NCH Strategic Facility Plan RFP Q & A

STRATEGIC ALIGNMENT & SERVICE DISTRIBUTION

1. Does this existing 2025 Strategic Plan have additional details that will be shared with the selected team? Have consolidation / distribution concepts for service offerings been studied already, or will the strategic part of our engagement broach this topic for the first time? Would NCH consider an abbreviated strategic planning work session at the outset of this engagement to align key affiliate leadership into a preferred direction for the future allocation of services, facilities, and providers?

The 2025 Strategic Plan is the complete public document. We welcome thoughtful interview questions to deepen understanding.

This engagement will represent the first comprehensive, Systemwide evaluation of service consolidation and distribution. While elements of alignment have evolved since Affiliation began in 2017, a formal, integrated study across all Affiliates has not yet been undertaken.

Yes, we would strongly consider an abbreviated strategic alignment session at the outset of the engagement. We believe early alignment among Affiliate leadership regarding future service allocation, facilities, and provider distribution will create a more focused and efficient planning process.

The purpose of this study is to evaluate and provide strategic recommendations regarding the consolidation and distribution of service offerings to ensure operational efficiency, resource alignment, and long-term sustainability across the System.

2. What is the primary problem or set of issues the Strategic Facility Plan is meant to address (e.g., financial sustainability, asset condition)? Focusing the Strategic Facility Plan on the essential issue(s) will ensure NCH's needs are met while keeping costs down.

This is the first Systemwide Strategic Facility Plan since Affiliation began in 2017.

The primary driver is long-term financial sustainability within an uncertain market environment and waning access to care across rural communities. While recent audits indicate asset condition is stronger than benchmark, sustainability, service viability, and strategic allocation of resources are central to this effort.

The goal is not simply to assess facilities, but to ensure the right services are delivered in the right locations in a way that protects rural access for the long term.

3. Given NCH is comprised of multiple affiliates, each maintaining its own governance, how does NCH envision major system-level planning decisions are made during the Strategic Facility Plan engagement? Or is the proposer free to define that structure?

North Country Healthcare (NCH) is a system parent organization comprised of multiple affiliated entities, each of which maintains its own governing board with fiduciary responsibility for its respective organization. As such, NCH

envisions a collaborative governance model for the Strategic Facility Plan engagement that appropriately balances system-level strategy with affiliate-level authority.

4. What is your fiscal year Start and End Date?

Our fiscal year is October 1 through September 30.

5. When do you present your annual operating and capital plan for approval?

Budget development begins in June and July and is presented to the Boards for approval in August and September.

MEDICAL STAFF DEVELOPMENT

6. The medical staff development plan linked on the website is from 2016/2017 (when Littleton Regional was also part of the group), but the RFP mentions a 2021 MSDP to be updated. Will the 2021 plan exclusive of LRH be shared? Is the assumption that any future MSDP is done at the system level, with input from each individual hospital site?

There is no additional documentation beyond what has been provided. Littleton Regional Hospital (LRH) is no longer part of the Affiliation.
We anticipate this engagement will assist in gathering updated medical staff input and translating that input into an actionable, System-informed Medical Staff Development Plan.

7. In inventorying the information for the Strategic Facility Plan RFP and it was noticed that for Appendix D Updated Medical Staff Development Plan (2021 version noted for review) is a 2017 document. Is this the right document to utilize, or is there a more current version to utilize?

No additional documentation is available. We expect the selected firm to support development of an updated and integrated Medical Staff Development Plan reflective of the current Affiliation structure.

CAPITAL CAPACITY & FINANCIAL FEASIBILITY

8. Before two future state planning scenarios for each affiliate campus are developed, will the system / affiliate leaders engage in a planning session with our team to understand capital capacity / viability? In other words, will we be able to work with your team to understand total affiliate and system cash on hand / fundraising / debt capacity before scenarios are developed?

Yes.

System and Affiliate leadership will engage in structured financial discussions early in the process to understand capital capacity, cash position, debt tolerance, and fundraising feasibility before advancing major future-state scenarios.

We will not seek community input on speculative options before internal alignment.
A core guardrail of this engagement is our commitment to maintaining hospital presence within current communities.

System leadership and the finance team will be integrated throughout the process to ensure that all recommendations are financially viable and sustainable.

9. In financial component of scenario planning and feasibility strategy, is the assumption that financial feasibility planning will be at the individual hospital level (building out CAH financial models incorporating the Medicare Cost Report), and then rolled up to a system summary? Are you also anticipating exam level financial feasibility at this point?

Yes. Financial modeling is expected at the individual hospital level, including CAH-specific considerations, and then rolled into a System-level summary.

10. Is there a specified project budget and completion date for this project?

For the proposal process, our priority is quality and durability of output over speed of delivery. We are seeking expert input regarding scope, cost, and phasing. We anticipate the full project is multi-year, phased initiative potentially dependent on funding availability.

EXISTING FACILITY & INFRASTRUCTURE INFORMATION

11. What level of existing infrastructure information exists and could be made available to the successful team? We are asking about information, such as existing MEP equipment inventories, original/past drawings (digitized or paper), utility bill data, etc.

Each Affiliate can provide comprehensive as-built documentation reflecting current conditions, including systems and utilities. Historical documentation, operational trends, and improvement initiatives can also be made available to the selected firm.

12. What level of detail is desired to document/describe existing facility conditions (i.e. high-level condition and capability vs. equipment item by item data)

A moderate level of detail is appropriate. Facilities Management maintains a solid understanding of current asset condition. The emphasis of this engagement is forward-looking strategic direction rather than exhaustive equipment inventory documentation.

13. To what extent will the scope include addressing IT/low voltage systems? Will IT/IS department personnel largely assess that infrastructure and outline what needs they have going forward?
a. Similar question about vendor type systems: security & access control, etc

A comprehensive IT framework and standardized network architecture are already in place Systemwide. Security and access control platforms have been standardized and integrated.

We expect these systems to be incorporated into the planning process and aligned with facility recommendations. IT leadership will be engaged early to ensure Integration.

While current systems are standardized, we welcome expert recommendations for optimization where appropriate.

Looking ahead, we expect the Facilities Master Plan to position campuses to support evolving digital care delivery, including virtual care environments, telehealth enabled spaces, resilient and redundant connectivity, smart building capabilities, and scalable enterprise infrastructure. Facility strategy and digital strategy are increasingly interconnected, and planning should reflect that integration.

14. Are there existing condition documents, most recent facility assessments / plans for the North Country Home and Hospice Agency and all Satellite Clinics?

Preliminary capital planning recommendations exist and remain flexible pending Master Facility Plan outcomes. A consolidated Facilities document is currently being finalized and will be shared with the selected firm.

15. Will the selected team receive floor plans for the remaining owned or leased properties beyond the 9 provided?

Yes. Full floor plans will be provided upon request. Where available, .dwg AutoCAD and .rvt Revit files will be shared. We will collaborate with prior vendors as needed to recover additional documentation.

16. Appendix B includes PFDF's of floor plans for all of the facilities. Will other drawings – specifically site plans and/or MEP drawings – be available to the team as the project gets started? Is it expected that the project team will update any of the drawings as part of the evaluation?

Yes. Full floor plans will be provided upon request. Where available, .dwg AutoCAD and .rvt Revit files will be shared. We will collaborate with prior vendors as needed to recover additional documentation. Yes, it is expected that drawings reflect future state changes as a final deliverable.

17. For the Facility Inventory & Maps provided in APPENDIX B, please confirm the following:

a. Inventory is inclusive of all sites in scope of the Strategic Facility Plan (i.e., no sites are missing).

All listed facilities are in scope for review. Some land assets are zoned as swampland and are not currently viable for expansion. Please see Appendix B; https://northcountryhealth.org/wp-content/uploads/sites/2/2026/01/Copy-2025-Insurance-Renewal-Property.pdf

b. Consultant will be provided with the original .dwg AutoCAD files or .rvt Revit files for all the facilities.

Where available, .dwg AutoCAD and .rvt Revit files will be shared. We will collaborate with prior vendors as needed to recover additional documentation.

c. Miscellaneous Locations listed on page 2 of the Facility Inventory are in or out of scope

While hospital campuses remain central, smaller off-site facilities are critical referral pipelines and service anchors. Assessment of these sites may be streamlined from a building systems perspective; however, functional review and service line alignment should remain comprehensive to support System sustainability. Please see Appendix B for all properties within project scope; https://northcountryhealth.org/wp-content/uploads/sites/2/2026/01/Copy-2025-Insurance-Renewal-Property.pdf

18. The Insurance Renewal Form provided in Exhibit B includes the floor areas of most of the properties, but a few are missing. Could you please provide the missing square footages? Would also appreciate it if we could get dates the buildings were constructed.

Please see the updated Appendix B for all properties within project scope; https://northcountryhealth.org/wp-content/uploads/sites/2/2026/01/Copy-2025-Insurance-Renewal-Property.pdf

19. We understand we need to walk through and evaluate the condition of each of the facilities listed in Appendix B and integrate the use – or disposition – of these properties into the overall SFP. May we assume our evaluation and projected use of the smaller off-site facilities will be high level, and the more detailed plans/diagrams outlined in the RFP will be focused on the main Hospital campuses?

a. Program / FGI compliance review?
b. Building code / Life Safety compliance review?
c. Building envelop assessment?
d. Structural assessment?
e. MEP/FP assessment to what level? Major infrastructure only?
f. Site and infrastructure assessment?

While the Hospital campuses remain a central focus of the Strategic Facility Plan, our smaller off-site locations are equally important to the System's long-term success. These facilities house primary care, specialty services, and behavioral health programs that serve as essential referral pipelines to our Critical Access Hospitals.

We anticipate that the physical plant assessment for smaller sites may be appropriately scaled in depth when compared to the main campuses. However, review of functionality, program alignment, compliance considerations, and service line recommendations should remain comprehensive to ensure operational cohesion and long-term sustainability across the System.

The expected scope of review should include, as appropriate: program and FGI compliance; building code and Life Safety compliance; building envelope and structural considerations; major MEP and fire protection infrastructure; and site and supporting infrastructure. The level of detail should be sufficient to inform strategic direction, capital prioritization, and future service allocation decisions.

DATA & MARKET INTELLIGENCE

20. Will NCH provide the consultant with internal utilization data for all entities, along with the New Hampshire's state-level encounter database for inpatient, outpatient, specialty, and emergency services?

Yes. NCH will provide internal utilization data from our EMR systems across all entities, as well as relevant public health and state-level data available to us. We expect this information to serve as a foundational input for demand forecasting, referral analysis, and service line modeling.

21. Does NCH currently subscribe to market intelligence services (e.g., Sg2, Advisory Board) that the consultant will be expected to utilize for referral analysis and demand forecasting?

NCH does not currently subscribe to external market intelligence platforms such as Sg2 or Advisory Board. Comprehensive market assessment and demand forecasting are expected deliverables within this engagement.

22. Will NCH be able to provide a summary of units or expect this as a deliverable from the planning? We would do this for all key planning units (Emergency Department, Imaging by modality, clinic visits, etc).

a. Example:

Location	Bed Days	Beds	Utilization
AVH		25	
UCVH		16	
WMC		25	
Total	7289	66	30%

Development of unit summaries for key planning areas such as Emergency Department volumes, imaging by modality, clinic visits, inpatient bed days, and utilization metrics will be incorporated as a formal deliverable within the selected firm's scope of work.

NCH can provide underlying data sets based on defined time parameters requested by the consulting team to support this analysis.

PROJECT STRUCTURE, TEAMING & GOVERNANCE

23. Will NCH assign staff to support this engagement, and if so, which roles and what level of time commitment should we anticipate?

Yes. NCH will dedicate appropriate System-level support and staff time to ensure the success of the engagement. Staff will be made available for interviews, data gathering, and working sessions. We welcome recommendations within proposals regarding anticipated support needs and role engagement.

24. Please provide a list of the staff, including title and brief description of their role, who will be supporting NCH data gathering and responding to questions.

A list of committee members and supporting staff, including titles and roles, will be provided to the selected firm and updated as appropriate throughout the project.

25. Does NCH have any preferences or expectations regarding integrated teams (e.g., advisory-led with architectural partnership), or is the proposer free to define that structure?

The proposer is free to recommend the team structure based on identified needs and best practice.

26. What level of in-person presence does NCH expect for this engagement, and are there specific milestones where in-person participation is preferred (site visits, stakeholder workshops, stakeholder meetings)?

All facilities should be evaluated in person by qualified personnel. Following initial site assessments, meetings may be conducted virtually with periodic on-site engagement as needed.

27. Is there a standard form of agreement or contract that would be utilized between North Country Healthcare and the selected firm?

There is no standard contract template. Vendors must carry insurance coverage of $1,000,000 per occurrence and $3,000,000 general aggregate, naming North Country Healthcare as a covered entity. A Business Associate Agreement will be required as applicable. Prior to contract execution, NCH will query the Office of Inspector General List of Excluded Individuals and the System for Award Management to confirm eligibility to participate in federal and state healthcare programs.

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