life)</i>	<i>\$50,000-\$60,000</i>	<i>2019</i>		<i>10-15 years</i>
<i>Hurst Tool Set (Jaws of Life)</i>	<i>\$50,000-\$60,000</i>	<i>2016</i>	<i>10 years</i>	<i>10-15 years</i>
<i>Rescue 42 Struts System</i>	<i>\$10,000-\$14,000</i>	<i>2010</i>	<i>16 years</i>	<i>5-10 years</i>
<i>Rescue 42 Struts System</i>	<i>\$10,000-\$14,000</i>	<i>2010</i>	<i>16 years</i>	<i>5-10 years</i>
<i>AMKUS rescue tools—including spreaders, cutters, and rams</i>	<i>\$50,000</i>	<i>2010</i>	<i>16 years</i>	<i>10 years</i>
<i>Paratech airbag set</i>	<i>\$16,000</i>	<i>2010</i>	<i>16 years</i>	<i>7-10 years</i>
<i>Paratech airbag set</i>	<i>\$16,000</i>	<i>2010</i>	<i>16 years</i>	<i>7-10 years</i>
<i>Misc hand tools</i>	<i>\$100,000+</i>			
<i>Handheld Radios</i>	<i>\$75,000+</i>		<i>Over 20 years old</i>	<i>Average 5-7 years</i>

4.4 Facilities Assessment

4.4.1 Station Location and Coverage Standards

Optimal EMS station placement is determined by response time targets and geographic coverage requirements. National standards provide the following benchmarks:

NFPA 1710 (Career Fire Departments)

- **Turnout time:** 60 seconds for EMS calls (time from notification to apparatus moving)
- **Travel time:** 4 minutes (240 seconds) for urban areas
- **Performance target:** 90% compliance with 5-minute total response time in urban areas

NFPA 1720 (Volunteer/Combination Departments)

- **Urban areas (>1,000/sq mi):** 9 minutes, 90% of the time
- **Suburban areas (500-1,000/sq mi):** 10 minutes, 80% of the time
- **Rural areas (<500/sq mi):** 14 minutes, 80% of the time
- **Remote areas:** Dependent on travel distance; response time performance should be negotiated with community

4.4.2 Station Inventory

Station	Location	Year Built	Bay Capacity	Units Housed	Primary Coverage
<i>Mountain Home 3600 Square Feet</i>	<i>2259 E 8th N Mountain Home ID 83647</i>	<i>2010</i>	<i>4</i>	<i>4 ambulances</i>	<i>Mountain Home, Mountain Home AFB, I-84 corridor, southern county population centers</i>
<i>Glenns Ferry 1800 Square Ft</i>	<i>170 East 2nd Ave Glenns Ferry, ID 83623</i>	<i>Unknown</i>	<i>1</i>	<i>1 ambulance</i>	<i>Eastern county, Three Island Crossing, I-84 east corridor</i>
<i>Pine 2632 Square Feet</i>	<i>Pine EMS 385 N Alpine Cir Pine, ID 83647- 6323</i>	<i>Unknown</i>	<i>2</i>	<i>2 ambulances</i>	<i>Northern mountain zone: Pine, Featherville, Atlanta (shared facility with Elmore County Sheriff)</i>
<i>Rescue 4200 Square Feet</i>		<i>1984</i>		<i>1 ambulance (overflow) +Rescue apparatus</i>	<i>Rescue operations; overflow vehicle storage from Mountain Home station</i>

All current facilities are at max capacity. Mountain Home only holds 4 ambulances and 4 crew members; additional Rescue ambulance is stored at the Rescue building. No office space is available for EMS staff. Current workstations are in the day room area. EMS Director, Deputy Chief, CHEMS staff, and Billing staff are all in different locations at other county locations. No possibility of expansion due to current layout. There is no dedicated DECON area. The parking bay is used for multiple tasks. There is no backup power; when outages occur, manual operation of Response Door must be initiated. There is no area for visitors' meetings or dedicated training at this location.

Station Facilities – Ownership and Building History

Station	Year Built	Ownership	Facility Configuration
Mountain Home	2010	Elmore County	Multi-agency facility: EMS station is attached to other county department spaces
Glenns Ferry	Unknown	Elmore County	Shared facility: EMS station is co-located with Glenns Ferry Fire Department
Pine	Unknown	Elmore County	Acquired from private owner as an existing structure; shared facility with Elmore County Sheriff's Office
Rescue Building	1984	Elmore County	Standalone facility near Mountain Home station

Facility Notes

Mountain Home Station (2010) The Mountain Home EMS station is a county-owned facility attached to multiple county department spaces. This shared-building configuration provides operational efficiencies but contributes to space constraints, as EMS cannot independently expand within the existing footprint.

Glenns Ferry Station (Year Unknown) The Glenns Ferry EMS station is county-owned and co-located with the Glenns Ferry Fire Department. Originally designed as a satellite station, the facility accommodates one ambulance and two crew members with no room for expansion on the current property.

Pine Station (Year Unknown) The Pine facility was acquired by the county from a private owner as an existing structure. It is a shared facility with the Elmore County Sheriff's Office, currently configured for two ambulances and two crew members. Unlike other stations, the property has room for expansion to accommodate future growth, office space, and a critically needed helipad.

Rescue Building (1984) The Rescue Building is the oldest facility in the EMS system. Located near the Mountain Home station, it currently houses rescue apparatus and one overflow ambulance that cannot be accommodated at the primary station due to bay capacity limits. The property has room for expansion, presenting a potential opportunity to address capacity constraints at the primary Mountain Home location.

4.4.3 Facility Condition Checklist

For each station, evaluate the following:

- **Bay size adequacy:** *Can current and planned apparatus fit with adequate clearance for equipment access?*
- **Living quarters:** *Adequate sleeping areas, bathrooms, kitchen facilities for 24-hour staffing?*
- **Decontamination/cleaning:** *Proper areas for equipment cleaning and personnel decontamination?*
- **HVAC/climate control:** *Adequate temperature control for apparatus bays and medication storage?*
- **Backup power:** *Generator capacity to maintain operations during power outages?*
- **ADA compliance:** *Station accessibility for staff and visitors?*

Facility Condition Assessment

Executive Summary

The Mountain Home EMS station has reached maximum operational capacity and lacks critical infrastructure required by current national standards. Key deficiencies include the absence of backup power, no dedicated decontamination area, insufficient crew quarters, fragmented administrative operations, and no space for training or expansion. These gaps create operational inefficiencies, potential regulatory exposure, and health and safety concerns for personnel.

National Standards and Industry Benchmarks

Applicable Standards

Standard	Title	Relevance
NFPA 1500	Fire Department Occupational Safety, Health, and Wellness Program	Facility safety requirements, fitness space, cancer prevention design
NFPA 1851	Selection, Care, and Maintenance of Protective Ensembles	PPE storage, decontamination, hot/warm/cold zone station design
NFPA 1585	Exposure and Contamination Control (new)	Station contamination control requirements
NFPA 110	Emergency and Standby Power Systems	Backup generator requirements for critical facilities
NEC Article 708	Critical Operations Power Systems	72-hour backup power capability for essential facilities
USFA FA-168	Safety and Health Considerations for the Design of Fire and EMS Stations	Federal design guidance

Key Standard Requirements

Decontamination and Contamination Control (NFPA 1851, NFPA 1585)

- Stations must incorporate "hot zone" design separating contaminated equipment from living spaces
- Separate laundry facilities required for contaminated PPE versus station clothing, towels, and bedding
- Decontamination areas with showers should be located off the apparatus bay for cleaning of contaminated gear and equipment
- Airlocks with positive-pressure airflow or air curtains recommended between apparatus bay and living spaces

Backup Power (NFPA 110, NEC Article 708)

- Fire stations are classified as critical facilities requiring emergency standby power
- NEC Article 708 requires critical operations power systems to support full load for a minimum of 72 hours
- Manual operation of bay doors during power outages directly impacts response times

Crew Quarters and Living Space

- Industry guidance recommends a minimum of 60 square feet of floor space per bunk
- Separate sleeping, locker, and hygiene facilities should be provided for each crew member
- Gender-neutral restroom, shower, and locker facilities required for new construction
- Common spaces for crew decompression support mental health and wellness per NFPA 1500

Training Facilities (NFPA 1500)

- Departments are required to maintain training programs; dedicated training space supports compliance
 - If hands-on training occurs at the station, decontamination of equipment must occur before re-entering living spaces
-

Current Facility Conditions – Mountain Home Station

Capacity Summary

Resource	Current State	Standard/Best Practice
Ambulance bays	4 units (at capacity)	Sufficient for current fleet; no reserve capacity
Overflow storage	1 unit stored off-site at Rescue building	Compromises response time and vehicle readiness
Crew quarters	4 personnel (at capacity)	Min. 60 SF per bunk; no expansion capability
Administrative workspace	None dedicated; staff use day room	Dedicated office space recommended
Training/meeting space	None	Required per NFPA 1500 training program standards
Decontamination area	None	Required per NFPA 1851 hot zone design
Backup power	None	Required per NFPA 110 / NEC Article 708
Expansion capability	None under current layout	—

Deficiency Analysis

1. No Backup Power System

Current Condition: The station has no emergency generator. During power outages, response bay doors must be operated manually.

Standard Requirement: NFPA 110 and NEC Article 708 classify fire and EMS stations as critical facilities requiring emergency standby power. The National Electrical Code requires critical operations power systems to maintain full function for a minimum of 72 hours.

Operational Impact:

- Delayed emergency response during power outages
- Manual door operation increases turnout time
- Loss of communications, lighting, and medical equipment charging
- Compromised ability to serve as community emergency resource

National Context: An estimated 15,490 fire stations nationwide operate without backup power—a recognized deficiency across the fire service.

Funding Opportunity: FEMA Hazard Mitigation Grant Program (HMGP) and Building Resilient Infrastructure and Communities (BRIC) grants fund generator installation at critical facilities including fire and EMS stations.

2. No Dedicated Decontamination Area

Current Condition: The station lacks a dedicated decontamination facility. No separation exists between contaminated gear/equipment and living spaces.

Standard Requirement: NFPA 1851 requires station design incorporating hot, warm, and cold zones to prevent cross-contamination. The standard mandates:

- Decontamination area with shower access off the apparatus bay
- Separate laundry facilities for contaminated PPE
- PPE storage ventilated and separated from living areas
- Airlock or positive-pressure separation between apparatus bay and living quarters

Operational Impact:

- Increased cancer risk for personnel from carcinogen exposure
- Infection control limitations (biological exposure from patient contact)
- Inability to properly decontaminate after hazmat or infectious disease responses
- Non-compliance with NFPA 1851 cleaning and decontamination requirements

Health Context: Cancer has emerged as a leading cause of firefighter and EMS line-of-duty deaths. Proper station design is now recognized as critical to reducing occupational cancer risk.

3. Crew Quarters at Maximum Capacity

Current Condition: The station accommodates 4 crew members with no ability to expand.

Standard Requirement:

- Minimum 60 square feet per sleeping position (industry guidance)
- Separate hygiene facilities for male and female personnel
- Individual lockers for bedding and personal clothing separate from PPE storage

Operational Impact:

- Cannot accommodate additional staffing for increased call volume
 - Cannot add personnel to address reserve ratio deficiency (currently 3.5:1 vs. 1.5:1 recommended)
 - Limited ability to accommodate visiting personnel, students, or mutual aid crews
-

4. No Dedicated Administrative Space

Current Condition: EMS leadership and support staff are dispersed across multiple county locations:

- | | |
|----------------|-----------------|
| • EMS Director | • CEMS staff |
| • Deputy Chief | • Billing staff |

On-site personnel use the day room as workstations; no dedicated office space exists.

Operational Impact:

- Communication delays between leadership and field personnel
- Administrative inefficiency from fragmented operations
- Day room unavailable for crew rest and decompression during work periods
- No private space for personnel counseling, performance discussions, or confidential communications

Wellness Context: NFPA 1500 emphasizes the importance of spaces where personnel can decompress from occupational stress. Using the day room as office space eliminates this function.

5. No Training or Meeting Space

Current Condition: No dedicated area exists for training, continuing education, or visitor/stakeholder meetings.

Standard Requirement: NFPA 1500 requires departments to maintain training programs. Dedicated training space supports compliance and reduces the need for off-site training that takes units out of service.

Operational Impact:

- Training must occur off-site, reducing unit availability
 - No space for crew briefings, quality improvement reviews, or protocol updates
 - No area for community outreach, stakeholder meetings, or interagency coordination
 - Hands-on training at the station would require decontamination protocols the facility cannot support
-

6. Multi-Use Apparatus Bay

Current Condition: The parking bay serves multiple functions beyond vehicle storage, creating workflow conflicts and limiting availability.

Standard Requirement: NFPA 1851 hot zone principles require the apparatus bay be treated as a contaminated area separate from living spaces. Multi-use increases cross-contamination risk.

Operational Impact:

- Workflow conflicts between competing uses
 - Increased contamination exposure if bay used for non-vehicle functions
 - Limited space for vehicle maintenance, equipment checks, and decontamination
-

7. No Expansion Capability

Current Condition: The current site layout precludes facility growth.

Operational Impact:

- Cannot add vehicle bays to improve reserve ratio
- Cannot add crew quarters to support increased staffing
- Cannot add decontamination, training, or administrative space
- Any significant improvement requires new construction or relocation

National Context

Recent NFPA research highlights the scope of fire station infrastructure deficiencies nationwide:

Finding	Statistic
Stations 40+ years old	21,000+
Stations needing renovation or replacement	~43%
Stations lacking exhaust emission control	27,500
Stations without backup power	15,490
Stations without female accommodations	25,800

The Mountain Home station's deficiencies are consistent with challenges facing EMS and fire facilities across the country. However, the combination of multiple deficiencies—no backup power, no decontamination, no expansion capability, and maximum capacity—creates compounding operational and safety risks.

Risk Summary

Deficiency	Safety Risk	Operational Risk	Regulatory Risk
No backup power	Delayed response during outages	Manual door operation; loss of communications	NFPA 110 / NEC 708 non-compliance
No DECON area	Cancer/infection exposure	Cannot properly decontaminate gear	NFPA 1851 non-compliance
Max crew capacity	—	Cannot increase staffing	—
No admin space	Wellness/stress concerns	Coordination delays	NFPA 1500 wellness provisions
No training space	—	Off-site training reduces availability	NFPA 1500 training requirements
No expansion path	All of the above compound over time	Cannot address fleet or staffing gaps	—

Rescue Building Assessment

Rescue Building – Mountain Home Area

Facility Overview

Characteristic	Current State
Location	Mountain Home area (near primary EMS station)
Current capacity	Beyond maximum
Current use	Rescue operations; overflow ambulance storage from primary station
Expansion capability	Yes – property can accommodate additional construction

The Rescue Building is located near the primary Mountain Home EMS station and currently serves dual functions: housing rescue apparatus and providing overflow storage for one ambulance unit that cannot be accommodated at the primary station.

Current Role in Operations

The Rescue Building's proximity to the primary station creates operational flexibility that partially mitigates the main station's capacity constraints:

- **Overflow vehicle storage** – One ambulance is stored at this location due to the primary station's 4-bay limit
- **Rescue operations base** – Houses rescue apparatus and equipment
- **Operational continuity** – Proximity allows reasonable response coordination despite split vehicle storage

However, storing a front-line ambulance at a separate facility introduces inefficiencies:

- Increased turnout time for crews accessing the off-site unit
- Split equipment and supply management
- Vehicle not immediately visible for daily checks and readiness verification

Capacity Status

Current Condition: The Rescue Building has reached full operational capacity under its current configuration. All available space is utilized for rescue operations and overflow ambulance storage.

Expansion Opportunity: Unlike the primary Mountain Home station, the Rescue Building property has room for facility expansion. This represents a significant strategic asset given that:

- The primary station cannot expand on its current footprint
- The Glenns Ferry satellite station cannot expand on its current property
- Only Pine Station and the Rescue Building offer on-site expansion potential

Strategic Considerations

The Rescue Building's expansion capability presents several planning options:

Option A: Expand EMS Capacity

- Construct additional ambulance bays to consolidate vehicles currently split between locations
- Add crew quarters to support increased staffing
- Reduces operational inefficiency of split vehicle storage
- Could address reserve ratio deficiency (currently 3.5:1 vs. 1.5:1 recommended)

Option B: Develop Support Functions

- Construct dedicated decontamination facility serving both Rescue Building and primary station
- Add training/meeting space unavailable at primary station
- Consolidate administrative staff currently dispersed across county locations
- Proximity to primary station makes shared support functions practical

Option C: Combined Approach

- Phased expansion addressing both vehicle capacity and support functions
- Master plan coordinating Rescue Building expansion with primary station limitations

Deficiency Analysis

The Rescue Building likely shares infrastructure deficiencies common to other department facilities:

Deficiency	Probable Status	Correctable On-Site?
Backup power	None	Yes
Decontamination area	None	Yes (with expansion)
Training/meeting space	None	Yes (with expansion)
Administrative space	None	Yes (with expansion)

Recommendations

Immediate Actions:

1. **Complete facility condition assessment** – Document current infrastructure status (backup power, DECON, etc.)
2. **Assess backup power needs** – Install generator if not present

Planning Actions:

3. **Develop site master plan** – Evaluate expansion options given property capacity
4. **Coordinate with primary station planning** – Rescue Building expansion may offer solutions to primary station constraints that cannot be addressed on-site
5. **Evaluate consolidated support functions** – Determine whether DECON, training, and/or administrative space at this location could serve both facilities

Summary

The Rescue Building represents one of only two department facilities (along with Pine Station) with on-site expansion capability. Given the primary Mountain Home station's inability to expand and the operational inefficiencies of split vehicle storage, the Rescue Building property should be evaluated as a strategic asset for addressing system-wide capacity and infrastructure needs.

Facility	Current Capacity	Expansion Possible	Strategic Value
Mountain Home (Primary)	At maximum	No	Operationally critical but constrained
Rescue Building	At maximum	Yes	High – expansion potential near primary station
Glenns Ferry	At maximum	No	Limited – eventual replacement needed
Pine	Near capacity	Yes	High – helipad need + expansion potential

Recommendations

Immediate Actions

1. **Install emergency generator** – Address life-safety and response capability gap; pursue FEMA HMGP/BRIC funding
2. **Develop interim decontamination protocol** – Establish temporary procedures pending facility improvements

Near-Term Planning

3. **Conduct facility needs assessment** – Engage qualified architect to evaluate options for renovation, expansion, or replacement
4. **Evaluate administrative consolidation** – Assess co-location of EMS Director, Deputy Chief, CHEMS, and Billing staff
5. **Identify interim training solution** – Secure access to training space pending facility improvements

Long-Term Capital Planning

6. **Include facility replacement/major renovation in capital improvement plan** – Current facility cannot be brought into full compliance with modern standards without significant investment
7. **Coordinate with fleet planning** – Facility constraints (4-bay maximum) limit ability to address vehicle reserve ratio; facility and fleet planning must be integrated

Assessment based on NFPA 1500, NFPA 1851, NFPA 110, NEC Article 708, USFA FA-168, and current facility conditions.

Satellite Station Facility Condition Assessment

Glenns Ferry and Pine Stations

Executive Summary

The department operates two satellite stations serving outlying areas of the county. Both facilities face significant infrastructure limitations, though their situations differ substantially. Glenns Ferry Station was designed as a minimal satellite facility with no expansion capability on the current property. Pine Station, while also constrained, offers expansion potential and serves as a critical access point for air medical transport in a region with frequent helicopter utilization.

Neither satellite station meets current national standards for decontamination, backup power, or administrative space. Addressing these deficiencies is essential to providing equitable service to outlying communities and ensuring personnel safety across all county facilities.

National Standards Reference

The same national standards applicable to the primary station apply to satellite facilities:

Standard	Title	Key Requirements
NFPA 1500	Fire Department Occupational Safety, Health, and Wellness Program	Facility safety, crew wellness, training programs
NFPA 1851	Selection, Care, and Maintenance of Protective Ensembles	Decontamination areas, PPE storage separation, hot/warm/cold zone design
NFPA 110	Emergency and Standby Power Systems	Backup power for critical facilities
NEC Article 708	Critical Operations Power Systems	Emergency power requirements for essential services
USFA FA-168	Safety and Health Considerations for the Design of Fire and EMS Stations	Federal facility design guidance

Satellite stations serving as primary response points for geographic areas carry the same operational and safety requirements as main stations. Personnel at these facilities face identical exposure risks and require equivalent protective infrastructure.

Glenns Ferry Station

Facility Overview

Characteristic	Current State
Design type	Satellite station
Ambulance capacity	1 unit
Crew capacity	2 personnel
Expansion capability	None – current property cannot accommodate expansion
Shared facility	No

Glenns Ferry Station was originally designed as a minimal satellite facility. While this configuration may have been adequate for historical call volumes and service expectations, it no longer meets current operational needs or national standards for EMS facilities.

Deficiency Analysis

1. No Expansion Capability

Current Condition: The station sits on property that cannot accommodate facility expansion. The single-bay, two-crew configuration represents the maximum buildout possible at this location.

Operational Impact:

- Cannot add vehicle capacity to support reserve units or future growth
- Cannot increase crew quarters to support additional staffing
- Cannot add required decontamination, training, or administrative space
- Any meaningful facility improvement requires property acquisition or relocation

The urgency of this constraint is compounded by documented population growth in the community the station serves. According to U.S. Census data, Glenns Ferry's population grew from 1,327 to 1,443 between 2022 and 2023 — an 8.74% single-year increase — while median household income grew 41.8% and local employment grew 18.2% in the same period. Both figures significantly exceed statewide averages and suggest active economic development rather than baseline demographic change. Three Island Crossing State Park, located two miles off Interstate 84 at the Glenns Ferry exit, generates year-round visitor traffic through the community with

campgrounds, eight cabins, and a nationally significant Oregon Trail interpretive center. The Glenns Ferry community is also actively pursuing economic development plans targeting light industry and expanded residential growth. A station that cannot grow to meet demand is particularly problematic when demand is demonstrably growing. The inability to expand on the current property is not a theoretical future constraint — it is a present operational limitation in a community with an active growth trajectory.

Strategic Implication: Long-term planning must assume this facility will require relocation to a larger site if service demands increase or if the department seeks to bring all facilities into compliance with current standards.

2. No Backup Power System

Current Condition: The station has no emergency generator.

Standard Requirement: NFPA 110 and NEC Article 708 classify EMS stations as critical facilities requiring emergency standby power capable of supporting operations for a minimum of 72 hours.

Operational Impact:

- Response capability compromised during power outages
- Bay doors require manual operation, increasing turnout time
- Loss of lighting, communications, and medical equipment charging
- Rural location may experience longer utility restoration times than urban areas

Risk Factor: Outlying stations serving geographically isolated populations have heightened backup power needs. Extended outages in rural areas compound response delays when the nearest alternative unit may be 30+ minutes away.

3. No Dedicated Decontamination Area

Current Condition: No decontamination facility exists. No separation between contaminated equipment and living/sleeping areas.

Standard Requirement: NFPA 1851 requires hot/warm/cold zone station design with dedicated decontamination areas, separate PPE laundry facilities, and physical separation between apparatus bay and living spaces.

Operational Impact:

- Increased carcinogen and infectious disease exposure for personnel
- Cross-contamination between gear and living quarters

- Non-compliance with NFPA 1851 requirements
- Personnel at satellite stations face identical exposure risks as main station crews but lack equivalent protective infrastructure

Equity Concern: Personnel assigned to satellite stations should not face greater occupational health risks due to inferior facility design.

4. Limited Crew Quarters

Current Condition: Facility accommodates 2 crew members at maximum capacity.

Standard Requirement: Industry guidance recommends minimum 60 square feet per sleeping position with separate hygiene facilities and individual lockers.

Operational Impact:

- Cannot increase staffing to meet demand fluctuations
 - No capacity for training personnel, ride-alongs, or mutual aid crews
 - Limited rest and recovery space for extended shifts
-

5. No Administrative or Training Space

Current Condition: No dedicated space for administrative functions, training, quality improvement, or community meetings.

Standard Requirement: NFPA 1500 requires departments to maintain training programs. Adequate space supports compliance and operational effectiveness.

Operational Impact:

- Training requires travel to main station, reducing unit availability
 - No space for crew briefings, protocol reviews, or continuing education
 - No area for community outreach or stakeholder engagement in the Glenns Ferry service area
-

Glenns Ferry Station Summary

Deficiency	Severity	Correctable at Current Site?
No expansion capability	Critical	No
No backup power	High	Yes (generator installation)
No decontamination area	High	No (space constraints)
Limited crew quarters	Moderate	No (space constraints)
No admin/training space	Moderate	No (space constraints)

Conclusion: Glenns Ferry Station can receive limited improvements (backup power) at the current site, but meaningful upgrades to meet current standards will require property acquisition or facility relocation.

Pine Station - Facility Overview

Characteristic	Current State
Design type	Shared facility
Shared with	Elmore County Sheriff's Office
Ambulance capacity	2 units
Crew capacity	2 personnel
Expansion capability	Yes – property can accommodate additional construction
Helipad	None (critically needed)

Pine Station presents a more favorable situation than Glenns Ferry. The shared-use arrangement with Elmore County Sheriff provides operational synergies, and the property has sufficient space to accommodate expansion for office, meeting room, and potentially helipad facilities.

Deficiency Analysis

1. No Helipad – Critical Need

Current Condition: No helipad exists at Pine Station despite frequent medical air transport utilization in the service area.

Operational Impact:

- Helicopter landing zones must be established ad hoc for each transport
- Delays in identifying and securing suitable landing areas
- Safety risks from improvised landing zones (terrain, obstacles, lighting)
- Increased on-scene time for critical patients requiring air transport
- Weather and visibility challenges compounded without established, lighted helipad

Geographic Context: Pine's remote location and distance from tertiary care facilities makes air medical transport a routine necessity rather than an exception. The frequency of helicopter utilization at this location justifies dedicated helipad infrastructure.

The recreational demand driving helicopter utilization in this zone is substantial and growing. The Pine-Featherville trail system encompasses 380 miles of off-highway vehicle, snowmobile, hiking, and mountain biking trails across four mountain ranges. Anderson Ranch Reservoir — a 4,730-acre reservoir with 50 miles of shoreline, ten campgrounds, and four large boat launches managed by the Boise National Forest — draws boaters, water skiers, anglers, and campers throughout the summer season. Trinity Hot Springs, Baumgartner Hot Springs, and Soldier Mountain ski resort extend visitation into shoulder seasons and winter months. The Idaho Backcountry Discovery Route, a regionally significant off-road motorcycle corridor, passes directly through Pine, attracting multi-day backcountry travelers with limited access to external emergency services. These activities generate the highest-acuity call types — OHV trauma, water emergencies, fall injuries, and altitude-related events — in the zone most dependent on air transport due to road access limitations and distance from trauma-capable facilities. An established helipad with proper lighting, markings, and approach paths significantly reduces the improvised landing zone hazards documented above and directly reduces on-scene time for the District's most time-critical northern zone patients.

Best Practice: Established helipads with proper lighting, markings, and approach/departure paths significantly improve air medical response times and safety. Many rural EMS stations serving similar geography include helipad facilities as standard infrastructure.

Expansion Opportunity: The property has room for helipad construction as part of a broader facility improvement plan.

2. No Backup Power System

Current Condition: The station has no emergency generator.

Standard Requirement: NFPA 110 and NEC Article 708 require emergency standby power for critical facilities.

Operational Impact:

- Response capability compromised during power outages
- Manual bay door operation increases turnout time
- Loss of communications particularly critical in remote location
- Shared facility means outage affects both EMS and Sheriff operations

Rural Consideration: Remote locations typically experience longer power outage durations and may have less utility infrastructure redundancy. Backup power is correspondingly more critical.

Shared Facility Benefit: Generator installation would benefit both EMS and Sheriff operations, potentially enabling cost-sharing arrangements.

3. No Dedicated Decontamination Area

Current Condition: No decontamination facility exists.

Standard Requirement: NFPA 1851 requires dedicated decontamination areas and separation between contaminated equipment and living spaces.

Operational Impact:

- Personnel exposure to carcinogens and infectious agents
- Cross-contamination risks in shared facility environment
- Non-compliance with current standards

Expansion Opportunity: Property space allows for decontamination area construction as part of facility improvements.

4. No Dedicated Office or Meeting Space

Current Condition: No dedicated administrative, office, or meeting room space for EMS operations.

Standard Requirement: Adequate administrative and training space supports NFPA 1500 compliance and operational effectiveness.

Operational Impact:

- No space for training, quality improvement, or protocol reviews
- No area for community engagement or interagency coordination
- Administrative functions cannot be performed on-site

Expansion Opportunity: The property can accommodate office and meeting room construction to support future growth and current operational needs.

5. Limited Crew Quarters

Current Condition: Facility accommodates 2 crew members.

Operational Impact:

- Staffing limited to current capacity
- No room for additional personnel during high-demand periods
- Limited space for training personnel or mutual aid crews

Consideration: Crew quarter expansion should be evaluated as part of any broader facility improvement plan, though current capacity may be adequate depending on service model.

Pine Station Summary

Deficiency	Severity	Correctable at Current Site?
No helipad	Critical	Yes – property has space
No backup power	High	Yes – generator installation feasible
No decontamination area	High	Yes – property has space
No office/meeting space	Moderate	Yes – property has space
Limited crew quarters	Low-Moderate	Possibly – evaluate with expansion plan

Conclusion: Pine Station offers significant potential improvement. The property can accommodate helipad construction, decontamination facilities, office/meeting space, and backup power installation. This facility should be prioritized for capital investment given both the expansion opportunity and the critical need for helipad infrastructure.

Comparative Analysis

Factor	Glenns Ferry	Pine
Ambulance capacity	1	2
Crew capacity	2	2
Expansion possible	No	Yes
Shared facility	No	Yes (Sheriff)
Helipad need	Standard	Critical
Backup power	None	None
Decontamination	None	None
Admin/training space	None	None
Long-term viability	Limited	Good with investment

Risk Summary – Satellite Stations

Station	Deficiency	Safety Risk	Operational Risk	Correctable On-Site?
Glenns Ferry	No backup power	Delayed response	Manual door operation	Yes
Glenns Ferry	No DECON	Cancer/infection exposure	Non-compliance	No
Glenns Ferry	No expansion	Compounds all risks	Cannot grow with demand	No
Pine	No helipad	Improvised LZ hazards	Delayed air transport	Yes
Pine	No backup power	Delayed response	Manual door operation	Yes
Pine	No DECON	Cancer/infection exposure	Non-compliance	Yes
Pine	No admin space	—	Training/coordination gaps	Yes

Recommendations

Glenns Ferry Station

Immediate Actions:

1. **Install emergency generator** – Addresses most critical correctable deficiency; pursue FEMA HMGP/BRIC funding

Long-Term Planning: 2. **Initiate site search for replacement facility** – Current property cannot support standards-compliant operations 3. **Develop interim decontamination protocol** – Establish temporary procedures pending facility replacement 4. **Include replacement facility in capital improvement plan** – Budget for property acquisition and new construction

Pine Station

Immediate Actions:

1. **Install emergency generator** – Critical need for remote location; cost-sharing opportunity with Sheriff's Office
2. **Begin helipad planning and design** – High utilization justifies dedicated infrastructure; improves patient outcomes and crew safety

Near-Term Capital Projects: 3. **Construct dedicated decontamination area** – Property can accommodate; brings facility into NFPA 1851 compliance 4. **Add office and meeting room space** – Supports training programs, administrative functions, and future growth

Planning Considerations: 5. **Develop comprehensive site plan** – Coordinate helipad, DECON, and office expansion into unified improvement project 6. **Explore shared funding with Elmore County Sheriff** – Generator and potentially other improvements benefit both agencies

Funding Opportunities

Improvement	Potential Funding Sources
Backup generators	FEMA HMGP, FEMA BRIC, state emergency management grants
Helipad construction	State EMS grants, rural health grants, hospital partnership
Facility expansion (Pine)	Capital improvement bonds, USDA rural development programs
Facility replacement (Glenns Ferry)	Capital improvement bonds, USDA rural development programs

Conclusion

The department's satellite stations face infrastructure deficiencies that mirror those at the primary Mountain Home facility. However, the two satellites present distinctly different planning scenarios:

Glenns Ferry requires long-term replacement planning. The current site cannot accommodate the improvements necessary to meet modern standards. Investment should focus on interim life-safety measures (generator) while planning for eventual relocation.

Pine represents a strategic investment opportunity. The property can accommodate helipad construction, decontamination facilities, and administrative space. Given the critical need for air medical transport infrastructure at this location, Pine should be prioritized for capital improvement funding.

Addressing satellite station deficiencies ensures personnel across all county facilities receive equivalent safety protections and that outlying communities receive service levels comparable to the primary service area.

Assessment based on NFPA 1500, NFPA 1851, NFPA 110, NEC Article 708, USFA FA-168, and current facility conditions.

4.5 Connection to Response Times

Equipment and facility constraints directly impact response time performance through multiple mechanisms:

4.5.1 Vehicle-Related Delays

- **Mechanical failures:** *Aging vehicles experience higher rates of critical failures (engine, transmission, brake system) that remove units from service*
- **Turn-around delays:** *Include clean-up, decontamination, documentation, and equipment replenishment—all impacted by vehicle condition and equipment availability*
- **Unit availability:** *Insufficient reserve fleet means no backup when primary units are out for maintenance*

4.5.2 Equipment-Related Delays

- **Equipment failures:** *Malfunctioning cardiac monitors, ventilators, or communications equipment can delay or compromise patient care*
- **Resupply delays:** *Inadequate supply management increases restock time between calls*
- **Communications failures:** *Radio dead spots or equipment failures delay dispatch notification and scene coordination*

4.5.3 Facility-Related Delays

- **Suboptimal station placement:** *Stations not positioned based on call density and travel time analysis result in longer travel distances*
- **Coverage gaps:** *Geographic areas beyond reasonable response time from any station*
- **Crew quarters limitations:** *Inadequate on-site quarters may impact turnout time performance*

4.6 Capital Expenditure Analysis

Capital investment is essential to maintaining operational readiness and meeting response time standards. This section documents recent capital outlays, identifies critical funding gaps, and projects future capital requirements to support sustainable EMS operations across Elmore County.

4.6.1 Recent Capital Investments (FY2024-FY2025)

The following table summarizes capital expenditures for the EMS and Rescue divisions over the past two fiscal years:

Division	Category	FY2024	FY2025
EMS	Ambulance	\$256,000	\$331,000*
	Cardiac Monitors	\$71,000	\$58,000
	EMS Subtotal	\$327,000	\$389,000
Rescue	Equipment/Vehicles	\$0	\$0
TOTAL		\$327,000	\$389,000

**Includes ambulance and truck purchase*

4.6.2 Future Capital Requirements (5-Year Projection)

Maintaining operational readiness while accommodating anticipated growth requires strategic capital planning. The following projections are based on industry replacement standards, current fleet condition, and projected service area expansion.

Capital Requirement	Frequency/Timeline	Estimated Cost
Replacement Ambulance <i>Maintains fleet readiness per NFPA 1917 standards</i>	Every 2 years	\$300,000- \$450,000 <i>per unit</i>
Fleet Expansion (Growth) <i>1-2 additional ambulances to address Mayfield Springs, West Mountain Home, and anticipated call volume increases</i>	Within 5 years	\$600,000- \$900,000 <i>total</i>
Facility Expansion <i>Address bay capacity, crew quarters, decontamination, and administrative space deficiencies (see Section 4.4)</i>	Planning: 1-2 years Construction: 3-5 years	TBD <i>(Requires facility study)</i>

4.6.3 Five-Year Capital Investment Summary

Component	5-Year Estimate
Replacement Ambulances (2-3 units @ 2-year cycle)	\$750,000 - \$1,125,000
Fleet Expansion (1-2 additional units)	\$600,000 - \$900,000
Cardiac Monitors/Medical Equipment	\$250,000 - \$350,000
Rescue Equipment (deferred replacement)	\$150,000 - \$200,000
TOTAL (Excluding Facility)	\$1,750,000 - \$2,575,000

Annualized Capital Requirement: \$350,000 - \$515,000 per year (excluding facility expansion)

Capital Planning Implications

Current capital investment levels are insufficient to address both replacement cycles and growth-driven expansion. The FY2024-FY2025 combined investment of \$716,000 falls short of the estimated \$700,000-\$1,030,000 annual requirement when accounting for fleet expansion and deferred Rescue equipment replacement.

Without dedicated capital funding mechanisms, the District will continue to defer critical replacements, increasing the risk of equipment failure, extended response times, and compromised patient outcomes.

5. FINANCIAL REVIEW

5.1 Section Summary

This section presents a comprehensive financial analysis of the Elmore County Ambulance District covering fiscal years 2022-2023, 2023-2024, and 2024-2025, with projections for FY 2025-2026. The analysis establishes the financial foundation supporting the need for enhanced levy authority and/or the creation of a new ambulance district with expanded taxing capacity.

Key Financial Questions This Section Addresses:

1. What are the district's primary revenue sources and their trends?
2. How have operating and capital expenditures evolved?
3. What is the magnitude of structural deficits?
4. How much has the County General Fund subsidized operations?
5. What funding level is required for sustainable operations?

Key Financial Findings:

- **FY2023 Structural Deficit:** \$551,340
- **FY2024 Structural Deficit:** \$800,000
- **FY2025 Structural Deficit:** \$1,071,976
- **FY2026 Projected Deficit:** \$1,295,924
- **Cumulative County Subsidy (FY23-26):** \$3,719,240

5.2 Revenue Sources

The Elmore County Ambulance District relies on three primary revenue categories: property tax levies, transport fees (patient billing), and grants. Understanding the proportion and stability of each source is critical for financial planning.

5.2.1 Property Tax Levy

The ambulance district levy is authorized under Idaho Code § 31-3908 for districts formed before July 1, 2020. The current statutory cap is 0.04% (4 mills) of market value for assessment purposes.

Current Levy Status (2025 Certified Levy Rates):

- Elmore County Ambulance M&O Levy: **0.000167371**
- *(per Idaho State Tax Commission certification)*
- Interpretation: This represents approximately 0.0167% of market value, well below the 0.04% statutory maximum

Historical Levy and Collection Rates

Source: Elmore County Levy Rate Calculation Worksheets (FY2022-FY2024) and Revenue Reports

Data Element	FY2022	FY2023	FY2024
Levy Rate	0.0184%	0.0186%	0.0174%
Collection Rate (%)	94.32%	96.71%	93.83%

Supporting Data

Data Element	FY2022	FY2023	FY2024
Balance to be Levied	\$579,212	\$590,295	\$622,647
Actual Taxes Collected	\$546,309	\$570,874	\$584,246
Net Taxable Market Value (A)	\$3.14B	\$3.17B	\$3.57B
Net Value plus Increment (A+B)	\$3.20B	\$3.24B	\$3.64B

Calculation Methodology

Collection Rate = Actual Taxes Collected ÷ Balance to be Levied × 100

Fiscal Year	Calculation	Result
FY2022	\$546,309 ÷ \$579,212	94.32%
FY2023	\$570,874 ÷ \$590,295	96.71%
FY2024	\$584,246 ÷ \$622,647	93.83%

Key Observations

- 1. Collection rates are consistently in the 94-97% range, which is typical for property tax collection in Idaho.
- 2. Levy rates have decreased from 0.0184% (FY2022) to 0.0174% (FY2024) despite increasing "Balance to be Levied" amounts. This reflects significant growth in assessed property valuation within the district.
- 3. The current FY2025 levy rate of 0.0167% continues this downward trend as property values have continued to increase.
- 4. The district is currently utilizing approximately 42% of its statutory maximum levy authority (0.04%), leaving significant unused levy capacity.

Actual Property Tax Revenue Collected:

FY2023	FY2024	FY2025	FY2026 (Proj.)
\$570,874	\$584,246	\$611,481	\$649,524

5.2.2 Transport Fee Revenue (Patient Billing)

Transport Billing Revenue: Why We're Collecting Less Despite Doing More

The Local Picture

Our transport billing revenue has dropped 10% over two years—from \$1,137,494 in FY2023 to \$1,022,664 in FY2025. This isn't a reflection of poor billing practices or reduced services. It's a systemic problem affecting ambulance services nationwide, and rural districts like ours are hit hardest.

What the Federal Data Now Confirms

In December 2024, the Centers for Medicare & Medicaid Services (CMS) released the first comprehensive study of ambulance costs and revenues in U.S. history. The findings confirm what rural EMS leaders have known for years: **the math doesn't work.**

The Bottom Line: It Costs More to Provide Transport Than We Get Paid

	National Average	Government Agencies (like us)
Cost to provide one transport	\$2,673	\$3,127
Average payment received	\$1,147	\$1,147
Loss per transport	\$1,526	\$1,980

Source: CMS Ground Ambulance Data Collection System Report, December 2024

For every patient we transport, we lose approximately **\$1,500 to \$2,000**. This isn't unique to Elmore County—it's the reality for ambulance services across the country.

Why Government-Run Services Cost More (And Why That's Not Waste)

The federal study found that governmental ambulance agencies average \$3,127 per transport versus \$1,778 for private for-profit companies. This difference exists because:

- **We respond to everything.** Private companies can be selective about which calls they take. We respond to every 911 call in our 3,075 square miles regardless of the patient's ability to pay or whether transport results.
- **We maintain coverage 24/7.** We staff ambulances around the clock even during low-call-volume periods. Private services often use "dynamic deployment" that leaves some areas uncovered during slow times.
- **We serve remote areas.** Our northern mountain zones require longer response and transport times. Private services typically won't serve these rural areas because the economics don't work.
- **We can't turn away patients.** We transport everyone who needs it. Our payer mix includes higher percentages of Medicare, Medicaid, and uninsured patients than urban or private services.

Where Our Money Goes

The federal study found that ambulance costs break down as follows:

- **69% Labor** – This is the biggest factor. Staffing an ambulance 24/7 requires paying for coverage even during quiet periods. Competitive wages are essential to recruit and retain qualified EMTs and paramedics in a tight labor market.
- **10% Vehicles** – Ambulances cost \$250,000-\$450,000 each and have limited service lives given our mileage and terrain.

- **13% Other operating costs** – Dispatch, billing services, insurance, training, compliance
- **4% Facilities and 4% Equipment/Supplies**

The Medicare Problem

Medicare is our largest payer, but Medicare reimbursement has not kept pace with costs:

- Medicare paid about **\$382** for a basic life support transport in rural areas in 2019
- By 2024, that had only increased to **\$448**—a 3.5% annual adjustment
- Meanwhile, ambulance chassis prices increased 25-50% and medical supplies increased 12% in just three years

The average Medicare payment of \$329 per transport covers only about **10%** of the actual \$3,127 cost for governmental agencies to provide that transport.

16 Years of "Temporary" Fixes: Congress Knows the System Is Broken

Rural and urban ambulance services currently receive small bonus payments on top of base Medicare rates—3% for rural services and 2% for urban services. These add-ons provide modest but meaningful support for our operating budget.

What's important for the Board to understand is the history of these payments:

These "temporary" add-ons were originally designed to last just 18 months.

In July 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which included the rural and urban ambulance add-on payments effective July 1, 2008 through December 31, 2009. Congress acknowledged then that base Medicare reimbursement was insufficient to cover the actual costs of providing ambulance services.

Since then, **Congress has extended these "temporary" payments at least 14 times over more than 16 years:**

Year Legislation

2010 Medicare and Medicaid Extenders Act

2011 Temporary Payroll Tax Cut Continuation Act

2012 Middle Class Tax Relief and Job Creation Act

2012 American Taxpayer Relief Act

2013 Pathway for SGR Reform Act

2014 Protecting Access to Medicare Act

2015 Medicare Access and CHIP Reauthorization Act (MACRA)

Year Legislation

2018 Bipartisan Budget Act

2023 Consolidated Appropriations Act

2025 American Relief Act

2025 Full-Year Continuing Appropriations and Extensions Act

2026 Continuing Appropriations Act (current)

The pattern tells a clear story: Congress has repeatedly acknowledged that Medicare ambulance reimbursement is inadequate yet has never permanently fixed the underlying rate structure. Instead, lawmakers pass short-term extensions—sometimes just months at a time—creating perpetual uncertainty for ambulance services trying to budget and plan for the future.

The current extension, included in the Consolidated Appropriations Act of 2026, preserves the 2% urban, 3% rural, and 22.6% super-rural add-on payments through December 31, 2027 (American Ambulance Association, 2026). While this 23-month extension provides more planning runway than previous short-term measures, it remains **a temporary fix**. Without permanent legislative reform to the underlying rate structure, these add-on payments will eventually expire, further widening the gap between reimbursement and the actual cost of providing service.

This isn't a new or disputed problem. It's a recognized, long-standing federal policy failure that shifts the burden of funding essential emergency medical services onto local governments and taxpayers.

Why This Matters for Elmore County

Our 10% revenue decline mirrors national trends, but our situation is compounded by factors specific to our district:

1. **Geography:** At 3,075 square miles, we cover one of the largest service areas in Idaho with some of the longest transport distances to appropriate receiving facilities.
2. **Demographics:** Our aging population means higher Medicare utilization, which reimburses less than commercial insurance.
3. **Hospital access:** Extended transport times to hospitals in Boise or Mountain Home increase our costs while reimbursement stays flat.
4. **Volume limitations:** We don't have enough call volume to spread fixed costs across more transports the way urban services can.

The National Context: This Is a Crisis, Not a Local Failure

The federal study collected data from nearly 3,700 ambulance agencies representing all types—urban, rural, government, private, nonprofit. The conclusion is clear: ambulance services nationwide operate at a structural loss that can only be sustained through tax subsidies, local funding, or service reductions.

Rural areas face the worst of it. Since 2005, 193 rural hospitals have closed, increasing ambulance transport distances. Response times that averaged 14 minutes before a hospital closure jumped to 25 minutes after—a 76% increase that costs lives in time-critical emergencies.

Some rural communities have seen their ambulance services collapse entirely. When that happens, 911 calls go unanswered or response times extend to an hour or more.

Idaho Status

Idaho has never declared ground ambulance EMS an essential service, such as police and fire. As a result, the state is not required to fund it. For decades, ground ambulance EMS agencies have struggled to find funding, and many rely heavily on volunteers and donations.

Recent Legislative History:

- SB 1416 passed the Senate in a 26-9 vote in 2024, but it never got a hearing in the House State Affairs Committee.
- In 2025, House Bill 206 was signed into law which transfers EMS oversight from the Department of Health and Welfare to the Idaho Military Division, but the bill still does not deem EMS essential, but calls it "critical to the life, health, and safety of Idahoans." The bill would not provide new funding for individual agencies.

National Status

In the United States, ground ambulance emergency medical services are not considered essential services. They are provided and funded mainly by local governments, which leads to a wide variation in the cost and quality of services.

Most states don't declare ground ambulance EMS to be an "essential service," meaning the state government isn't required to provide or fund them. Specifically, only 13 states and the District of Columbia have passed laws making EMS an essential service, meaning **37 states (including Idaho) have not**.

Unlike fire and police protection, which are recognized as essential services by the Federal Government, it has been left to local governments to determine if ground ambulance emergency medical services are necessary.

Note: Air ambulance services operate under a different regulatory framework. They are federally regulated under the Federal Aviation Act and the Airline Deregulation Act of 1978, which preempts state regulation of air ambulance prices, routes, and services. Air ambulance funding typically comes through different mechanisms including hospital systems, private subscription services, and in some states, dedicated surcharges (such as motor vehicle registration fees).

Funding Implications

Police departments are supported and receive funds from the U.S. Department of Justice along with local tax dollars, and fire departments are supported by the U.S. Fire Administration, although many underserved areas also rely on volunteer firefighters to fill gaps.

In states that don't provide funding, ground ambulance EMS agencies often must rely on Medicaid and Medicare reimbursements and money they get from local governments.

Recognizing ground ambulance EMS as an essential service enhances opportunities for access to federal grant funding. Because ground EMS providers are not recognized as essential workers, they have to fight for Tier I priority to receive vaccinations if there is limited vaccine supply for any level of pandemic severity.

What Other Communities Are Doing

Facing the same math, rural ambulance districts across the country are pursuing:

- **Dedicated local funding** (tax districts, levies, municipal contributions)
- **Supplemental payment programs** through state Medicaid
- **Service diversification** (interfacility transfers, event standby, community paramedicine where regulations allow)
- **Regional partnerships** to share costs and resources
- **Advocacy** for permanent Medicare rate increases at the federal level

FY2023	FY2024	FY2025	FY2026 (Proj.)
\$1,137,494	\$1,036,501	\$1,022,664	\$1,200,000

Collection Rates by Payer Type:

Payer Type	Collection Rate	Notes
Medicare	30-35%	Reimbursement based on fee schedule, not actual cost
Medicaid	20-25%	Idaho Medicaid rates typically lower than Medicare
Private Insurance	30-40%	Highly variable—some pay above Medicare, others below
Self-Pay	5-10%	Includes uninsured and patient responsibility portions

5.2.3 Total Revenue Summary

Revenue Source	FY2023	FY2024	FY2025	FY2026 Proj.
Property Tax	\$570,874	\$584,246	\$611,481	\$649,524
Transport Billing	\$1,137,494	\$1,036,501	\$1,022,664	\$1,200,000
Solar/Wind Farm*	\$60,000	\$74,000	\$85,000	\$95,000
Grants	\$55,933	\$124,701	\$30,450	\$100,000
Misc Revenue	\$49,111	\$97,570	\$74,146	\$80,000
CHEMS Revenue	N/A	N/A	N/A	\$363,734
Solar Farms Annual Fee	N/A	N/A	N/A	\$490,315
TOTAL REVENUE	\$1,873,412	\$1,917,018	\$1,823,741	\$2,978,573

* Note: Solar and wind farm revenue reflects existing financial relationships with energy projects operating in Elmore County, including the Black Mesa Solar project and Sawtooth Wind Farm. This revenue source will be supplemented by Crimson Orchard Solar (120 MW, \$304M investment, operations planned for 2027) and a second wind and solar facility (CUP-2024-04, approved 2024), both anticipated to generate additional revenue under similar arrangements. The construction phases of these projects also generate occupational medical call demand in rural county zones; see Section 3.7.6 for analysis.

5.3 Expenditures

5.3.1 Operating Costs

Operating costs comprise the recurring expenses necessary to maintain daily ambulance service operations. Wages and benefits consistently represent 75-85% of operating costs, consistent with national EMS industry benchmarks.

Expense Category	FY2023	FY2024	FY2025	FY2026 Budget
Payroll & Benefits	\$1,909,628	\$2,051,409	\$2,161,861	\$3,107,381
Operating Costs	\$452,543	\$593,626	\$618,363	\$947,116
Vehicle Purchase	\$0	\$256,762	\$331,812	\$220,000
TOTAL EXPENDITURES	\$2,425,530	\$2,700,862	\$2,915,106	\$4,274,497

Note on Personnel Cost Figures: The FY2026 payroll figure shown in this section (\$2,161,861) reflects Ambulance District Department 429 only, as reported in the County's fund accounting structure. The personnel cost figure shown in Section 3.7 (\$3,048,371) reflects total district-wide personnel cost across all four operational departments (Ambulance Service, Administrative, Rescue, and CHEMS). The difference of approximately \$886,510 represents the personnel budgets of the Administrative, Rescue, and CHEMS departments, which are funded through separate departmental budget lines. Both figures are internally consistent with their respective source data; the discrepancy is definitional, not a factual error. [Note: pending confirmation from District Director — see payroll reconciliation query.]

5.3.2 Capital Costs

Capital expenditures include ambulance vehicles, cardiac monitors, power stretchers, and other major equipment with multi-year useful lives.

Typical Capital Cost Benchmarks:

- Type I/III Ambulance: \$275,000-\$375,000 (new); remount option 40-50% savings
- Cardiac Monitor/Defibrillator: \$35,000-\$45,000 per unit
- Power Stretcher System: \$25,000-\$35,000 per ambulance
- Mobile/Portable Radios: \$3,000-\$8,000 per unit

Capital Expenditure History

Source: Elmore County Expenditure Reports, Fund 129 Ambulance District

Category	FY2022	FY2023	FY2024	FY2025*
Equipment	\$106,552	\$56,755	\$42,724	\$12,170
Vehicles	\$0	\$256,762	\$331,812	\$331,812
Total Capital Expenditures	\$106,552	\$313,517	\$374,536	\$343,982

*FY2025 data reflects Year-to-Date actuals (99.73% of fiscal year elapsed as of report date)

Current Capital Replacement Schedule

Based on the fleet inventory data (Section 4.2.2), replacement policy (5-year/150,000-mile threshold), and condition assessments, the following replacement schedule is recommended:

Ambulance Fleet Replacement Schedule

Priority	Unit	Year	Age	Mileage	Condition	Action	Target FY
1	Unit 3	2016	10 yrs	170,000	Poor	Replace	FY2026
2	Unit 6	2019	7 yrs	162,000	Poor	Replace	FY 2026-27
3	Atlanta Amb.	2010	16 yrs	Unknown	Fair	Replace	FY 2027
4	Prairie Amb.	2003	23 yrs	Unknown	Poor	Replace	FY 2027
5	Unit 7	2019	7 yrs	132,000	Fair	Remount/Replace	FY 2028
6	Unit 8	2019	7 yrs	90,000	Fair	Remount/Replace	FY2028-29
7	2011 Expedition	2011	15 yrs	135,000	Poor	Replace	FY2027
8	Unit 2517	2017	8 yrs	30,000	Good	Monitor	FY2029+
9	Unit 9	2023	3 yrs	26,000	Good	No action	FY2030+
10	Unit 10	2024	2 yrs	12,000	Good	No action	FY2031+

Rescue/Support Vehicle Replacement Schedule

Priority	Unit	Year	Age	Mileage	Cond.	Action	Target FY
1	Atlanta Rescue	2000	26 yrs	Unknown	Poor	Replace	FY2026-27
2	Prairie Rescue (F350)	2002	24 yrs	Unknown	Poor	Replace	FY2027
3	Unit 2692 (International)	1994	32 yrs	50,292	Fair	Replace	FY2027-28
4	Unit 2693 (GMC 2500)	2002	24 yrs	165,880	Poor	Replace	FY2028
5	Pine Rescue (F550)	2014	12 yrs	167,000	Fair	Monitor/Replace	FY2029
6	Unit 2690 (FreightLiner)	2016	10 yrs	22,160	Good	Monitor	FY2030+
7	Unit 2691 (Dodge 3500)	2020	6 yrs	12,632	Good	No action	FY2032+
8	Rescue 1	2025	1 yr	6,000	Good	No action	FY2040+

Medical Equipment Replacement Schedule

Equipment Type	Current Age	Service Life	Recommended Action	Target FY
Video Laryngoscopes (McGrath)	12+ yrs	7-10 yrs	Replace	FY2026
Transport Ventilator (LTV 1200)	20+ yrs	5-10 yrs	Replace	FY2026
Suction Units (Devilbiss) - 7 units	15+ yrs	7-10 yrs	Replace	FY2026-27
Stair Chairs (Stryker 6252) - 5 units	10+ yrs	7-10 yrs	Replace	FY2027
Portable Radios (HT 1250) - 6 units	10+ yrs	5-7 yrs	Replace	FY2026-27
Power Stretchers (Stryker) - 6 units	10 yrs	10-12 yrs	Replace	FY2027-28
MDT/Laptops (Dell) - 6 units	7 yrs	3-5 yrs	Replace	FY2026
Tablets (Microsoft Surface) - 4 units	7 yrs	3-5 yrs	Replace	FY2026
Cardiac Monitors (Zoll X) - 7 units	2.5 yrs	8 yrs	No action	FY2031+

Rescue Equipment Replacement Schedule

Equipment Type	Purchase	Age	Svc Life	Action	Target FY
Rescue 42 Struts System (x2)	2010	16 yrs	5-10 yrs	Replace	FY2026
AMKUS Rescue Tools	2010	16 yrs	10 yrs	Replace	FY2026-27
Paratech Airbag Sets (x2)	2010	16 yrs	7-10 yrs	Replace	FY2026
Handheld Radios (Rescue)	Various	20+ yrs	5-7 yrs	Replace	FY2026
Hurst Tool Set	2016	10 yrs	10-15 yrs	Monitor	FY2028-29
Hurst Tool Set	2019	7 yrs	10-15 yrs	No action	FY2031+
Hurst Tool Set	2022	4 yrs	10-15 yrs	No action	FY2034+

Replacement Program Notes

1. COVID Backlog Recovery: The 2-year program stall during COVID-19 created a replacement backlog. The schedule above accelerates replacements in FY2026-FY2028 to recover deferred purchases.
2. Budget Constraints: Current budget supports remounting only, not full replacement or fleet expansion. Full implementation of this schedule requires additional capital funding.
3. Outlying Stations: Atlanta, Prairie, and Pine stations have historically relied on donated vehicles from Idaho Power. This schedule transitions these stations to planned replacement cycles.
4. Reserve Ratio: Current 3.5:1 front-line to reserve ratio exceeds the 1.5:1 industry standard. Achieving the recommended ratio requires 2-3 additional reserve units not reflected in this replacement-only schedule.

5.4 Deficit Analysis

A structural deficit exists when recurring expenditure consistently exceeds recurring revenues. This section quantifies the gap between sustainable revenue sources (property taxes and net transport collections) and operating costs.

Fiscal Year	Total Revenue	Total Expenses	Operating Deficit
FY 2022-2023	\$1,873,412	\$2,425,530	\$551,340
FY 2023-2024	\$1,917,018	\$2,700,862	\$800,000
FY 2024-2025	\$1,823,741	\$2,915,105	\$1,071,976
FY 2025-2026 (Projected)	\$2,978,573	\$4,274,497	\$1,295,924
4-YEAR TOTAL	\$8,592,744	\$12,315,994	\$3,719,240

Deficit Trend Analysis:

- FY2023 to FY2024: +45% increase (\$248,660)
- FY2024 to FY2025: +34% increase (\$271,976)
- FY2025 to FY2026: +21% increase (\$223,948)
- **FY2023 to FY2026: +135% total increase (\$744,584)**

5.5 County General Fund Contributions

When ambulance district revenues are insufficient to cover operating costs, Elmore County has historically supplemented operations from the County General Fund (PILT Fund). This represents a subsidy from general taxpayers beyond the dedicated ambulance levy.

Fiscal Year	Revenue Deficit from County PILT Fund
FY 2022-2023	\$551,340
FY 2023-2024	\$800,000
FY 2024-2025	\$1,071,976
FY 2025-2026 (Projected)	\$1,295,924
CUMULATIVE TOTAL	\$3,719,240

Budget vs. Actual for Each Fiscal Year

Category	Description	Annual Budget	Actual
FISCAL YEAR 2022			
<i>Ambulance</i>			
	A Budget (Payroll)	\$2,020,524.00	\$1,905,156.56
	B Budget (Non-Payroll)	\$569,417.00	\$522,757.89
	Total Ambulance	\$2,589,941.00	\$2,427,914.45
<i>Extrication</i>			
	A Budget (Payroll)	\$29,195.00	\$28,073.49
	B Budget (Non-Payroll)	\$59,000.00	\$23,298.58
	Total Extrication	\$88,195.00	\$51,372.07
	Combined Total (Ambulance & Extrication)	\$2,678,136.00	\$2,479,286.52
	Inter-fund Loans or Advances (PILT)		\$153,041.53

FISCAL YEAR 2023			
<i>Ambulance</i>			
	A Budget (Payroll)	\$1,986,181.00	\$1,909,628.00
	B Budget (Non-Payroll)	\$754,600.00	\$452,543.14
	Total Ambulance	\$2,740,781.00	\$2,362,171.14
<i>Extrication</i>			
	A Budget (Payroll)	\$22,300.00	\$39,021.14
	B Budget (Non-Payroll)	\$48,500.00	\$24,338.08
	Total Extrication	\$70,800.00	\$63,359.22

	Combined Total (Ambulance & Extrication)	\$2,811,581.00	\$2,425,530.36
	Inter-fund Loans or Advances (PILT)		\$551,339.96

FISCAL YEAR 2024			
<i>Ambulance</i>			
	A Budget (Payroll)	\$2,056,720.00	\$2,051,409.25
	B Budget (Non-Payroll)	\$645,000.00	\$593,626.48
	Total Ambulance	\$2,701,720.00	\$2,645,035.73
<i>Extrication</i>			
	A Budget (Payroll)	\$32,935.00	\$35,876.72
	B Budget (Non-Payroll)	\$51,000.00	\$19,949.60
	Total Extrication	\$83,935.00	\$55,826.32
	Combined Total (Ambulance & Extrication)	\$2,785,655.00	\$2,700,862.05
	Inter-fund Loans or Advances (PILT)		\$800,000.00

FISCAL YEAR 2025			
<i>Ambulance</i>			
	A Budget (Payroll)	\$2,398,732.00	\$2,161,860.87
	B Budget (Non-Payroll)	\$713,000.00	\$618,363.23
	Total Ambulance	\$3,111,732.00	\$2,780,224.10
<i>Extrication</i>			
	A Budget (Payroll)	\$45,213.00	\$46,257.68
	B Budget (Non-Payroll)	\$49,500.00	\$19,451.14
	Total Extrication	\$94,713.00	\$65,708.82
<i>CHEMS (new dept)</i>			
	Total Chems	\$100,756.00	\$69,173.18
	Combined Total (Ambulance, Extrication CHEMS)	\$3,307,201.00	\$2,915,106.10
	Inter-fund Loans or Advances (PILT)		\$1,071,976.30

6. RESPONSE TIME PERFORMANCE DEEP DIVE

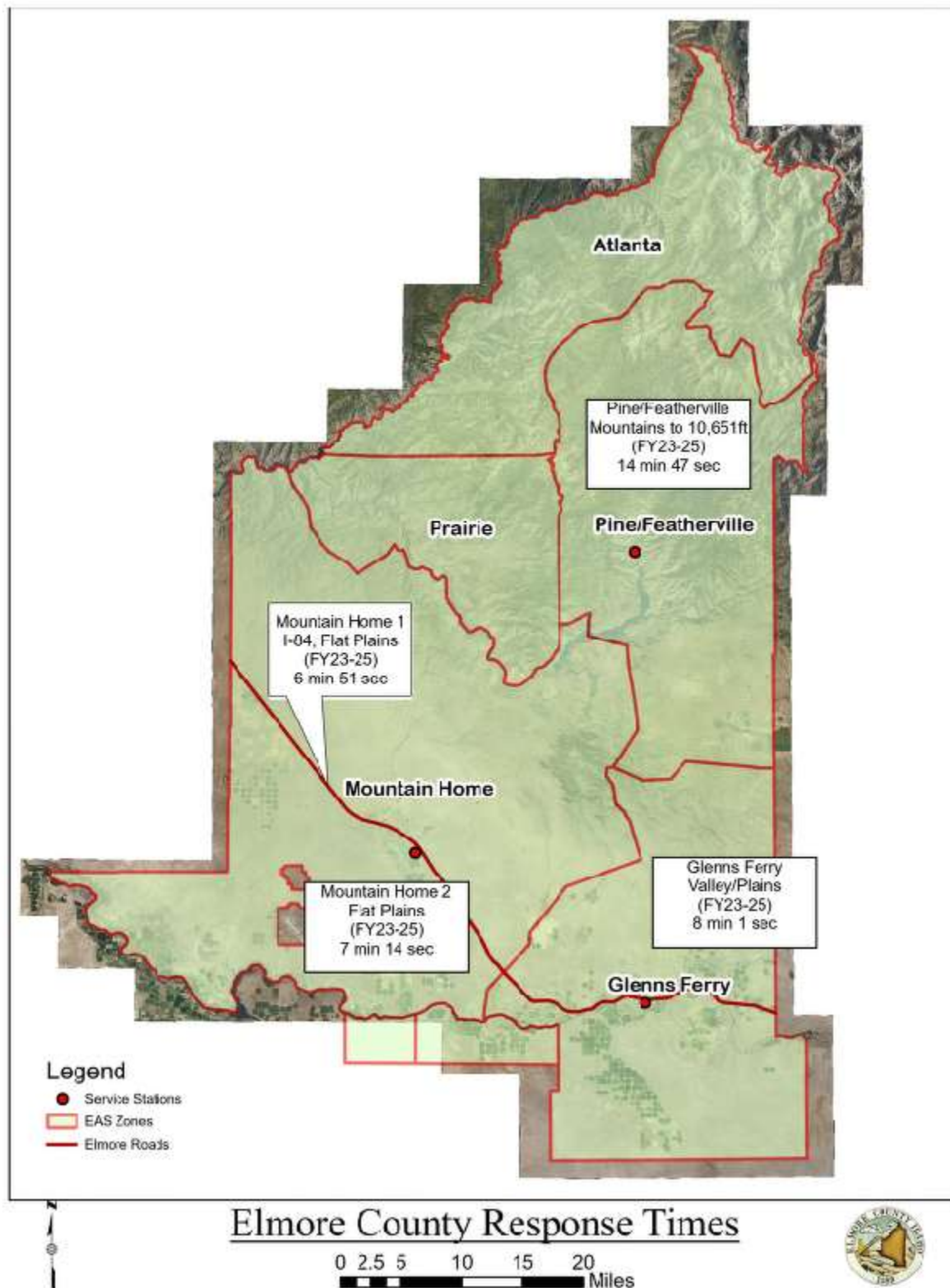
6.1 Response Time Analysis

Industry Standards for Comparison

- **NFPA 1710 (Urban/Suburban):** 90% of emergency responses within 8 minutes of dispatch
- **NFPA 1720 (Rural):** Varies by population density, typically 14 minutes for areas with <500 people per square mile
- **Idaho Statewide Average:** ~80 calls per 1,000 population utilization rate

Current Performance by Service Zone

Area Type	Population Density	Target Standard	Current Performance	Status
Mountain Home (Urban)	High	8 min (90th %ile)	6 min 51 sec avg	COMPLIANT
Mountain Home AFB	Medium	9 min (90th %ile)	7 min 14 sec avg	COMPLIANT
Glenns Ferry	Medium	10 min (80th %ile)	8 min 1 sec avg	COMPLIANT
Pine/Featherville	Very Low	14 min (80th %ile)	14 min 47 sec avg	MARGINAL
Remote Mountain Areas	Very Low	20-30 min	45-90+ min	CRITICAL



6.2 Clinical Implications of Response Times

Cardiac Arrest: Research published in *Circulation* demonstrates that cardiac arrest survival decreases 7-10% for every minute CPR and defibrillation are delayed, with resuscitation success rates falling to 0-2% after 10 minutes without intervention (Larsen et al., 1993; Waalewijn et al., 2001). The American Heart Association confirms that CPR administered within 10 minutes is critical for survival and prevention of brain damage (AHA, 2024).

Trauma Care: The National Association of Emergency Medical Technicians' Prehospital Trauma Life Support (PHTLS) program recommends scene times of 10 minutes or less for critically injured patients (Holder et al., 2020; NAEMT, 2024). The "golden hour" in trauma care emphasizes that prompt treatment within the first hour after injury provides the highest likelihood of survival (Cowley, 1975).

Stroke: Tissue plasminogen activator (tPA) for ischemic stroke must be administered within 3 hours of symptom onset (extended to 4.5 hours for selected patients) per American Heart Association/American Stroke Association guidelines (Jauch et al., 2013). Research published in *Stroke* demonstrates that earlier treatment correlates with better outcomes, with optimal treatment occurring within 90 minutes of symptom onset (Saver et al., 2010).

Rural EMS Context: A study published in *JAMA Surgery* found that rural EMS response time medians are 14 minutes compared to 7 minutes nationally, with nearly 1 in 10 rural encounters waiting almost 30 minutes for EMS arrival (Mell et al., 2017). Rural trauma patients are four times more likely to be transported to lower-level trauma centers (Turcinovic et al., 2025).

6.3 Level Zero Events and Mutual Aid Response

A "Level Zero" event occurs when all 4 ambulance units are committed, and no ambulances are available within the district to respond to incoming emergency calls. During these periods, incoming 911 calls are placed in a queue, and patients must wait until a unit clears from another call or becomes available through mutual aid from a neighboring jurisdiction.

Causes of Level Zero Events

Cause	Frequency/Duration	Impact
Simultaneous Calls	When 4+ calls occur concurrently	All 4 units committed; mutual aid required
Interfacility Transfers	250-300/year × 2.5 hr avg	1-2 units unavailable during transfer
Hospital Offload Delays	Adds 30-90 min per transport	Crew held awaiting patient handoff
Construction Workforce Events (near-term)	Increasing through 2027–2028 as energy and residential construction projects peak	Concentrated temporary workforces in rural zones generate occupational trauma and medical calls. Crimson Orchard Solar construction (through 2027), casino construction (~3,000 workers at peak), and Mayfield Springs residential construction will overlap with the District's current 4-unit deployment capacity.
Equipment Failures	Rare; hours to days	Reduces available fleet below 4 units

The frequency and duration of Level Zero events is expected to increase as seven documented regional growth drivers add population and workforce activity to the service area over the next three to five years. Of particular concern is the overlap of multiple large-scale construction projects during the 2026–2028 period: Crimson Orchard Solar (underway, operations 2027), the casino construction phase (nearly 3,000 construction workers at peak), and Mayfield Springs residential buildout will all coincide with the District's current 4-unit deployment model. Construction worksites in rural areas generate occupational injury calls that are frequently multi-casualty, time-sensitive, and located in zones where mutual aid response times already exceed clinically acceptable thresholds.

Mutual Aid Resources and Response Times

When Elmore County experiences Level Zero events with all 4 units committed, mutual aid must be requested from neighboring jurisdictions. Response times from these agencies significantly exceed acceptable clinical thresholds:

Agency	Coverage Area	Est. Response Time
Ada County Paramedics	Mountain Home area (40-45 mi via I-84)	50-60+ minutes
Magic Valley Paramedics	Eastern Elmore County	45-60 minutes
Acute Rescue/EMS	Northern Elmore County	90+ minutes
MHAFB 366th Medical Group	Limited civilian mutual aid	Variable/Limited

CLINICAL CONSEQUENCE: Mutual aid creates response time delays of 25-60 additional minutes beyond normal benchmarks, which is clinically catastrophic for cardiac arrest (survival decreases 7-10% per minute), clinically unacceptable for severe trauma (violates "Golden Hour" principle), and potentially fatal for stroke patients (may miss tPA treatment window).

6.4 Clinical Impact Assessment

Extended response times have quantifiable clinical consequences. Based on peer-reviewed research and the district's response time data:

Estimated Annual Clinical Impact

Condition	Clinical Evidence	Estimated Impact
Cardiac Arrest	Survival decreases 7-10% per minute without CPR/defibrillation	6-12 preventable deaths/year
Major Trauma	Scene times >10 min associated with increased mortality; I-84 crashes	3-6 preventable deaths/year
Stroke	tPA window 3-4.5 hours; optimal treatment within 90 min	5-10 miss optimal window
TOTAL	Combined preventable mortality and severe disability	9-18 deaths + 10-20 disabilities

Northern Mountain Zone Response Deficiencies

The northern mountain zone faces estimated response times of 45-90 minutes under optimal conditions and exceeding 2 hours during winter. This population of 2,000-3,000 permanent residents (plus 3,000-5,000 seasonal visitors) faces response times that render time-critical interventions ineffective, regardless of whether an ALS or BLS unit responds. **These delays result in unsurvivable conditions for cardiac arrest, severe trauma, and stroke.**

7. FUTURE REVENUE PROJECTIONS

7.1 Section Summary

This section analyzes the current levy authority of the Elmore County Ambulance District, compares potential revenue under enhanced or new district structures, and evaluates long-term financial sustainability under various scenarios. The analysis supports decision-making regarding whether to pursue enhanced levy authority within the existing district or form a new ambulance service district under Idaho Code § 31-3911 et seq.

Key Questions This Section Addresses:

1. What is the current levy authority and actual levy rate?
2. How much additional revenue could a 4-mill levy generate?
3. What are the pathways to enhanced levy authority?
4. Would forming a new district provide greater funding capacity?
5. What is the long-term sustainability outlook under each scenario?

7.2 Current Levy Authority

The Elmore County Ambulance District was formed after January 1, 1976 but prior to July 1, 2020 and is governed by Idaho Code Section 31-3908. This statute establishes both the **current levy rate** and the **maximum levy authority**, as well as the requirements for increasing that levy.

7.2.1 Existing Ambulance District's Property Tax Levy Authority (Idaho Code § 31-3908)

Levy Type	Rate and Requirements
Current Levy Rate	0.0167% of market value
Maximum Levy Rate Authority	0.04% (four-hundredths percent) of market value — requires 2/3 (66.67%) voter approval for permanent override at a May or November election.

7.2.2 Current Levy Rate (Publicly Available Data)

Data Element	Value
Elmore County Ambulance M&O Levy (2025 Certified)	0.000167371
Expressed as Percentage of Market Value	0.0167%
Maximum Levy Rate Authority	0.04%
UNUSED LEVY CAPACITY	0.0233% (58% of maximum)

Interpretation: The current levy rate is a fraction of the maximum levy authority (0.04%). Any increase in excess of 3% (plus new construction added) to the existing base of the current Ambulance District levy requiring a permanent override must comply with Idaho Code § 31-3908, including the applicable 2/3rds (66.67%) supermajority voter-approval threshold and election timing requirements.

Levy Revenue Comparison Analysis

Impact of Declining Levy Rate on District Revenue (FY2022-FY2025)

Historical Levy Rates (FY2022-FY2025)

Source: Elmore County Levy Rate Calculation Worksheets

Fiscal Year	Levy Rate	As Percentage	% of Maximum
FY2022	0.000184419	0.0184%	46.1%
FY2023	0.000186165	0.0186%	46.5%
FY2024	0.000174480	0.0174%	43.6%
FY2025	0.000167371	0.0167%	41.8%

Assessed Valuation Trend (FY2022-FY2025)

Source: Elmore County Levy Rate Calculation Worksheets

Fiscal Year	Net Taxable (A)	With Increment (A+B)	YoY Growth
FY2022	\$3.14B	\$3.20B	—
FY2023	\$3.17B	\$3.24B	+1.1%
FY2024	\$3.57B	\$3.64B	+12.4%
FY2025	\$3.88B	\$3.96B	+8.7%

4-Year Growth (FY2022 to FY2025): +23.6% (\$740M increase in net taxable market value)

4-Year Assessed Valuation Trend (FY2022-FY2025)

Source: Elmore County Levy Rate Calculation Worksheets

Fiscal Year	Net Taxable Value (A)	Value + Increment (A+B)
FY2022	\$3,140,742,683	\$3,203,419,625
FY2023	\$3,170,823,018	\$3,239,160,341
FY2024	\$3,568,595,028	\$3,640,660,021
FY2025	\$3,880,750,807	\$3,956,193,069
4-Year Growth	+23.6%	+23.5%

Historical Levy Rates (FY2022-FY2025)

Source: Elmore County Levy Rate Calculation Worksheets

Fiscal Year	Levy Rate	As Percentage
FY2022	0.000184419	0.0184%
FY2023	0.000186165	0.0186%
FY2024	0.000174480	0.0174%
FY2025	0.000167371	0.0167%
4-Year Change	-0.000017048	-9.2%

Elmore County Ambulance District

Levy Rate Decrease Analysis

1. Observation

The Ambulance District levy rate decreased by 9.2% from FY2022 (0.0184%) to FY2025 (0.0167%).

2. Why the Levy Rate Decreased

The levy rate is calculated, not directly set:

Levy Rate = Balance to be Levied ÷ Net Taxable Market Value

Think of it like a household grocery budget. A family of four has \$100 per month for groceries—that's \$25 per person. Then a fifth family member moves in, but household rules only allow the grocery budget to increase by 3%, bringing it to \$103. Now, that \$103 is split five ways, so each person's share drops to \$20.60.

Each person's contribution went *down*, however, there is actually *less* money per person to work with. The household grew by 25%, but the budget only grew by 3%.

To make matters worse, grocery prices are rising faster than the budget can keep up. The same \$103 doesn't buy what \$100 used to. So, now you're feeding more people with money that buys less. You start cutting back—fewer fresh vegetables, more generic brands, smaller portions. The quality and quantity of food on the table declines.

That's what happened in Elmore County. The ambulance district's budget grew by 12%, property values grew by 24%, and operational costs—fuel, equipment, wages, medical supplies—continue to climb. Each property owner's share went down, but the district now has relatively fewer resources to serve a larger, faster-growing county.

Each person pays less, but each person may get less quality. That's exactly what we're trying to avoid.

That's why the County General Fund has had to contribute additional money to cover the gap—and why long-term funding solutions are being explored.

When property values (denominator) grow faster than the budget (numerator), the levy rate decreases:

Factor	4-Year Change	Avg. Annual
Budget (Balance to be Levied)	+12.1%	+3.9%
Property Values (Net Taxable Market Value)	+23.6%	+7.3%
Resulting Levy Rate	-9.2%	-3.2%

Property values grew at approximately twice the rate of budget increases, causing the levy rate to decline.

3. Idaho's 3% Budget Limitation

Under Idaho Code § 63-802, annual property tax budget increases are limited to:

- **3%** of prior year budget, plus
- **New construction** value added to tax rolls, plus
- **Annexation** (newly added territory)

The 3% cap applies to levy REVENUE (budget dollars), not the levy rate. When property values grow faster than 3%, the levy rate will decline even if the district takes its maximum allowed increase.

4. Summary

The 9.2% levy rate decrease is primarily a mathematical result of property values growing faster (23.6%) than budget amounts (12.1%). Whether the district took its full allowable 3% budget increase each year requires verification through the L-2 Budget Certification Forms.

7.3 Comparison to New District with 4-Mill Levy

If a new ambulance service district were formed under Idaho Code § 31-3911 et seq. (governing districts formed on or after July 1, 2020), the district would have the same 0.04% standard levy authority under Idaho Code § 31-3915, with the option for voter-approved enhancement to 0.06%.

7.3.1 Revenue Projection Framework

The following formula calculates potential levy revenue:

Levy Revenue = Total Assessed Valuation × Levy Rate		
Scenario	Levy Rate	Estimated Revenue*
Current Levy	0.0167%	\$649,524
Full 4-Mill Levy (0.04%)	0.04%	\$1,552,300
Enhanced 6-Mill Levy (0.06%)	0.06%	\$2,328,450
ADDITIONAL REVENUE AT 4-MILL	+0.0233%	+\$902,776

**Note: Based on FY2025 Net Taxable Market Value of \$3,880,750,807 (Source: Elmore County Levy Rate Calculation Worksheet).*

Calculation Details:

Scenario	Formula	Result
Current Levy	$\$3,880,750,807 \times 0.000167371$	\$649,524
Full 4-Mill Levy	$\$3,880,750,807 \times 0.0004$	\$1,552,300
Enhanced 6-Mill Levy	$\$3,880,750,807 \times 0.0006$	\$2,328,450
Additional at 4-Mill	$\$1,552,300 - \$649,524$	\$902,776

Key Finding:

Moving from the current levy rate to the full 4-mill statutory maximum would generate approximately **\$902,776 in additional annual revenue** without requiring voter approval—potentially covering 70% of the projected FY2026 deficit of \$1,295,924.

7.3.2 Taxpayer Impact Analysis

Annual tax impact per \$100,000 of assessed home value:

Levy Scenario	Rate	Cost per \$100K
Current Levy	0.0167%	\$16.74/year
Full 4-Mill Levy	0.04%	\$40.00/year
Enhanced 6-Mill Levy	0.06%	\$60.00/year
INCREASE (Current → 4-Mill)	+0.0233%	+\$23.26/year

Comparison to Other Idaho Ambulance Districts:

- Gooding County Ambulance District: Sought \$411,392 permanent override levy (~\$17.20 per \$100,000); required 66.67% supermajority; failed in May 2024 and November 2025
- Bingham County Ambulance District: Passed \$567,000 temporary override levy (~\$13 per \$100,000) in May 2025 with 67.10% voter support
- Canyon County Paramedics: Proposed \$7.9 million temporary override levy (~\$18.62 per \$100,000) in May 2025

7.4 Pathways to Enhanced Levy Authority

There are limited statutory pathways to increase funding for ambulance services through property tax levies. The availability and process for each option depend on whether ambulance services are provided by the **existing ambulance district under Idaho Code § 31-3908** or by a **new ambulance district formed under Idaho Code § 31-3911**.

7.4.1 Option A: Increase Levy Within Existing District (Idaho Code § 31-3908)

Under Idaho Code § 31-3908, the existing ambulance district may seek to increase its levy rate up to the statutory maximum of **0.04% (four-hundredths percent) of market value**.

Requirements:

- Approval by **2/3 (66.67%) of qualified electors**
- Election held in **May or November**

Pros:

- Utilizes existing district structure
- Provides increased funding within current statutory framework

Cons:

- Requires supermajority voter approval
- Revenue is capped at 0.04%
- Election outcome is uncertain

Key Limitation:

The existing district **cannot exceed 0.04% levy authority**, and any increase toward that maximum requires **2/3 voter approval**.

7.4.2 Option B: Formation of New Ambulance District with Initial Levy Authority (Idaho Code § 31-3911)

Formation of a new ambulance district under Idaho Code § 31-3911 provides both a **governance restructuring** and a framework for establishing initial levy authority. However, the availability of meaningful levy authority for a newly formed district is also affected by **Idaho Code § 63-802**, which governs property tax budget limitations.

Initial Levy Authority

Upon formation of a new ambulance district:

- The district may be established upon approval by a **simple majority (50% +1) of qualified electors**
- Following formation, the new district board has authority to **establish an initial property tax levy up to 0.04% of market value for its initial fiscal year**

This initial levy is part of the formation and initial funding of the district and does not require a separate **2/3 override election**.

Impact of Idaho Code § 63-802 (Property Tax Limitation Law)

Idaho Code § 63-802 limits increases in property tax budgets and includes provisions addressing newly formed taxing districts.

If a new ambulance district is formed:

- **Within three (3) years** of an existing district providing the same service; and
- With **substantially the same boundaries** as the existing district;

then the new district's property tax authority may be treated as a continuation of the prior district's taxing authority.

Result:

The new district may **not gain additional effective levy capacity**, and its budget authority may be limited to the prior district's base, subject to the 3% annual increase limitation.

Boundary Consideration

To avoid the limitations imposed by Idaho Code § 63-802, a newly formed ambulance district should have **boundaries that differ from the existing district**.

If the new district has **different boundaries**, it may be treated as a **new taxing district**, allowing the district to establish an initial levy based on its formation authority rather than being constrained by the prior district's levy base.

Key Consideration:

If the new district has the **same or substantially similar boundaries**, the formation of a new district

may **not result in any meaningful increase in available levy authority**, and the district could remain subject to the same fiscal constraints as the existing district.

Formation Requirements

- Petition signed by at least **50 qualified electors**
 - **City consent resolutions** for incorporated areas
 - Public hearing process
 - Approval by a **majority of voters** at a May or November election
-

Pros

- Allows establishment of an **initial levy up to 0.04%** following formation
 - Provides opportunity to **reset the property tax base**, subject to compliance with Idaho Code § 63-802
 - Enables restructuring of governance and service delivery
 - Positions the district for long-term financial sustainability
-

Cons

- More complex and time-consuming process
 - Requires coordination with cities and stakeholders
 - Requires careful consideration of **district boundaries**
 - If boundaries are substantially the same, **no effective increase in levy authority may result**
-

Future Enhanced Levy Authority

Once a new ambulance district is formed, the district may, in a **subsequent fiscal year**, seek to increase its levy rate above 0.04% through an override election.

- Maximum enhanced levy: **0.06% of market value**
 - Requires **2/3 (66.67%) voter approval**
 - Election held in **May or November**
-

Summary of Option B

Formation of a new ambulance district may provide a pathway to establish a **sustainable initial levy** and access enhanced levy authority in the future. However, the effectiveness of this approach depends on compliance with Idaho Code § 63-802, including whether the new district is structured in a manner that allows it to be treated as a **new taxing district rather than a continuation of the existing district**.

7.4.3 Future Enhanced Levy Authority (Up to 0.06%)

Once a new ambulance district is formed, the district may, in a **subsequent fiscal year**, seek to increase its levy rate above 0.04% through an **override election**.

Enhanced Levy Authority:

- Up to **0.06% (six-hundredths percent)** of market value

Requirements:

- Approval by **2/3 (66.67%)** of qualified electors
- Election held in **May or November**

Key Distinction:

- The **initial levy (up to 0.04%)** may be established following formation of the district with **majority voter approval of the district itself**
- Any increase **above 0.04%** requires a **separate 2/3 supermajority election**

Implications:

This two-step structure allows the new district to:

1. Establish a **baseline funding level** upon formation; and
 2. Seek **additional funding authority in the future**, if needed, with voter approval
-

7.4.4 Option C: Maintain Current Structure Without Levy Increase

The District may continue operating under its current levy rate of **0.0167%**, with any funding shortfall addressed through other sources.

Implications:

- Continued reliance on **County General Fund subsidies**
 - Increasing financial pressure due to rising costs
 - Potential need for **service reductions or delayed capital investment**
 - Increased risk of **longer response times**
-

7.4.5 Summary of Levy Authority

- **Existing District (§ 31-3908):**
 - Maximum levy: **0.04%**
 - Requires **2/3 voter approval** to increase
- **New District (§ 31-3911):**
 - Initial levy: Up to **0.04%**, following **majority approval of district formation**
 - Future levy increase up to **0.06%**, requiring **2/3 voter approval**

Key Policy Consideration:

Formation of a new ambulance district with slightly difference boundaries provides a pathway to establish a **sustainable initial funding level** without the immediate need for a supermajority election, while preserving the ability to seek additional funding in the future subject to voter approval. The ability of a newly formed ambulance district to establish a new levy base would otherwise be limited by Idaho Code § 63-802 if the new district is formed with the same boundaries within three (3) years of the existing District.

7.5 Long-Term Sustainability Comparison

7.5.1 Background

Elmore County, Idaho Property Value Trends (2020-2025)

Overview

Elmore County experienced the same dramatic property value surge seen throughout Idaho during the COVID-19 pandemic, followed by a market correction and stabilization period. Idaho's housing market experienced a sharp run-up of 2020–2022 followed by a cooling period, with home values now stabilizing rather than surging as higher mortgage rates and expanded inventory temper demand. Innago

Key Trend Data

Pre-Pandemic to Peak (2020-2022): The statewide median home price rose by more than \$200,000 from the start of 2020 to the summer of 2022—prior to that, the state of Idaho had never experienced such a sharp and sustained surge in home values. Sammamish Mortgage Home prices in Idaho rose rapidly after the pandemic hit, climbing 38.6% year-over-year from Q2 2020 to Q2 2021, as remote work fueled demand from families wanting to relocate from high-cost states like California. Veros

2022 Peak and Correction: Idaho was one of the hottest real estate markets in America during COVID, but in July 2022, the market started to shift—homes stopped selling overnight, and inventory started to increase, which leveled off prices. Build Idaho

2023-2025 Stabilization: For Elmore County specifically, the median sales price was \$335,000 in June 2023, an increase of 0.5% from a year ago. KTVB In June 2025, Elmore County home prices were up 3.9% compared to last year, selling for a median price of \$369K. Redfin

Approximate Property Value Trajectory

Year	Estimated Median Home Value	Notes*
2020	~\$200,000-\$220,000	Pre-pandemic baseline
2021	~\$280,000-\$300,000	Pandemic surge
2022	~\$340,000-\$360,000	Market peak
2023	~\$317,000-\$335,000	Post-peak correction
2024	~\$345,000-\$360,000	Stabilization
2025	~\$346,000-\$375,000	Modest growth

Note: Exact historical figures for Elmore County specifically are limited; these estimates are derived from available data points and statewide trends.

Current Market Conditions (2025)

The typical home value in Mountain Home, ID is \$346,124, with home values up 2.4% over the past year. Zillow The estimated median house or condo value in Elmore County as of 2023 was \$317,232. City-Data

*A note on data availability: Elmore County is a smaller, rural market, so granular historical data is more limited compared to larger metropolitan areas like Ada County (Boise). The Idaho State Tax Commission and Elmore County Assessor's Office may have additional detailed assessment records if you need more specific historical valuations for your work.

Elmore County, Idaho Property Value Forecast (2025-2030)

Summary of Projected Trends

Based on available forecasts and economic indicators, Elmore County property values are projected to experience **modest, steady appreciation** of approximately 2-4% annually through 2030, rather than the dramatic surges seen during 2020-2022.

Key Forecast Indicators

Short-Term (2025-2026): Experts predict mortgage rates will hover in the low 6% range for most of 2026, and we forecast a modest 3-4% price appreciation for 2026—this is healthy and means your home is a safe investment. 375loan

According to Lawrence Yun, chief economist for the National Association of Realtors, median home prices are forecasted to increase modestly by 3% in 2025 and 4% in 2026. Norada Real Estate

Medium-Term (2026-2030): Dr. Lawrence Yun, Chief Economist and Senior Vice President of Research, National Association of Realtors, believes the housing market will appreciate 15 to 25% over the next five years. He thinks that the seller's market will continue because housing inventory will remain low. Innago

A housing market crash in Idaho is not likely in 2025 and 2026. Home prices are not dropping suddenly and remain 80% above pre-COVID levels, with sustained growth projected through 2025. Houzeo

Projected Property Value Trajectory for Elmore County

Year	Estimated Median Home Value	Annual Change
2025	\$350,000-\$375,000	+2-4%
2026	\$360,000-\$390,000	+3-4%
2027	\$375,000-\$410,000	+3-5%
2028	\$390,000-\$430,000	+3-5%
2029	\$405,000-\$450,000	+3-5%
2030	\$420,000-\$475,000	+3-5%

Note: These projections are estimates based on statewide trends and expert forecasts. Actual values may vary based on local conditions.

Factors Influencing the Forecast

Supporting Price Growth:

1. **Population Growth:** Idaho's population is projected to reach 2.4 million by 2034, with the state growing at approximately 1.5% annually through 2034. Idaho Labor Market Information
2. **Continued In-Migration:** According to the U.S. Census Bureau, the statewide population grew by nearly 7% from 2020 to 2023, well above the national growth rate for that same period. Sammamish Mortgage
3. **Market Stabilization:** Peering toward 2026, analysts believe Idaho's housing market will continue on an upward trajectory overall, assuming no significant disruptions or changes in economic policy that might influence homebuyer confidence. Norada Real Estate
4. **Limited Inventory:** As of 2025, Idaho continues to rank among the top states for residential construction activity on a per-capita basis, reflecting strong builder response to sustained population growth and housing demand. Innago

Factors That May Moderate Growth:

1. **Rural Population Dynamics:** Approximately 79% of population growth is projected in urban counties, with over half projected in just three counties (Ada, Canyon, and Kootenai). Rural counties will see slower growth. Idaho Labor Market Information
2. **Housing Affordability Challenges:** Over the past two decades, Idaho's rural populations have been aging and struggling with housing affordability. Coeur d'Alene Press
3. **Military Housing Market Fluctuations:** Mountain Home Air Force Base, Idaho saw a -3.1% decrease in BAH rates for 2025, reflecting some softening in local rental markets. Federal News Network
4. **Mortgage Rate Environment:** Most forecasts are anticipating home prices to continue climbing but at slower rates than they have been, with 2025 being the second consecutive year that inflation-adjusted prices have fallen. Idaho News

Special Considerations for Elmore County

Elmore County's property values are influenced by several unique factors:

- **Mountain Home Air Force Base:** The base provides economic stability but military housing allowance changes can affect local rental and purchase markets
- **Rural Classification:** As a rural county, growth will likely trail urban areas

- **Proximity to Boise:** Benefits from spillover demand from the Treasure Valley but distance limits this effect
- In rural Idaho, where a relatively high share of the population is of or near retirement age, the housing stock is primarily single-family (houses) instead of multi-family (apartments), and most households own rather than rent. Idaho Department of Labor

Important Disclaimer: Long-term property value forecasts (beyond 1-2 years) carry significant uncertainty. These projections are based on current economic conditions and expert analysis, which may change due to factors including interest rate changes, economic recessions, policy changes, or unforeseen events. Consider consulting with local real estate professionals and financial advisors for decisions requiring specific property valuations.

7.5.2 Elmore County Levy Revenue Projections

FY 2025-26 through FY 2029-30

Key Assumptions

- **Assessed valuation growth:** 3.5% annually (midpoint of 3-4% property value forecast)
- **Current levy revenue growth:** 3% annually (maximum allowed under Idaho Code § 63-802)
- **4-Mill and 6-Mill levies:** Fixed rates (0.04% and 0.06%) applied to growing assessed values
- **Projected costs:** Starting at \$1,945,448 for FY2025-26, growing at 3% annually
- **Base assessed valuation:** \$3,880,750,807 (FY2025 Net Taxable Market Value)

The revenue projections above are based on property value forecasts derived from existing residential and commercial activity. They do not yet incorporate the assessed value additions that will result from seven documented regional development projects identified in Section 3.7.6. The \$326–\$342 million Crimson Orchard Solar project (operations 2027), the \$311 million Shoshone-Bannock casino resort (pending federal approval), and the Mayfield Springs master-planned community (2,325 homes at buildout) each represent substantial additions to the county's taxable assessed value base. Under the current levy structure this will paradoxically reduce the levy rate while increasing absolute levy revenue — the same dynamic that produced the 9.2% levy rate decline documented in Section 7.2.2: the tax base grows faster than the budget cap allows revenue to grow, causing the rate to fall even as collections rise modestly. The implication for levy authority planning is significant: establishing a new district with initial levy authority at the full 4-mill rate prior to these assessed value additions would capture the maximum benefit of the growth-driven base expansion, before the rate-suppression effect of rapid property value growth erodes the effective levy percentage further.

Five-Year Levy Revenue Projection Table

Year	Current Levy	4-Mill Levy	6-Mill Levy	Proj. Costs	Gap*
FY 2025-26	\$669,010	\$1,606,631	\$2,409,946	\$1,945,448	\$338,817
FY 2026-27	\$689,080	\$1,662,863	\$2,494,294	\$2,003,811	\$340,948
FY 2027-28	\$709,753	\$1,721,063	\$2,581,595	\$2,063,925	\$342,862
FY 2028-29	\$731,046	\$1,781,300	\$2,671,950	\$2,125,843	\$344,543
FY 2029-30	\$752,977	\$1,843,646	\$2,765,469	\$2,189,618	\$345,972

*Gap = Projected Costs minus 4-Mill Levy Revenue; positive indicates shortfall

Key Findings

- 1. The 4-Mill levy alone will not close the gap.** Even at the full 4-mill rate, there is a persistent \$340,000-\$346,000 annual shortfall throughout the projection period.
- 2. The 6-Mill levy creates a surplus.** At 6 mills, revenue exceeds projected costs by \$464,000-\$576,000 annually, which could fund reserves or capital needs.
- 3. The gap remains relatively stable.** Because both costs and assessed values grow at similar rates (3% vs 3.5%), the gap does not widen dramatically over the projection period.

Methodology Notes

Under Idaho Code § 63-802, annual property tax budget increases are limited to 3% of prior year budget, plus new construction value added to tax rolls, plus annexation. The 3% cap applies to levy REVENUE (budget dollars), not the levy rate. When property values grow faster than 3%, the levy rate will decline even if the district takes its maximum allowed increase.

The FY2025-26 projected costs figure of \$1,945,448 is derived from the current levy revenue of \$649,524 plus the projected FY2026 deficit of \$1,295,924.

Disclaimer: *These projections are estimates based on statewide property value trends and standard growth assumptions. Actual values may vary based on local economic conditions, policy changes, and other factors. Consult with local financial advisors and county officials for decisions requiring specific property valuations.*

8. NEEDS AND ASSOCIATED COSTS

8.1 Section Summary

This section quantifies the costs associated with addressing the Elmore County Ambulance District's operational needs identified in earlier sections. Based on call volume analysis showing 60-90 annual "Level Zero" events and the district exceeding 3,000 calls for two consecutive years, a third ambulance unit is needed to meet response benchmarks and ensure adequate coverage.

Summary of Projected Needs:

Category	Estimated Annual Cost
Personnel (10.0 FTEs for 3rd stations)	\$850,000 - \$1,050,000
Equipment Replacement (Annualized)	\$120,000 - \$150,000
Facilities (Annualized Capital/Lease)	\$50,000 - \$100,000
TOTAL ESTIMATED NEW COSTS	\$1,020,000 - \$1,300,000

8.2 FY2026 Approved Budget by Department

Department	FY2026 Adopted Budget
Dept 429 - Ambulance District	\$3,772,100
Dept 430 - Rescue	\$287,080
Dept 431 - CHEMS	\$215,317
TOTAL FY2026 BUDGET	\$4,274,497

8.3 Personnel Costs

8.3.1 FY2026 Personnel Budget - Ambulance District (Dept 429)

Personnel Category	FY2026 Budget
Salaries	\$1,282,848
Extra Help	\$300,000
Social Security	\$120,340
Medicare	\$28,144
Health/Dental/Vision	\$563,865
Supplemental Insurances	\$1,169
PERSI Retirement	\$227,608
Overtime	\$358,126
TOTAL PERSONNEL (A-Budget)	\$2,882,100

8.3.2 3-Unit Staffing Model Requirements

To operate one ambulance unit 24/7 requires approximately 10 FTEs. Data needed:

Data Element		Status
Data Element	Data / Finding	Source
Current FTE count by position (FY2026)	43 fixed FTEs: Administrative 3 (Director 1, Billing Clerk 2, Office Manager 0 unfilled); Ambulance Service 22 (Deputy Chief 1, Lieutenant 4, Paramedic 2, EMT 15; Chief 0 unfilled); Rescue 16 (Captain 1, Lieutenant 1, Technicians 14); CHEMS 2 (Director 1, Community Paramedic 1). Variable PT Help and Reservists excluded from fixed total.	Roberts, A. (2026) internal spreadsheet. See Section 3.7.1, Table 1.
3-unit staffing model cost estimates	Operating a 5th unit (3-unit addition to current 4): 35–40 FTEs conservative, 45–50 FTEs robust (Section 3.3.2). District projects 31 Ambulance Service FTEs by FY2029 at total district personnel cost of \$4,374,173/year. Net incremental cost above FY2026 baseline: ~\$1,325,802/year.	Sections 3.3.2 and 3.7.4.
Relief factor calculation	Not explicitly calculated in the District's staffing model. The PT Help/Reservist line ('Varies' headcount, \$430,600 FY2026 wages) functions as the relief pool. Industry standard ~16.7% implies 3–4 relief FTEs for the current 22-person Ambulance Service. Recommend verification with District finance prior to finalizing.	PT Help line: Roberts (2026) spreadsheet. Industry benchmark: Section 3.3.1.

8.4 Total Projected Cost vs. Revenue Scenarios

8.4.1 Funding Gap Analysis

Category	FY2026
Total Projected Expenditures	\$4,274,497
Self-Generated Revenue (without County subsidy)	\$2,978,573
FUNDING GAP (County Subsidy Required)	\$1,295,924

Key Finding: Even with a 4-mill levy (the statutory maximum without voter approval), a funding gap would remain. This gap must be addressed through: (1) City funding partnerships, (2) Contract services, (3) Voter-approved enhanced levy, or (4) Enhanced transport billing.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 Key Conclusions

1. The structural deficit has grown from \$551,340 in FY2023 to a projected \$1,295,924 in FY2026 (135% increase).
2. Cumulative County General Fund subsidies over 4 years total \$3,719,240.
3. Personnel costs represent approximately 75-85% of total operating costs.
4. The current levy rate (0.0167%) is only 42% of the statutory maximum (0.04%).
5. Transport billing revenue declined from \$1,137,494 (FY2023) to \$1,022,664 (FY2025), a 10% decrease.
6. Without new revenue, response times will worsen due to personnel/equipment shortages.
7. With expanded levy authority, District can meet standards, reduce county subsidies, and deliver equitable service across all communities.
8. Seven documented, permitted, or actively financed regional growth drivers will accelerate call volume beyond current staffing capacity if not addressed proactively. These include: the Mayfield Springs master-planned community (groundbreaking October 2024, 2,325 homes); two competing casino resort proposals representing over \$620 million in combined investment; a Qatari Emiri Air Force training facility planned at Mountain Home AFB; \$300 million-plus in I-84 corridor highway improvements; active construction of the \$304 million Crimson Orchard Solar project and two additional county-approved energy facilities; seasonal recreational surges in the Pine/Featherville zone; and documented 8.74% single-year population growth in Glenns Ferry. Each driver is sourced and documented in Section 3.7.6.

9.2 Recommendations

Based on the findings of this report, the following actions are recommended to establish a sustainable, long-term funding structure for ambulance services in Elmore County:

1. Form a New Ambulance District Pursuant to Idaho Code § 31-3911

The most effective path to establish a sustainable funding structure is to form a new ambulance district under Idaho Code § 31-3911.

Upon formation:

- The new district may be established upon approval by a **simple majority (50% +1) of qualified electors**
- The newly elected district board will have the authority to **establish an initial property tax levy of up to 0.04% of market value for its initial fiscal year**

This approach allows the District to establish a **baseline level of funding without requiring a 2/3 supermajority election**, which has historically proven difficult to achieve.

The urgency of formation is reinforced by seven documented regional growth drivers — including active construction of a \$304 million solar project, two casino resort proposals, a Qatari Air Force training facility, and the largest residential development in Elmore County's history — that will generate call volume increases requiring additional funded capacity within the District's planning horizon. See Section 3.7.6 for sourced documentation.

2. Structure the New District Boundaries to Comply with Idaho Code § 63-802

To ensure that the new district has the ability to establish an effective levy base, the boundaries of the new district shall differ from the existing district.

If the new district is formed with the same or substantially similar boundaries as the existing district within a short period of time, Idaho Code § 63-802 may limit the new district's ability to establish a new levy base.

Accordingly, careful consideration of district boundaries is necessary to ensure the new district is treated as a **new taxing district for property tax purposes**.

3. Provide the New District Board with Flexibility to Establish the Initial Levy

Following formation, the new district board should evaluate service needs, costs, and financial projections to determine the appropriate initial levy rate, up to **0.04% of market value**, for the initial fiscal year.

This approach provides the Board with the flexibility to:

- Align funding with actual service costs
 - Ensure adequate staffing, equipment, and coverage
 - Reduce reliance on County General Fund subsidies
-

4. Obtain City Consent and Coordinate Dissolution of Existing District

Formation of a new ambulance district requires:

- **Consent of the Cities of Mountain Home and Glenns Ferry** to participate in the new district; and
- Coordination of the **dissolution of the existing ambulance district**

City participation is essential to ensure a **countywide, unified EMS system** and to provide equitable service to all residents.

5. Continue Public Education and Outreach

Given the importance of ambulance services to public safety, continued outreach and communication with residents is critical to:

- Explain the need for a sustainable funding model
 - Describe the formation process for a new district
 - Provide clear information regarding costs and benefits
-

Summary of Revised Recommendations

The recommended strategy is to:

- **Form a new ambulance district**
- **Establish an initial levy (up to 0.04%) following formation**
- **Structure boundaries to comply with Idaho Code § 63-802**
- **Obtain City consent and dissolve the existing district**

This approach provides the most practical and legally sound pathway to achieve long-term financial sustainability.

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