District Responses to RFP Questions

The Northern Shelby County Joint Ambulance District (the "District") received written questions regarding the District's Request For Proposal dated July 10, 2026 ("RFP") to provide Ambulance Services to the District. Below the questions are restated along with the responses, ("Responses"). These Responses are being posted for public review and are also being provided directly to all potential proposers who contacted the District. The Responses supplement the RFP, and where the Responses clarify, explain, or change the RFP, the Responses shall amend the RFP. If conflicts exist between the Responses and the RFP, the Responses shall control. The Responses and the RFP remain subject to the final contractual agreement which will be negotiated between the successful proposer and the District.

Operations & Deployment

1. **Is the District expecting one ALS ambulance staffed 24/7, or two simultaneously staffed ALS ambulances at all times? The RFP appears to reference both.**

   District Response: The District's intended baseline is one fully staffed ALS ambulance, consisting of at least one Ohio-certified Paramedic and one Ohio-certified EMT, available in-house within the District twenty-four hours per day, seven days per week. The provider must also maintain a reliable backup or surge-capacity response plan for overlapping calls. The backup crew may operate at the BLS level, provided the proposal explains how ALS capability will be supplied when clinically required and how the provider will maintain dependable coverage for simultaneous incidents. The District is not requiring two simultaneously staffed ALS ambulances in-house at all times.

2. **Is the provider expected to own or lease station facilities, or will the District provide them?**

   District Response: The District will provide ambulance bay spaces within the District for use by the selected provider. The provider will not be required to purchase or lease separate primary station facilities for the required in-District deployment.

3. **If facilities are provided, what utilities, maintenance, and capital improvements are included?**

   District Response: The District will provide ambulance bay space at facilities. The property owners will maintain the bay facilities in a reasonable condition, including ordinary building maintenance and repairs. The selected provider will be responsible for all utilities associated with its use of the facility, as well as any capital improvements, alterations, specialized equipment, or other facility modifications required specifically for its operations or service-delivery model. The final agreement will further define responsibility for cleaning, furnishings, insurance, and the approval and ownership of any provider-funded improvements.

4. **May providers utilize existing nearby stations outside the District if response time standards are consistently met?**

   District Response: The District-provided facilities will serve as the primary locations for the required in-District deployment. A provider may use nearby outside stations or resources as supplemental support, but those locations may not replace the required District facilities or in-District coverage unless the District gives written approval through the procurement or final agreement.

5. **Are standby units permitted to perform interfacility transports when not committed to 911 coverage?**

   District Response: Units and crews committed to satisfying the District's required 911 coverage, backup, or surge-capacity obligations may not be used for interfacility transports when that use would reduce the required District coverage or delay their availability for District calls. A provider may perform interfacility transports with separate resources that are not counted toward the District's required deployment. The proposal must clearly distinguish dedicated District resources from other organizational resources.

6. **What CAD system does Shelby County 911 utilize, and are CAD integration costs the responsibility of the provider?**

District Response: Shelby County 911 utilizes the Zuercher CAD system by CentralSquare Technologies. Direct integration between the provider's systems and the Shelby County 911 CAD system is not required by the District. If a provider elects to pursue CAD integration or another enhanced electronic interface, subject to approval by Shelby County 911, all associated costs shall be the responsibility of the provider.

Regardless of whether direct CAD integration is utilized, the selected provider will remain responsible for furnishing the operational and performance information required by the District under the final agreement.

7. **Does the District anticipate any changes to dispatch protocols or response determinants before the January 1, 2027 service start?**

District Response: The District does not presently anticipate any changes to Shelby County 911 dispatch protocols or response determinants before the January 1, 2027 service start date. The selected provider will operate under the dispatch procedures and practices then in effect at the Shelby County 911 Center.

Shelby County 911 has Emergency Medical Dispatch capabilities available within its system but does not currently utilize EMD as part of its routine dispatch process. Priority-dispatch information is also incorporated into the County's system; however, those priority determinations are treated as recommendations rather than mandatory response requirements.

Any changes implemented by Shelby County 911 in the future will be communicated to the selected provider and incorporated into operations as appropriate.

Historical Data

8. **Could the District provide the following historical information (preferably for the past three years)?**

- EMS call volume
- Transport volume
- Mutual aid in/out
- Priority distribution
- Hospital destinations
- Payer mix (Medicare, Medicaid, Commercial, Self-Pay, VA, etc.)
- Response time performance
- Unit Hour Utilization (UHU) or hourly call distribution

District Response: The District will provide historical information that is in its possession or can reasonably be obtained from Shelby County 911 and the existing service providers. The RFP currently identifies approximately 850 EMS dispatches annually and indicates that the heaviest demand generally occurs between 0600 and 1800. The District does not guarantee the completeness or accuracy of historical data and proposers remain responsible for their own analysis. Call volume, transport volume, mutual-aid activity, hospital destinations, response timestamps, and hourly distribution will be supplied to the extent available. Priority distribution may be limited because Shelby County does not routinely utilize priority dispatch, although priority information contained in available CAD data will be supplied to the extent available. Payer-mix and collection data may not be in the District's possession and may be unavailable or limited because those records are maintained by the current providers or their billing vendors.

Financial & Contract Structure

9. Is the annual fixed service fee intended to supplement patient billing revenue, or is patient billing revenue expected to fully support operations?

District Response: The annual fixed service fee is intended to supplement patient billing and collection revenue so that the selected provider can maintain the required staffing, fleet, readiness, and service levels. Proposers should not assume that patient billing revenue alone will fully support operations. Each proposal must clearly identify the requested annual fixed fee and the assumptions used for patient revenue, collections, write-offs, uncompensated care, and any other revenue source.

10. Will patient billing revenue belong entirely to the provider?

District Response: Patient billing revenue and the related accounts receivable generated from services performed under the contract will be retained by the provider and considered in the provider's proposed fixed service fee. The provider will be responsible for billing, collections, compliance, refunds, write-offs, and uncompensated care, subject to the Resident Compassionate Billing Policy and the reporting and audit provisions of the final agreement.

11. Does the District anticipate any levy or subsidy funding in addition to the annual fixed service fee?

District Response: The District expects to use its available public revenues, including levy proceeds, to pay the annual fixed service fee established in the contract. The District does not presently anticipate a separate operating subsidy in addition to the awarded fixed fee. A proposer should include all requested public support in its fixed-fee proposal and separately identify any assumptions or optional service costs.

12. Is the annual fixed service fee subject to CPI or other inflation adjustments during renewal terms?

District Response: No automatic CPI or inflation adjustment is established in the RFP. The initial and renewal pricing terms will be defined in the final agreement. Proposers should clearly state their requested pricing for the initial term and any proposed formula, cap, or conditions for renewal-year adjustments. The District may accept, reject, or negotiate those terms.

Performance Standards

13. How will response times be measured (call received to dispatch, dispatch to en route, or dispatch to arrival)?

District Response: The primary response-time standard will be measured from the Shelby County 911 dispatch timestamp to the ambulance's arrival-on-scene timestamp. Turnout time will be measured separately from dispatch to en route. Call-received-to-dispatch processing time may be monitored as a system metric but will not be attributed to the provider unless the provider controls that interval. Hospital transport and turnaround intervals will also be tracked separately.

14. How will exclusions such as severe weather, road closures, train crossings, or dispatch delays be handled?

District Response: The District will consider documented requests to exclude individual incidents from response-time compliance calculations when the delay was materially caused by extraordinary circumstances outside the provider's reasonable control.

Examples of circumstances that may qualify include declared emergencies, severe weather conditions that materially impede response, complete roadway closures, blocked railroad crossings when no reasonable alternate route is available, verified dispatch or communications-system delays outside the provider's control, mass-casualty incidents, or similar extraordinary events.

Routine traffic, ordinary weather conditions, predictable construction or roadway conditions for which reasonable alternate routing is available, routine simultaneous call volume, preventable staffing shortages, and preventable vehicle or equipment failures will not ordinarily qualify for exclusion.

The provider will be responsible for identifying the affected incident and submitting reasonable supporting documentation. The final agreement will establish the timeframe and procedure for submitting and reviewing exclusion requests.

15. Will dispatch processing delays be excluded from provider performance calculations?

District Response: Yes. Because provider response performance will begin at the dispatch timestamp, the call-processing interval before dispatch will not be included in the provider's response-time calculation. If a dispatch or communications error occurs after the initial dispatch and materially affects the provider's response, the provider may request an exclusion supported by CAD or audio records.

16. Can the District provide the proposed liquidated damages schedule referenced throughout the RFP?

District Response: No. The District has not established a liquidated-damages schedule and does not anticipate establishing a specific schedule prior to contract negotiations with the selected provider.

Any liquidated damages or other financial remedies ultimately included in the service agreement will be established through contract negotiations and expressly stated in the final agreement. For purposes of the RFP, references suggesting that progressive, immediate, or automatic financial damages will be assessed shall not create an independent right to impose such damages.

Fleet & Equipment

17. The RFP requires ambulances to enter service under 100,000 miles and be retired at 250,000 miles or seven years. Is there any flexibility for newer remounted ambulances?

District Response: Yes. Professionally remounted ambulances may be used provided they are properly licensed, appropriately certified, safely maintained, and suitable for reliable service under the contract.

Ambulances included in the provider's initial fleet at the commencement of the contract will not be subject to the 100,000-mile entry limitation, provided they otherwise satisfy the District's fleet requirements and are acceptable for reliable service.

After commencement of the contract, any replacement or additional ambulance newly introduced into District service must have no more than 100,000 miles on its current chassis at the time it is placed into service.

The District has also revised the mandatory retirement standard from seven (7) years to ten (10) years. An ambulance must be removed from District service when its current chassis reaches either ten (10) years of age or 250,000 cumulative miles, whichever occurs first.

For professionally remounted ambulances, compliance with the age and mileage requirements will be based upon the current chassis, rather than the age of the ambulance module. The provider must be able to document the remount, chassis replacement, applicable certification, maintenance history, inspections, and current condition..

18. Must reserve ambulances remain physically located within the District at all times?

District Response: The reserve vehicle counted toward the provider's required District backup capacity should be assigned to the District and normally maintained at an approved location that permits prompt substitution. It need not remain physically inside the District during maintenance, inspection, repair, fueling, or similar temporary activities, provided an equivalent replacement is available and required coverage is not reduced. Additional organizational reserve units located outside the District may supplement the plan but should not be the sole reserve relied upon for routine readiness.

19. Are there existing radio systems or other equipment that the provider may utilize?

District Response: The District anticipates that radio equipment compatible with the Shelby County interoperable communications system may be available for use by the selected provider. The availability, quantity, programming, maintenance, replacement, and other terms associated with any District- or member-jurisdiction-provided radios will be determined during contract negotiations with the selected provider.

Proposers should identify in their proposals any assumptions regarding the use of District-provided radios and should separately identify any material cost impact if the provider is required to furnish its own radio equipment.

Except for station facilities and any radio equipment specifically agreed upon in the final contract, the District does not presently anticipate furnishing ambulances, medical equipment, supplies, software, or other operational assets. The provider will remain responsible for ensuring that all communications equipment used under the contract is compatible with applicable Shelby County systems and procedures.

Billing & Reporting

20. Can the District clarify the intent of the "Resident Compassionate Billing Policy"?

District Response: The policy is intended to protect verified residents and taxpayers of the District's member jurisdictions from aggressive collection of patient-responsibility balances after the provider bills available insurance, Medicare, Medicaid, or other third-party coverage. For those eligible individuals, the provider should accept available third-party payment as payment in full and should not pursue routine co-pays, deductibles, or remaining balances through aggressive collection activity unless the District Board expressly authorizes an exception. A customary soft-billing approach that seeks insurance information and submits claims without pursuing the resident for an unpaid balance is consistent with the intended policy.

21. Is balance billing prohibited only for District residents, or for all patients?

District Response: The RFP's balance-billing restriction is intended to apply to verified residents and taxpayers of the District's member jurisdictions. Nonresidents may be billed for lawful patient-responsibility amounts under the provider's standard billing policy, subject to applicable federal and state law, payer contracts, hardship policies, and the final agreement. No patient may be billed in a manner prohibited by law.

22. How will residency be verified?

District Response: Residency may be verified by the provider through the patient's service address, government-issued identification, utility or municipal records, voter or tax records, medical insurance information, or other reasonable documentation. Taxpayer status may be verified through county property records or other reliable records showing ownership of taxable property within a member jurisdiction on the date of service. The provider should use a reasonable, nonburdensome verification process and permit patients to submit additional documentation when initial records are inconclusive.

23. Are there existing billing policies or ordinances that providers will be required to follow?

District Response: The District is not presently identifying a separate existing District billing ordinance or policy beyond the requirements stated in the RFP and the policy that will be incorporated into the final contract. The selected provider must also comply with all applicable federal and state billing laws, payer requirements, and any lawful rate or billing provisions adopted by the District before or during the contract term.

24. What ePCR platform does the District currently use?

District Response: The District does not currently own or operate an electronic patient care reporting (ePCR) platform. The selected provider will be responsible for furnishing, maintaining, and operating its own ePCR system that complies with applicable Ohio and federal law.

The provider's ePCR system must be capable of producing the operational, aggregate, de-identified, and, when lawfully required, incident-specific information necessary for administration of the District's contract. The provider will also be responsible for meeting applicable data-exchange and reporting requirements involving Shelby County 911, receiving hospitals, regional systems, and the State of Ohio and applicable federal requirements.

The District is not requiring the use of a particular ePCR vendor or platform.

25. What CAD export format is required?

District Response: The District is not requiring a specific proprietary CAD export format. The selected provider will be responsible for obtaining available CAD data and reports from Shelby County 911 and providing that information to the District as part of its required reporting.

CAD information shall be provided in the format available from Shelby County 911. The provider will not be required to create a separate or customized CAD export format that is not reasonably available through the County's system.

The provider will also remain responsible for providing any additional operational, ePCR, staffing, fleet, billing, or other contract-required information within its possession or control.

26. Can sample monthly reporting templates be provided?

District Response: The District does not presently have final monthly reporting templates. The selected provider should demonstrate that it can report the categories identified in the RFP. Standard templates, field definitions, submission dates, and secure delivery methods will be developed with the selected provider before the service start date. The District intends to use consistent, reasonably attainable reports rather than require duplicative manual reporting when equivalent system-generated information is available.

27. Is the required electronic access expected through API integration or read-only user accounts?

District Response: The District's preference is secure read-only access when it is technically available, legally permitted, and reasonably priced. API integration is not automatically required. When direct access is unavailable or inappropriate, approved reports, dashboards, secure exports, or de-identified data may satisfy the requirement. Access will be limited to information reasonably necessary for contract administration and will comply with HIPAA, Ohio confidentiality law, cybersecurity requirements, and applicable QA/QI protections.

Transition & Contract

28. Is there an incumbent provider?

District Response: Ambulance service is currently delivered through existing local service arrangements, but the newly formed District does not have a single incumbent provider operating under a District-wide contract equivalent to the scope contemplated by this RFP. Proposers should treat the procurement as the establishment of a new unified District service agreement rather than the simple renewal of an existing District contract.

29. If so, will the incumbent cooperate during the transition?

District Response: The District will coordinate in good faith with current service providers, member jurisdictions, Shelby County 911, medical direction, and the selected provider to support an orderly transition. The District will provide the station facilities described in the addendum or final agreement,

but it cannot guarantee the actions of current providers or other third parties. The selected provider must therefore submit a transition plan that can achieve operational readiness even if access to incumbent personnel, records, equipment, or other third-party resources is limited.

30. Will any District-owned assets transfer to the successful provider?

District Response: The District will make ambulance bays available for the selected provider's use, but ownership of those bays will not transfer. The District does not presently anticipate transferring ownership of ambulances, medical equipment, radios, supplies, software, or other operational assets. Proposers should assume they are responsible for all operational resources necessary to perform the awarded scope except for facilities, radios, or other resources expressly identified by the District in these responses or the final agreement.

31. Can the District provide a draft contract for review prior to proposal submission?

District Response: A complete draft contract is not presently available. The RFP, these formal answers, and any other written addendum issued by the District will establish the procurement requirements, while the final agreement will be negotiated with the selected provider and approved by the District Board. Material terms affecting proposal pricing or responsiveness will be governed by the RFP as clarified or modified by these responses and any other written addendum issued by the District before proposals are due.

32. Is any limitation of liability language contemplated in the final agreement?

District Response: The final agreement is expected to allocate responsibility through insurance, indemnification, remedies, and other risk provisions. The District has not committed to a specific limitation-of-liability clause. Any proposed limitation may be considered during contract negotiations but must be consistent with Ohio law, the District's public responsibilities, available insurance, and the nature of the risk. The District will not agree in advance to a blanket release of liability for a provider's negligence, willful misconduct, regulatory violations, or failure to perform essential services.

33. Would the District consider modifying the unrestricted audit and inspection provisions to better protect proprietary business information?

District Response: Yes. The District requires meaningful access to verify contract compliance, but it does not intend to obtain unrelated proprietary information or disregard patient privacy, QA/QI protections, trade-secret law, or cybersecurity requirements. Routine inspections should generally be scheduled and limited to District-assigned operations. Unannounced inspections may be used when reasonably necessary to investigate an immediate safety concern, verify active staffing or readiness, or address suspected material noncompliance. Records requests will be limited to contract-relevant information and subject to applicable confidentiality protections.

34. Can the District clarify what constitutes termination "for cause" versus "for convenience"?

District Response: Termination for cause will apply when the provider materially breaches the agreement, fails to cure a curable default within the stated period, repeatedly fails required performance standards, loses required licensure or insurance, engages in fraud or material regulatory misconduct, abandons service, becomes unable to maintain operations, or creates an immediate and substantial threat to public safety. Certain serious defaults may permit immediate action when a cure period would be impractical or unsafe. Termination for convenience means the District may end the agreement without alleging provider default by giving the notice established in the final contract. In that event, the provider would be paid for properly performed services through the effective date and would remain responsible for orderly transition obligations.

Evaluation

35. What are the District's biggest concerns with the current EMS system?

District Response: The District's principal concerns are establishing dependable and sustainable twenty-four-hour coverage, ensuring consistent ALS availability, improving readiness for overlapping calls, reducing avoidable reliance on outside mutual aid, creating measurable response and service accountability, supporting effective coordination among six member jurisdictions and public-safety partners, and securing a financially stable model that can be maintained throughout the contract term. The District also values a reliable workforce, safe equipment, transparent reporting, compassionate resident billing, and an orderly transition to a unified service model.

36. Beyond cost, what factors will most differentiate the highest-scoring proposal?

District Response: Cost will be considered in relation to the overall value and sustainability of the proposal rather than as the sole determining factor. The strongest proposals will demonstrate a credible and fully staffed in-District deployment model; reliable backup for overlapping calls; realistic response performance; workforce recruitment and retention; qualified clinical and operational leadership; safe and dependable fleet resources; effective coordination with dispatch, first responders, medical direction, and hospitals; sound QA/QI and reporting systems; financial stability; lawful and compassionate billing; a detailed transition plan; and a clear ability to meet commitments from the first day of service.

37. Would the District consider alternative deployment models if proposed performance metrics are exceeded?

District Response: The District is willing to consider well-supported alternative deployment models that improve service, reliability, or value, but proposers should clearly distinguish an alternative from their response to the District's clarified baseline requirements. An alternative should include staffing, location, unit-hour, response-time, backup, cost, and risk assumptions and explain how it will meet or exceed the District's required outcomes. The District may negotiate a modified scope after evaluation, but it cannot assure that a proposal omitting a mandatory baseline requirement will be considered responsive unless that requirement has been expressly clarified or modified by these District responses or another written addendum issued by the District.

38. Are interviews expected to include formal operational presentations, or will they primarily consist of Q&A?

District Response: If interviews are conducted, the District anticipates a structured session that may include a brief operational presentation followed by questions and answers. Proposers selected for interview will receive advance notice of the format, allotted time, required attendees, presentation topics, and any technology or materials permitted. The same core process and time limits will be applied to each interviewed proposer.

District Responses to ARS Questions

1. Requests for Clarification

a. Pg. 7 "District Responsibilities/Role" 1st paragraph, 2nd sentence: Please clarify the District's intent with respect to the statement that "[t]he District retains absolute administrative and operational oversight of the EMS delivery system." As an independent nonprofit organization and contracted EMS provider, the selected provider should be responsible for its own administration, staffing, management, and operational policies and procedures. The phrase "absolute administrative and operational oversight" could be interpreted as granting the District authority that extends beyond appropriate contract oversight and into the day-to-day management and internal operations of the selected provider by an entity that does not necessarily have the required operational knowledge of running an EMS operation. Accordingly, clarification is requested regarding the intended scope of the District's oversight authority and how it is intended to coexist with the selected provider's independent responsibility for administering and operating its organization.

District Response: The District does not intend to manage the selected provider's internal administration or day-to-day operations. The selected provider will remain independently responsible for its personnel, staffing assignments, employment practices, clinical management, internal policies and procedures, and lawful operation. The District's oversight is intended to apply to administration and enforcement of the service agreement and to system-wide matters affecting ambulance service within the District, including monitoring performance, reviewing required reports, verifying staffing and deployment commitments, coordinating participating jurisdictions and public-safety partners, and enforcing contractual accountability requirements.

b. Pg. 7 "District Responsibilities/Role" 1st paragraph, 3rd Sentence: Please clarify the District's intent with respect to the following statement: "[the District] maintains the sole, non-delegable authority to design deployment frameworks, adjust geographic response zones, coordinate service delivery, and enforce systemic accountability to promote optimal, equitable performance throughout the jurisdiction." Also, please clarify the District's intent to request control but with immunity from liability.

District Response: The District intends to retain authority over system-level matters necessary to provide equitable and reliable coverage, including contractual coverage requirements, approval of station or posting locations, geographic service areas, coordination when multiple providers are involved, and corrective action when performance standards are not met. The provider will remain responsible for daily deployment, staffing assignments, supervision, clinical decisions, and internal operations, subject to the final agreement. The immunity language on page 5 applies to the procurement, evaluation, and selection process; it is not intended as blanket immunity for post-award operational decisions.

c. Pg. 7 "District Responsibilities/Role" 3rd paragraph: Please clarify the District's intent with respect to the third paragraph in its entirety, including, but not limited to, the District's intentions as to its stated role as "primary administrative liaison" and "final decision-making authority" with respect to the contracted services.

District Response: The District will serve as the central administrative point of contact for coordination among the provider, member jurisdictions, Shelby County 911, local first responders, medical-direction

authorities, receiving hospitals, and other stakeholders. "Final decision-making authority" is intended to apply to interpretation and enforcement of the contract and to system-wide service matters within the District's statutory authority. It does not extend to the provider's corporate governance, employment decisions, routine personnel supervision, or independent clinical decisions governed by medical direction and applicable law.

d. Pg. 8 “Performance Requirements” 3rd paragraph: regarding the methodology and criteria for compliance calculations, the process and standards associated with the “automatic administrative review,” the requirements and implementation of the “mandatory 30-day corrective action plan,” and the structure and application of any “progressive liquidated financial damages.” In particular, concerns exist regarding the apparent prohibition on exclusions for factors outside a provider’s reasonable control, including speed-limit compliance, hospital turnaround delays, roadway construction, and traffic congestion. These issues are especially relevant for transports to and from highly traveled areas of Shelby and adjacent counties (including I-75, state routes and county roads), where construction activities and traffic conditions can significantly affect travel times. Accordingly, the District is requested to clarify how these uncontrollable factors will be accounted for in performance assessments and compliance determinations. Additionally, further explanation is requested regarding the calculation and escalation of any progressive liquidated financial damages, including the safeguards that will be implemented to ensure that such penalties remain proportionate and do not jeopardize the financial viability of the selected provider.

District Response: Response-time compliance will be calculated monthly from verified CAD timestamps. The primary response standard will be measured from dispatch to arrival on scene, while turnout will be measured from dispatch to en route. Hospital turnaround or wall time will be tracked separately and is not part of the dispatch-to-arrival calculation, although documented hospital delays may be considered when reviewing system availability. The District will consider documented exclusion requests for extraordinary circumstances outside the provider's reasonable control, such as dispatch-center delays, declared emergencies, extreme weather, full roadway closures, blocked railroad crossings when no reasonable alternate route exists, or mass-casualty incidents. Routine traffic, ordinary weather, predictable construction, simultaneous call volume, preventable staffing shortages, and preventable mechanical failures will not ordinarily qualify. If performance falls below the required threshold, the District will review the underlying incidents and requested exclusions, provide written notice, and require a corrective-action plan. A final liquidated-damages schedule has not been established and any damages, cure periods, escalation, and limits will be stated in the negotiated contract; no damages will be assessed unless authorized by that agreement.

e. Pg. 9 “Governance, Interagency Coordination, and Stakeholder Requirements” 2nd paragraph: The District is requested to clarify who (or what entity) will be conducting the monthly operational reviews/audit and what “public transparency metrics” will be audited.

District Response: Monthly operational reviews will be administered by the District through its Board, a designated contract administrator, or an authorized consultant. Depending on the subject, the District may request participation from provider leadership and representatives of dispatch, medical direction, first responders, hospitals, or other stakeholders. "Public transparency metrics" means aggregate, non-patient-specific information suitable for reporting to the Board and public, such as call volume, response-time compliance, mutual-aid use, unit availability, fleet uptime, and aggregate complaint information. Protected health information, confidential patient records, privileged QA/QI material, and legally protected business information will not be publicly disclosed.

f. Pg. 10, Subsection 1 “Monthly Operational & Performance Reports”: Please clarify the parameters of the requested UHU data and define ‘critical care’ for purposes of this reporting requirement.

District Response: For purposes of the RFP, one Unit Hour means one appropriately staffed and equipped ambulance available for deployment for one hour. Monthly UHU reporting should identify the scheduled and actual unit hours provided for District service, the applicable staffing and service level, and periods during which an assigned unit was unavailable or out of service.

“Critical care” is a reporting category only and does not independently require the selected provider to establish or maintain a separate critical-care transport program. Critical-care reporting applies only if that service is included in the provider’s awarded scope or is actually performed. If no critical-care transports are performed during a reporting period, the provider may report zero or not applicable.

For reporting purposes, critical-care transport means a transport requiring personnel, equipment, monitoring, or clinical capabilities beyond those ordinarily provided by a standard ALS ambulance, as permitted by applicable law and medical direction.

g. Pg. 10, Subsection 1 “Monthly Operational & Performance Reports” top of page: Please clarify the rationale for the District’s need for “comprehensive Fleet Status Report tracking mechanical failures, out-of-service time, and preventative maintenance compliance for all assigned apparatus.”

District Response: The Fleet Status Report is intended to verify that vehicles assigned to the District remain safe, operationally ready, and available at the levels committed in the proposal. Mechanical failures and extended out-of-service periods can directly affect coverage, response performance, and reserve capacity. The report will apply only to vehicles assigned to or used for the District contract and should identify significant failures, dates and duration of out-of-service periods, whether replacement coverage was maintained, and preventive-maintenance compliance. The District does not intend to direct the provider's internal maintenance program or require unrelated proprietary maintenance information.

h. Pg. 10, Subsection 4 “Annual Financial Transparency and Solvency Audits”, last sentence and pg. 15 “Demonstration of Financial Depth, Corporate Stability and Regulatory Compliance” 1st paragraph: Please clarify the “established timeframe” for purposes of compliance without penalty. Please clarify the intended penalty for non-compliance including further explanation regarding the calculation and escalation of any progressive liquidated financial damages, including the safeguards that will be implemented to ensure that such penalties remain proportionate and do not jeopardize the financial viability of the selected provider.

District Response: For proposal submission, each proposer must provide audited financial statements for its two most recently completed fiscal years as part of its proposal.

For ongoing contract compliance, the selected provider shall submit its annual independent financial audit within one hundred twenty (120) days following the close of its fiscal year. The District may grant a reasonable written extension for good cause, including circumstances outside the provider's reasonable control, provided the provider timely explains the delay and furnishes any reasonably requested interim financial information.

The District has not established a liquidated-damages amount or escalation schedule and does not anticipate establishing such a schedule prior to contract negotiations with the selected provider. No automatic or progressive financial penalty will be assessed under the RFP for failure to submit the

annual audit. Any notice requirements, cure periods, liquidated damages, or other financial remedies will be expressly established in the final negotiated agreement.

i. Pg. 11 “Billing Reporting/Billing Policy” top of page: Please clarify the type of information that will be required for “oversight” purposes.

District Response: Billing oversight information may include the provider's written billing and collection policy, rate schedule, material policy changes, aggregate charges and collections, contractual adjustments and write-offs, aging of accounts receivable, payer-category summaries, resident/nonresident treatment, complaint and dispute activity, and documentation of compliance with the resident billing requirements. Information should be aggregated or de-identified whenever possible. Patient-specific information will be requested only when reasonably necessary to investigate a complaint, audit compliance, or meet a legal obligation and only in a manner permitted by HIPAA and other applicable law.

j. Pg. 11 “ePCR/State Reporting/HIPAA Compliance” Please clarify what is meant by the requirement that reports be “compatible with District…systems and requirements,” including identification of the specific systems, formats, software platforms, and reporting standards with which the successful provider will be expected to comply.

District Response: The District does not own or operate an ePCR platform and is not requiring the use of a specific ePCR vendor, software platform, proprietary interface, or API. The selected provider will furnish, maintain, and operate its own legally compliant ePCR system and comply with all applicable Ohio EMS reporting requirements.

For purposes of the RFP, compatibility means the provider's ability to satisfy the District's reporting requirements and applicable data-exchange requirements involving Shelby County 911, receiving hospitals, regional systems, and the State of Ohio. Shelby County 911 utilizes the Zuercher CAD system by CentralSquare Technologies; direct integration with that system is not required. The provider will obtain available CAD data and reports from Shelby County 911 and provide that information to the District as required.

Reports and other information provided directly by the provider shall be furnished in secure, commonly usable electronic formats reasonably acceptable to the District. Any additional interfaces, access methods, security requirements, or reporting specifications will be established as necessary in the final agreement.

k. Pg. 16 “Mutual Aid Participation, System Accountability, and Regional Interoperability”, second full paragraph. Please clarify the circumstances by and manner in which the District plans to “explicitly authorize” mutual aid requests from neighboring jurisdictions.

District Response: The District does not intend to approve individual mutual-aid responses in real time. Requests for mutual aid from neighboring jurisdictions will be initiated through Shelby County 911, another authorized dispatch center, or the applicable incident-command structure in accordance with established automatic-aid, mutual-aid, or emergency-response protocols.

The phrase “explicitly authorized” is intended to mean that the mutual-aid request originates through an authorized dispatch or incident-command process rather than through an informal or unauthorized request.

The provider may respond to such requests provided doing so does not reduce the District's required minimum coverage below the level established in the RFP and final agreement, except when otherwise authorized during a mass-casualty incident, declared emergency, or similar extraordinary event.

l. Pg. 17. "Revenue Architecture, Compassionate Billing and Financial Compliance Mandates", second paragraph, third sentence: The RFP states that the system must maintain interoperability "with the District's ePCR software" – please clarify whether the District plans to provide ePCR software to the selected provider?

District Response: No. The District does not own or presently plan to provide an ePCR platform to the selected provider. The selected provider will furnish, maintain, and operate its own legally compliant ePCR system.

The provider may utilize its own ePCR and billing systems, provided they support accurate clinical documentation, billing and coding, applicable Ohio EMS reporting requirements, secure data exchange, and the reporting requirements established in the final agreement.

2. Non-Customary/Unattainable Standards

a. Pg. 6, 2nd paragraph, 2nd sentence – Shelby County Dispatch does not use EMD. The District is requested to revise this section to reflect the actual operating procedures of Shelby County Dispatch.

District Response: For purposes of the RFP, Shelby County 911's current operating procedures are as follows: Shelby County 911 has EMD capability available within its system but does not currently utilize EMD as part of its routine dispatch process.

Shelby County 911 utilizes the Zuercher CAD system by CentralSquare Technologies. The selected provider will operate in accordance with the County's then-current call-taking, CAD, radio, and dispatch procedures. Direct electronic integration between the provider's systems and the Shelby County 911 CAD system is not required.

If Shelby County 911 modifies its dispatch procedures during the contract term, the selected provider will be expected to comply with the applicable procedures then in effect.

b. Pg. 8, 1st paragraph, 2nd sentence – The ALS staffing requirement set forth herein may have the adverse effect of limiting response times due to staffing. Additionally, the RFP's definition of ALS appears to be inconsistent with the definition established under the Ohio Revised Code and applicable Ohio EMS regulations. We respectfully request that the District revise the ALS definition to ensure consistency with governing law and regulatory standards. Furthermore, we request that the District reconsider the proposed ALS staffing requirement, as it appears unnecessarily restrictive and operationally burdensome given the service demands, geographic characteristics, and established EMS practices within Shelby County. Such revisions would better align the RFP with industry standards and promote a more effective service delivery model.

District Response: The District's intended minimum staffing requirement is one continuously staffed, in-District ALS ambulance operating twenty-four (24) hours per day, seven (7) days per week, 365 days per year, with a minimum crew of one Ohio-certified Paramedic and one Ohio-certified EMT.

Backup or surge-capacity units may operate at the BLS level, provided the provider demonstrates how ALS capability will be supplied when clinically required and how required District coverage and

response-time standards will be maintained. Proposers may propose additional ALS capacity or other deployment resources beyond this minimum.

The RFP's references requiring every regularly scheduled ambulance, or multiple frontline ambulances, to be continuously staffed at the ALS level shall not be interpreted to require multiple continuously staffed ALS ambulances.

For purposes of Appendix A, the definition and scope of ALS remain subject to applicable Ohio law and administrative rules. The District's requirement that the primary in-house ALS ambulance be staffed by at least one Ohio-certified Paramedic and one Ohio-certified EMT is a contractual staffing requirement and is not intended to redefine ALS under Ohio law.

c. Pg. 8, "Performance Requirements" 1st paragraph, 2nd sentence (through the remainder of the paragraph and the entirety of the 2nd paragraph): Ambulance services within Shelby County do not currently operate under the model contemplated by this provision. The specified requirements are not consistent with prevailing regional practices and, given the size and rural nature of the service area, are unlikely to be reasonably achievable by any provider. We respectfully request that the District revise this language to better align with local operational realities and industry standards.

District Response: The District's objective is measurable, reliable response performance, but it recognizes that the specific 12:59/90-percent standard, 60-second turnout requirement, exclusion rules, and mutual-aid restrictions must be supportable within the District's rural geography and actual dispatch practices. The District will consider reasonable, evidence-based performance commitments proposed by respondents. Final enforceable performance benchmarks will be established in the negotiated agreement after consideration of historical data, geographic conditions, staffing models, and the selected provider's proposed service model. Monthly reporting, corrective action for sustained deficiencies, and accountability for preventable staffing or fleet failures will remain required.

d. Pg. 9, "Governance, Interagency Coordination, and Stakeholder Requirements" 3rd and 4th paragraphs: Dispatch/PSAP and hospital department meetings are all communicated via the EMS coordinator. Attempting to coordinate a multi-agency, multi-entity meeting on 24 hours notice is unattainable, given personnel availability at any given time and further explanation is requested regarding the calculation and escalation of any progressive liquidated financial damages, including the safeguards that will be implemented to ensure that such penalties remain proportionate and do not jeopardize the financial viability of the selected provider.

District Response: Routine dispatch, hospital, medical-direction, and interagency coordination will occur through established communication channels, including the Shelby County EMS Coordinator where applicable. Regularly scheduled meetings will be communicated with reasonable advance notice.

Extraordinary or emergency meetings may be called when necessary to address a significant performance issue, material contract matter, or immediate public-safety concern. The District will generally provide twenty-four (24) to forty-eight (48) hours' notice when circumstances permit. The provider may participate through an appropriately authorized alternate representative or by remote means when reasonable and acceptable under the circumstances.

A good-faith inability of a particular representative to attend an extraordinary meeting on short notice will not automatically constitute noncompliance when the provider promptly communicates the conflict and provides an appropriate alternate representative, remote participation, or timely follow-up.

The District has not established a liquidated-damages amount or escalation schedule. Any liquidated damages or other financial remedies will be established through negotiations with the selected provider and expressly stated in the final agreement. No automatic financial penalty will be imposed under the RFP solely because a particular representative is unavailable for a meeting.

e. Pg. 10, top of page: Shelby County does not utilize priority dispatch. Revision is requested to reflect actual operating standards in Shelby County.

District Response: Shelby County 911's dispatch system includes priority-dispatch information; however, those priority determinations are treated as recommendations and do not independently establish the selected provider's required response obligations under the District contract.

For monthly reporting, the provider should use the call classifications, priority information, response determinants, or other categories actually available through Shelby County 911's CAD system. The provider will not be required to create or assign dispatch-priority categories that are not contained in the County's available CAD data.

Emergency and non-emergency responses should be separately identified when that distinction is supported by the available data. The District's contractual response requirements will be governed by the RFP and final agreement rather than solely by a CAD-generated priority designation

f. Pg. 13 “Medical Supplies, Logistics, and Controlled Substance Inventory Mandates” 1st paragraph: It is not operationally feasible to barcode and individually track every item carried on an ambulance, as each unit contains a substantial volume and variety of medical supplies, equipment, and inventory. Anna Rescue's inventory management and controlled-substance accountability practices are maintained in compliance with all applicable requirements of the Ohio State Board of Pharmacy and other governing regulatory authorities. The imposition of additional District-mandated tracking requirements beyond those established by the State Board of Pharmacy would create a significant administrative (and cost) burden without a corresponding operational, clinical, or regulatory benefit. Accordingly, it is requested that the RFP be revised to require compliance with applicable state and regulatory inventory-control standards proscribed by the State Board of Pharmacy rather than imposing tracking requirements that exceed those prescribed by the appropriate regulatory authorities. Additionally, please clarify the statement regarding the restocking of on-hand, mutually carried supplies, as a provider may not be able to replace specific brands that are not kept in stock, therefore items may not be able to be replaced without purchases being made, and no threshold limitations have been noted. In accordance with licensing with the Ohio State Board of Pharmacy, no medications in any form will be issued to another agency.

District Response: The District's intent is to require an effective and auditable inventory-control process sufficient to ensure that required medical supplies, equipment, and medications are available, appropriately maintained, and protected from expiration, recall, compromise, or unauthorized access. The District does not intend to require item-level RFID or barcode tracking of every routine medical supply when the provider maintains another reliable inventory-control process that complies with applicable law, State Board of Pharmacy requirements, DEA requirements where applicable, medical-direction requirements, and manufacturer specifications.

The first-responder restocking requirement will be limited to consumable medical supplies that are mutually carried, actually used in connection with the incident, and legally transferable. The RFP will not require the selected provider to transfer medications or controlled substances to another agency. If an identical brand or item is not reasonably available, an equivalent approved supply may be provided when appropriate, or replacement may occur promptly through an established supply process.

The purpose of this requirement is to support continuity of first-responder medical supplies, not to require the provider to maintain every brand used by each member jurisdiction or to undertake transfers prohibited by applicable licensing or regulatory requirements.

g. Pg. 14 "Emergency Management, Disaster Response, and County EMA Integration" 2nd paragraph, 1st sentence: This paragraph references trainings that are not applicable to EMS only agencies. The District is requested to revise this provision to indicate certifications required for EMS only agencies (not fire).

District Response: The District does not intend to require an EMS-only provider or its personnel to maintain fire-service certifications solely as a condition of this contract.

Personnel assigned to District operations will be expected to maintain NIMS/ICS training appropriate to their assigned duties and incident-management responsibilities, together with any training required by applicable law, Shelby County emergency-management requirements, medical direction, or the final agreement. Training expectations for field personnel, operational supervisors, dispatch personnel employed by the provider, and executive or liaison personnel will be proportionate to the functions those individuals are expected to perform during an emergency or activation.

For purposes of the RFP, personnel are not required to maintain a blanket NIMS/ICS course sequence, and executive personnel are not automatically required to maintain ICS-300 and ICS-400 regardless of their assigned incident-management role. Required NIMS/ICS training shall be appropriate to the individual's assigned duties and responsibilities.

h. Pg. 14 "Emergency Management, Disaster Response, and County EMA Integration" 2nd paragraph. 3rd and 4th sentences: The statements made herein are noncustomary – the provider will perform as required by local and state-based protocol. The District is requested to revise this section to reflect standard local and state protocols.

District Response: During a declared emergency, mass-casualty incident, Emergency Operations Center activation, or other significant public-safety event, the selected provider shall operate within the applicable NIMS/ICS structure and in accordance with applicable local and state emergency plans, law, medical direction, and established emergency-response protocols.

The reference in the RFP to provider assets being subject to the "direct operational control" of the Incident Commander is intended to require coordination of resource deployment, staging, mission assignments, and incident priorities through the lawful incident-command structure. It does not transfer ownership of provider assets to the District or Incident Commander and does not authorize direction of clinical care, personnel, or equipment in a manner inconsistent with applicable law, provider licensure, medical direction, or crew and patient safety.

When reasonably necessary based upon the nature and scale of an incident, the provider shall make an appropriately qualified operational supervisor or liaison available to coordinate with the Shelby County Emergency Operations Center, Incident Commander, Shelby County EMA, dispatch, and other participating agencies. The form and location of that participation may be determined based upon the needs of the incident.

Deployment of District-assigned frontline and reserve resources during an emergency or MCI shall be coordinated through the applicable incident-command structure while preserving essential emergency medical coverage within the District to the extent reasonably possible under the circumstances.

i. Pg. 15 "Mutual Aid Participation, System Accountability, and Regional Interoperability" 1st paragraph, last sentence: As similarly indicated herein (in Section 3.c), the contracting provider does not have access to response time information for mutual aid providers. As such, the

requested data is neither available to nor within the possession or control of the contracting provider, making compliance with this request impossible.

District Response: The selected provider will be responsible for reporting mutual-aid information within its possession or control and information reasonably available through CAD data or reports obtained from Shelby County 911. This should include, when available, the time mutual aid was requested, the responding agency, applicable dispatch and response timestamps, and the operational reason for requesting mutual aid.

The provider will not be required to create, independently verify, or obtain information that is not contained in the available Shelby County 911 data and is controlled exclusively by another responding agency. This includes clinical information or operational timestamps maintained solely by the mutual-aid provider. When a required data element is not reasonably available, the provider may identify that element as unavailable in its report.

For purposes of the RFP, the requirement to report the exact dispatch time, response times, clinical levels, and other information concerning incoming mutual aid applies only to the extent that such information is within the provider's possession or reasonably available through Shelby County 911's CAD data or reports.

j. Pg. 16 “Revenue Architecture, Compassionate Billing and Financial Compliance Mandates”, first paragraph: Provider is set up with a third-party billing company that will set up soft bill for taxpayers/residents and hard bill for non-residents. Please confirm that this procedure will meet the requirements set forth in the indicated paragraph. Additionally, additional insight is requested from the District regarding the ability of the selected provider to use hard billing in cases of excessive use or abuse of 911 services with no transport.

District Response: Yes. The use of a qualified third-party billing company is permitted, provided the provider remains responsible for compliance with all billing requirements established by the District and applicable law.

A billing model that soft bills verified District residents or taxpayers and lawfully hard bills non-residents is consistent with the District's intended Resident Compassionate Billing Policy, provided that verified residents or taxpayers are not subjected to aggressive balance billing or predatory collection practices. The provider should clearly describe its proposed billing and collection procedures in its proposal.

The District has not authorized hard billing of verified District residents or taxpayers based solely upon alleged excessive use or abuse of the 911 system, including non-transport responses. The provider shall not implement such a practice unless the District Board subsequently adopts a written policy expressly authorizing it and the practice is incorporated into the final agreement. Any such policy would need to establish the circumstances and criteria under which charges may be imposed and remain consistent with applicable law.

For non-residents, billing may be conducted in accordance with the provider's approved billing policies, applicable law, and the final agreement.

3. Overreaching/Unreasonable Requests

a. Pg. 7, “District Responsibilities/Role” 2nd paragraph. Due to legal and regulatory considerations, including patient privacy and confidentiality requirements, it is not reasonable for the District to request unrestricted access to ePCR, QA/QI, and other protected data and information. Such access could place responding entities at risk of noncompliance with applicable laws and regulations. Accordingly, we respectfully request that the District revise this provision to ensure that bidding entities can comply with all legal and confidentiality obligations.

District Response: The District agrees that its contract-oversight and audit rights are subject to applicable federal and state privacy, confidentiality, cybersecurity, medical-direction, and legally applicable QA/QI protections. The references in the RFP to auditing ePCR, CAD, and clinical QA/QI information are not intended to require unrestricted or permanent access to protected health information, privileged or legally protected quality-review materials, or unrelated proprietary information.

For purposes of contract administration, the District will rely primarily upon aggregate or de-identified clinical information, available CAD data and timestamps, staffing and licensure records, operational reports, and other information reasonably necessary to verify compliance with the contract.

Patient-specific clinical information may be requested only when reasonably necessary for a particular complaint, incident review, contract-compliance matter, or authorized quality-review process and only to the extent disclosure and use are permitted by applicable law and medical-direction requirements.

The provider will not be required to provide permanent direct administrative access to its ePCR or other internal clinical systems when the information necessary for District oversight can reasonably be supplied through secure reports, data exports, dashboards, or another appropriate method. Nothing in the RFP requires the provider to disclose information that it is legally prohibited from disclosing.

b. Pg. 9, "Data Submission and Required Reporting Framework" 1st paragraph, 1st sentence: While it is reasonable to expect that basic call data will be provided, ePCR data, in particular, is not subject to public review. Basic call data can be provided within a reasonably attainable timeframe at the District's request.

District Response: The District's reporting requirements are intended to provide information necessary for contract administration and performance oversight and are not intended to require routine public disclosure or unrestricted transmission of patient-specific ePCR records.

Routine operational and performance reporting shall consist of available CAD information and other contract-related data, together with aggregate or de-identified clinical information where appropriate. The reference in the RFP to reports being generated from "unedited CAD and ePCR data architectures" means that required reports should be based upon reliable underlying source data; it does not require the provider to routinely transmit complete, unredacted, patient-specific ePCR records to the District.

Patient-specific ePCR or other protected clinical information may be requested only when reasonably necessary for a particular complaint, incident review, contract-compliance matter, or authorized quality-review process and only to the extent disclosure and use are permitted by applicable law, medical direction, and applicable confidentiality requirements.

Regularly scheduled reports shall be provided within the reporting timeframes established by the RFP and these responses. Additional or ad-hoc requests shall be fulfilled within a reasonable timeframe based upon the nature, volume, availability, and complexity of the information requested and any necessary privacy or legal review. The provider will not be required to produce information that it is legally prohibited from disclosing.

Information provided to the District will be handled in accordance with applicable confidentiality, privacy, and public-records requirements; receipt of information by the District does not, by itself, mean that protected patient or clinical information is subject to unrestricted public disclosure.

c. Pg. 10, Subsection 1 "Monthly Operational & Performance Reports": The contracting provider does not have access to response time information for mutual aid providers. As such, the requested data is neither available to nor within the possession or control of the contracting

provider, making compliance with this request impossible.

District Response: The selected provider will be responsible for reporting incoming mutual-aid information within its possession or control and information reasonably available through CAD data or reports obtained from Shelby County 911.

For purposes of the Page 10 requirement to report incoming mutual-aid response times, the provider shall report applicable dispatch and response timestamps to the extent those timestamps are reasonably available through Shelby County 911 or otherwise within the provider's possession or control. The provider will not be required to independently obtain, verify, or certify response-time information maintained exclusively by the outside mutual-aid agency.

When a requested data element is not reasonably available, the provider may identify that information as unavailable in its monthly report. The provider will not be considered noncompliant solely because another agency controls information that is not reasonably available to the provider.

d. Page 10, Subsection 3 “Quarterly Staffing, Licensure, and Workforce Reports”: The request for employee rosters, personnel certification information, and workforce data—including turnover and vacancy rates—appears overly broad at this juncture. Additionally, several of the certifications and training requirements identified in the RFP, including "live fire" emergency training hours, do not appear to be required for or applicable to the services contemplated by the RFP. Accordingly, the necessity and appropriateness of these reporting requirements is respectfully questioned, and the District is requested to clarify the relevance of such information to the evaluation of proposals and ongoing contract administration.

District Response: The purpose of the quarterly staffing, licensure, and workforce reporting requirement is to allow the District to verify that personnel assigned or eligible to perform services within the District are properly licensed, credentialed, trained, and available to maintain the staffing and deployment model represented by the selected provider.

For purposes of this requirement, quarterly personnel reporting shall be limited to personnel assigned to or eligible to work under the District contract and shall include verification of the licenses, certifications, credentials, and expiration dates applicable to the duties those personnel perform. The District does not require unnecessary personal information such as Social Security numbers, home addresses, personal medical information, or other information unrelated to contract administration. A provider may use an internal or unique employee identifier in place of unnecessary personal identifying information, provided the District can reasonably verify the person's qualifications when necessary.

Workforce turnover and vacancy information may be reported in aggregate and is intended to assist the District in evaluating staffing stability, service continuity, and the provider's ability to maintain required coverage. The District is not seeking unrelated company-wide personnel information.

The reference to “live fire” training does not require an EMS-only provider to conduct or participate in fire-service training. For purposes of the RFP, the quarterly training requirement shall instead apply to training reasonably related to the services provided under the contract, including EMS clinical training, mass-casualty and disaster response, applicable NIMS/ICS training, communications and interoperability, and appropriate joint-response training with local public-safety agencies.

Similarly, references to National Registry status or specialized certifications such as ACLS, PALS, and PHTLS are intended to require verification when those credentials are applicable to the employee's position or otherwise required by law, medical direction, or the final agreement; the listing of a credential in the RFP does not independently require every employee to maintain every listed certification.

The quarterly reporting requirement applies to ongoing administration of the awarded contract. Proposal evaluation will focus on whether the proposer demonstrates the staffing, credentialing, training, and workforce capacity necessary to perform its proposed service model.

e. Pg. 12 “Fleet Specifications, Capital Infrastructure, and Reserve Capacity Requirements”, 1st paragraph: The fleet standards set forth in this provision are unreasonable and operationally unattainable. The requirements exceed applicable regulatory standards and impose specifications that may not be necessary to ensure the safe and cost-effective delivery of ambulance services. Accordingly, it is requested that the RFP be revised to require that all ambulance vehicles be maintained in compliance with applicable state laws, regulations, and ALS requirements, rather than being subject to additional standards established solely by the District.

District Response: The District's intent is to ensure a safe, dependable, appropriately equipped, and reasonably modern ambulance fleet. The District does not intend to require that every vehicle satisfy the most current CAAS GVS or federal KKK specification when the vehicle or a professional remount was lawfully certified under an applicable standard in effect at the time.

All ambulances used in District service must be properly licensed by the State of Ohio for the service level provided, safely maintained, appropriately equipped, and compliant with the applicable ambulance vehicle standard under which the vehicle or professional remount was lawfully certified. Professionally remounted ambulances are permitted, provided the remount and current chassis satisfy applicable licensing, certification, safety, maintenance, and operational requirements.

Ambulances included in the provider's initial fleet at commencement of the contract will not be subject to the 100,000-mile entry limitation, provided they otherwise satisfy the District's requirements and are suitable for safe and reliable service.

After commencement of the contract, any replacement or additional ambulance newly introduced into District service must have no more than 100,000 miles on its current chassis when placed into service.

An ambulance must be removed from District service when its current chassis reaches either ten (10) years of age or 250,000 cumulative miles, whichever occurs first. For a professionally remounted ambulance, age and mileage will be determined based upon the current chassis rather than the age of the ambulance module. The provider must be able to document the remount, chassis replacement, applicable certification, maintenance history, inspections, and current condition.

The District is therefore not limiting its fleet requirements solely to the minimum standards imposed by state law or regulation. The age, mileage, reliability, and replacement requirements stated above are contractual standards intended to ensure dependable service throughout the contract term.

f. Pg. 12 “Fleet Specifications, Capital Infrastructure, and Reserve Capacity Requirements” 2nd paragraph, 3rd sentence: Maintenance of reserve ambulances that are mechanically and operationally identical to frontline units is neither financially prudent nor practically achievable. EMS equipment is frequently upgraded or replaced on an individual basis through targeted grant funding or other funding sources that apply only to specific units or equipment. Requiring corresponding upgrades across all reserve units whenever a frontline unit receives new equipment would create a significant and unnecessary financial burden without a commensurate operational benefit. Accordingly, it is requested that the RFP be revised to require that reserve ambulances be fully functional, properly maintained, and compliant with all applicable state and operational standards, rather than ‘mechanically identical’ to frontline units.

District Response: The District agrees that reserve ambulances are not required to be mechanically identical to frontline units or to contain identical makes and models of medical equipment.

For purposes of the RFP, a reserve ambulance must be fully operational, properly licensed and maintained, appropriately equipped for the service level of the unit it is intended to replace, and available in sufficient readiness to permit prompt substitution when a frontline ambulance is unavailable. A reserve used to replace the primary ALS ambulance must provide the equipment and patient-care capabilities necessary to continue ALS service.

Reasonable differences in chassis, vehicle manufacturer, model year, equipment manufacturer or model, and equipment acquired through grants or other funding sources are acceptable. Essential equipment and systems must provide functionally comparable capabilities, and personnel must be appropriately trained to operate the reserve vehicle and its equipment so that use of the reserve does not result in a material reduction in patient-care capability or an avoidable interruption of required coverage.

The RFP references to reserve ambulances being "mechanically identical" and having "identical ALS equipment sets" should therefore be understood to mean operationally comparable and appropriately equipped for their intended substitution role, rather than literally identical. The requirement that reserve capacity be maintained in a state of readiness remains applicable.

g. Pg. 16 "Mutual Aid Participation, System Accountability, and Regional Interoperability", first full paragraph: Limiting the percentage of mutual aid called into the District's territory is procedurally impossible. Mutual aid requests are handled through 911 and the provider does not control the dispatch time, response time or justifications for mutual aid. This provision is requested to be revised or struck from the RFP.

District Response: The District's objective is to prevent routine or excessive dependence upon neighboring agencies resulting from inadequate staffing, deployment, fleet availability, or other preventable failures to maintain the resources committed to District service. The District recognizes, however, that the selected provider does not control every dispatch decision or every circumstance resulting in mutual aid being sent into the District.

For purposes of the RFP, the three percent (3%) monthly mutual-aid threshold is an administrative-review trigger only and is not a maximum allowable percentage, an automatic finding of noncompliance, or an automatic basis for financial damages or increased unit hours.

If incoming mutual-aid utilization exceeds three percent (3%) of the District's monthly emergency call volume, the District will review the circumstances contributing to that utilization. The review may consider verified simultaneous incidents, extraordinary call volume, mass-casualty or emergency conditions, dispatch decisions outside the provider's control, and other circumstances affecting resource availability.

Corrective action may be required when the District determines that repeated or excessive reliance on incoming mutual aid was materially caused by the provider's preventable failure to maintain the staffing, vehicles, unit hours, or other resources committed under its proposal and the final agreement. Mutual aid resulting from circumstances outside the provider's reasonable control will not, by itself, constitute contractual noncompliance.

No liquidated damages or other financial remedies will be automatically assessed solely because the three percent threshold is exceeded. Any such remedies will be governed by the final negotiated agreement.

h. Pg. 16 "Mutual Aid Participation, System Accountability, and Regional Interoperability", second paragraph: Please explain the District's stated requirement that the selected provider use

Lockbox Banking for payment collection. This method is not cost-effective and additional rationale is needed to support this requirement – additionally, Anna Rescue does not directly collect payments, but collections are handled by a third-party billing company. The District is requested to confirm that the use of a third party billing company for collections will satisfy the District's stated "lock box" requirement. The District is further requested to provide support for its request to audit billing processes and conduct an annual independent coding audit.

District Response: The District does not require the selected provider to utilize a specific Lockbox Banking product or dedicated escrow account. The purpose of that provision is to ensure that billing and revenue attributable to District services can be accurately identified, tracked, reconciled, and audited.

A secure and auditable billing and accounting process will satisfy this requirement if it allows District-related billing activity and revenue to be separately identified and reconciled through appropriate accounts, subledgers, reports, or other reliable accounting controls. The provider is not required to establish a separate banking arrangement when its existing accounting and billing system can provide equivalent transparency and accountability.

The use of a qualified third-party billing company is expressly permitted. The provider may use such a company for billing, collections, payment processing, and related functions, provided the provider remains responsible for compliance with the District's billing requirements and the final agreement.

The District's billing audit requirements are intended to verify compliance with applicable billing and coding requirements, the District's Resident Compassionate Billing Policy, approved rate structures, and required financial reporting. The District is not seeking unrestricted access to unrelated corporate billing information. Any District review will be limited to records and billing activity reasonably related to services provided under the District contract and will remain subject to applicable privacy and confidentiality requirements.

The annual independent coding-audit requirement may be satisfied through an independent, risk-based coding or billing compliance review of a reasonable sample of District-related claims rather than an audit of every individual claim. The review must be performed by a qualified person or entity sufficiently independent of the coding activity being reviewed and must be adequate to evaluate compliance with applicable billing and coding requirements. An existing third-party compliance or audit program may satisfy this requirement if it provides substantially equivalent independent review and documentation.

The provider shall continue to provide sufficient monthly billing and revenue information to permit reconciliation of District-related activity, including applicable gross billings, collections, contractual adjustments or write-offs, uncompensated care, and accounts-receivable information. The RFP currently identifies those reporting categories.

i. Pg. 17 "Unannounced Inspections, Real-Time Auditing, and Contract Compliance Access", first paragraph: Please clarify the District's rationale for conducting audits that are already being performed by Council and the Board of Pharmacy? Duplicative audits and/or inspections are not only burdensome, but costly in both time and resources for the agency. Reconsideration is requested.

District Response: The District does not intend to duplicate the regulatory inspection or enforcement functions of the Ohio Board of Pharmacy, Ohio EMS authorities, or other governmental or accrediting bodies. The purpose of District audits and inspections is limited to verifying the selected provider's compliance with the District service contract.

District review may include matters such as staffing and credential compliance, availability and condition of District-assigned vehicles and equipment, required operational readiness, contract reporting, and other matters reasonably related to performance of the District agreement. Where

existing regulatory inspection or audit documentation reasonably demonstrates compliance with a particular requirement, the District may rely upon that documentation rather than unnecessarily duplicating the same review.

Routine contract-compliance inspections will generally be conducted with reasonable notice and in a manner designed to minimize disruption to the provider's operations. Unannounced inspections may be conducted when reasonably necessary to address an immediate health or safety concern, verify active staffing or operational readiness, investigate suspected material noncompliance, or address another circumstance requiring prompt verification.

District inspections will not unnecessarily interfere with emergency response or patient care and will remain subject to applicable patient-privacy, confidentiality, security, and other legal requirements.

j. Pg. 17 “Unannounced Inspections, Real-Time Auditing, and Contract Compliance Access”, second paragraph: Review of the information requested in this paragraph is secured by state and local standards. The request by the District is, again, duplicative in nature and costly in both time and resources for the agency. Reconsideration is requested.

District Response: The District's purpose is to obtain information reasonably necessary to administer and enforce the service contract, not to duplicate regulatory reviews or obtain unrestricted access to records that are unrelated to District operations.

The provider shall furnish records and information reasonably related to performance of the District contract and legally available for disclosure. Aggregate or de-identified information should be used when it reasonably satisfies the District's oversight need. Personnel training, licensure, credentialing, staffing, fleet, financial, billing, and operational records may be reviewed to the extent reasonably necessary to verify compliance with the final agreement.

The RFP does not require unrestricted disclosure of unrelated personnel files, legally protected disciplinary information, privileged or protected QA/QI materials, patient information, proprietary information, trade secrets, or other records that are legally prohibited from disclosure. Claims of confidentiality, privacy, or proprietary protection will be evaluated under applicable law rather than being categorically prohibited.

Routine records requests shall be fulfilled within a reasonable period based upon the nature, volume, availability, and complexity of the information requested and any necessary legal, privacy, or confidentiality review. The RFP's forty-eight (48) hour reference should not be interpreted as an absolute deadline applicable to every records request. Information reasonably necessary to address an immediate health or safety concern, active operational issue, or suspected material noncompliance should be provided as promptly as practicable, while more extensive or complex requests may reasonably require additional time.

Failure to produce information that is legally protected from disclosure, or inability to satisfy an unreasonable production timeframe due solely to the scope or complexity of the request, will not by itself constitute contractual noncompliance. Any remedies for failure to comply with a lawful and reasonable records request will be governed by the final agreement and will not result in automatic financial penalties under the RFP.

4. Other Areas of Concern

a. Pg. 10, Subsection 2 “Monthly Clinical & Quality Assurance Reports”: The requested QA/QI reports are completed by the medical director and Hospital EMS coordinator and are not necessarily under the control of the provider. The District is requested to clarify its need for QA/QI reports when there is a potential lack of medical knowledge and proper protocols for such

review are not present.

District Response: The District does not intend to replace or duplicate the clinical QA/QI functions of the provider's medical director, hospital EMS coordinator, or other qualified clinical-review personnel. Nonclinical District personnel will not independently direct patient-care review or make clinical determinations outside an appropriate medical-direction or quality-review process.

For purposes of the RFP, the monthly clinical and QA/QI reporting requirement is intended to provide the District with aggregate or de-identified information sufficient to demonstrate that an appropriate clinical quality program is functioning and that material trends relevant to District service are being identified and addressed. This may include aggregate protocol-compliance information, hospital offload delays, applicable clinical-performance indicators, high-acuity event benchmarking, and the status of corrective or educational actions when appropriate. The RFP currently identifies those categories as the intended focus of the monthly report.

Clinical interpretation, individual patient-care review, and clinical corrective guidance shall remain under appropriately qualified medical direction or other authorized clinical-review processes.

When particular QA/QI reports, analyses, or data are maintained or controlled by a medical director, hospital EMS coordinator, receiving hospital, or another entity rather than the provider, the provider shall furnish the information reasonably available to it or, when appropriate, facilitate an aggregate summary or other suitable review through the applicable clinical authority. The provider will not be considered noncompliant solely because protected or independently controlled clinical-review material is not within its possession or legally available to it.

The District does not require routine disclosure of patient-identifying information, privileged or legally protected peer-review material, or other protected clinical information. Patient-specific information may be requested only when reasonably necessary for an authorized complaint, compliance, or clinical-review process and when disclosure is permitted by applicable law and medical direction.

b. Pg. 12, first full paragraph: The third line references “live fire” drills which are not appliable to the services contemplated by the RFP. It is noted that there are various references to fire-specific items throughout the RFP that should be corrected or removed.

District Response: The District agrees that an EMS-only provider is not required to conduct or participate in fire-service “live fire” training solely as a condition of this contract.

For purposes of the RFP, references to “live fire” or similar fire-specific training requirements shall be understood to require role-appropriate joint EMS/public-safety training relevant to the provider's responsibilities. Appropriate subjects may include incident command, communications and interoperability, mass-casualty response, patient triage, rescue-interface procedures, patient packaging and transfer, coordination with fire and law-enforcement first responders, and scene safety.

Nothing in the RFP requires an EMS-only provider or its personnel to obtain fire-service certifications, perform fire-suppression functions, or participate in fire-specific training that is unrelated to their EMS or incident-response responsibilities.

Other fire-related terminology appearing in the RFP shall likewise apply to the selected provider only to the extent it is reasonably relevant to ambulance operations, EMS integration, joint incident response, or coordination with member-jurisdiction fire departments.

c. Pg. 14, 2nd paragraph: Please clarify the District's intentions with respect to this paragraph with respect to a non-union provider.

District Response: The Continuity of Operations Plan (COOP) requirement applies to both union and non-union providers. A non-union provider is not required to develop collective-bargaining procedures or a union-strike response plan when those circumstances are not applicable to its organization.

For purposes of the RFP, references to "labor disruptions or union strikes" and similar language are intended more broadly to address significant staffing or workforce disruptions that could materially affect the provider's ability to maintain required District coverage. Depending upon the provider's organizational structure, this may include coordinated work stoppages, significant employee absences, illness outbreaks, recruitment or retention failures, or other substantial staffing shortages.

Each proposer should address the workforce risks reasonably applicable to its organization and describe the contingency measures it would use to maintain the required level of service during such a disruption.

The reference to deploying out-of-market executive, supervisory, or mutual-aid personnel within twelve (12) hours should not be interpreted as requiring a non-union provider to deploy executive personnel merely because a staffing shortage occurs. The provider must instead demonstrate the ability to obtain and deploy appropriately qualified replacement or supplemental personnel as reasonably necessary to restore and maintain the required District staffing and coverage. The provider remains responsible for maintaining the minimum service and staffing requirements established by the RFP and these responses.

Any failure associated with a staffing or labor disruption will be evaluated based upon the circumstances, including whether the provider took reasonable and timely measures to maintain or restore required coverage. Financial remedies will not be automatically imposed under the RFP and will be governed by the final negotiated agreement.

d. Section 3, Minimum Qualifications #5 – given the timeline for responses to the RFP and the final contract award, the selected agency will not have sufficient time to ramp up in advance of the anticipated contract start date of January 1, 2027. It is requested that the District consider an additional ramp up period at the beginning of the contract to ensure contract compliance.

District Response: The District intends to maintain January 1, 2027 as the service commencement date and expects the selected provider to be fully operational for its awarded scope of services on that date. The District does not presently intend to authorize a reduced-service or partial-compliance ramp-up period after service commencement.

Following award, the District and selected provider will develop a detailed pre-service transition and mobilization schedule addressing matters such as personnel recruitment and credentialing, station readiness, vehicle and equipment deployment, communications and dispatch coordination, billing and reporting processes, training, operational testing, and other activities necessary for service commencement.

For purposes of Minimum Qualification #5, "100% of operations" means full compliance with the awarded scope of services and the requirements of the RFP as clarified by these District responses as of January 1, 2027. It does not require compliance with provisions of the original RFP that have been modified or clarified through these responses.

The District may consider reasonable adjustments to individual pre-service transition milestones when circumstances warrant, provided such adjustments do not jeopardize continuity of emergency medical service or the provider's ability to meet the required minimum staffing, coverage, and operational

standards on January 1, 2027. Any material change to the service commencement requirement would require express agreement by the District.

e. Appendix A – Many of the definitions contained in Appendix A appear to be inconsistent with the definitions of the same terms under the Ohio Revised Code. These discrepancies create ambiguity and may lead to confusion regarding the interpretation and application of the RFP requirements. Accordingly, it is respectfully requested that the District revise Appendix A to align its definitions with applicable Ohio law or otherwise provide clarification where deviations are intended.

District Response: The District does not intend to revise or restate the definitions contained in Appendix A. The definitions in Appendix A shall remain applicable for purposes of interpreting the RFP and the contractual requirements established by the District.

Nothing in Appendix A is intended to supersede, replace, or modify a definition established by controlling federal or Ohio law. To the extent that a definition contained in Appendix A conflicts with a definition contained in the Ohio Revised Code, Ohio Administrative Code, or other controlling law, the definition established by controlling law shall prevail.

Where a term is used by the District for purposes of establishing a contractual requirement or performance standard, the RFP and these District responses shall govern the contractual application of that requirement, provided that the requirement does not conflict with controlling law.