STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

September 25, 2012

VIA Email & U.S. MAIL

Michael Silgen, Vice President
Memorial Hospital at Easton
219 South Washington St.
Easton, Maryland 21601

Re: Memorial Hospital at Easton
Hospital Replacement and Relocation
Matter No. 12-20-2339

Dear Mr. Silgen:

Commission staff has reviewed the above-captioned application of Memorial Hospital at Easton ("MHE" or "the Hospital") for Certificate of Need ("CON") approval of the replacement and relocation of the Hospital. Staff requests that you provide responses the following information:

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Regarding the response to Item 9, please provide the following clarifications:
   a. On the physical bed capacity form, MHE indicated that there is a total capacity for 132 beds including the rehabilitation beds, but on the OHCQ and MHCC Application for Annual Licensed Bed Designation, MHE indicated that the total physical bed capacity at MHE in FY 2012 was 150 beds (this number was not provided for FY 2013). Please correct or reconcile these numbers; and
   b. Please complete the attached spreadsheet detailing the actual physical bed capacity before and after the project.

2. Regarding the project description (Item 14):
   a. Please provide a map with the location for the proposed relocated MHE at the intersection of Longwoods Road and Route 50, as well as the current location in the City of Easton on South Washington Street. Please include the major roads that will provide access to the new hospital location;

b. Does the proposed project include the relocation of all the programs and services that are currently provided at the current South Washington Street location to the proposed Longwood Road location?
c. While plans for the existing site are not finalized, please discuss whether Shore Health System intends to or is considering the operation of any health programs and services at the South Washington Street location;
d. Please provide further details as to the features and functions included in the $16 million in software and related costs to implement a new electronic health record system. Will MHE implement a similar system at Dorchester General Hospital, and will this provide interoperability with the other hospitals in the University of Maryland Medical System;
e. Explain the nature of the inconvenience of driving into downtown Easton for patients. Can this inconvenience be quantified in some way?
f. Specify the total square footage of the existing physical plant in a manner comparable to the total square footage of the new facility as reported on Chart 1 (page 8);
g. Summarize the number, the type (public, patient/service, trauma) and location of elevators in the existing facility. Explain the term "stps" and the numbers accompanying its use in Chart 1 such as public – 5(18 stps); and
h. Provide the following detail for the existing MHE and the new facility:
   i) The number and type of devices in the Imaging Department;
   ii) The types of services that will be located in the Cardiopulmonary/Vascular Services program;
   iii) The number of cardiac catheterization laboratories;
   iv) The number of sterile operating rooms and non-sterile, minor procedure rooms, as well as the number of recovery beds in the Prep/Stage II Recovery area; and
   v) Will all 14 obstetric ("OB") post partum beds be in a labor/delivery/ recovery/ post partum configuration?

3. Regarding Chart 1 on page 8 through 10, will the expenditures for offsite improvements (outside the loop) be allocated and charged to future developments that benefit from them? If yes, how will such allocations be made? If no, why not?

PART II – PROJECT BUDGET

4. Explain how the $7,000,000 in contingency allowance (line 1c(3)) was estimated.

5. Explain how the capitalized construction interest of $24,901,333 (line 1d(1)) was calculated. Also explain why there is no interest income included in the source of funding for this project. This explanation should specify how and when the proceeds from the sale of the bonds will be disbursed.

6. Please provide additional detail on the calculation of the inflation (line 1d(2) that shows exactly how you arrived at the budgeted amount of $4,679,795. Include an explanation of why the inflation amount covers 27 months and an explanation of what is meant by MHCC Index 11.3 – 14.4.

7. Explain how the estimated cost for loan placement fees, bond discount, and debt service reserve fund were calculated.

PART III – CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

8. The response to COMAR 10.24.10.04A(1), Information Regarding Charges does not satisfy the requirements of the standard. Specifically the list of charges submitted with the application and available on the Hospital's website is not completely consistent with the definition of a representative list as specified in the definition section of the Acute Care Hospital Services chapter (COMAR 10.24.10.06)(29). The definition requires that at a minimum the list contain "the average charge per case for the ten most frequently occurring inpatient diagnoses (determined by diagnosis-related group or "DRG") for discharged medical/surgical patients, and also for discharged obstetric patients, discharged pediatric patients, and discharged acute psychiatric patients, if the hospital operates an inpatient unit for any of these latter three services. The list submitted with the application and available on the website contains the charges for a total of 12 inpatient procedures that are not identified with a particular inpatient service. Therefore, you will need to revise the charge information available in written form at the Hospital and on the Hospital's website. The charge information must include, at a minimum, for inpatients the average charge per case for the 10 most frequently occurring diagnoses for discharged medical/surgical patients, the 10 most frequently occurring diagnoses for discharged obstetric patients, and the10 most frequently occurring diagnoses for discharged pediatric patients, all as determined by DRG. The written policy should also be revised to make it clear that the list of charges will be updated at least quarterly as required by part (b) of the definition. It will be necessary for MHE to make these changes prior to the docketing of this application.

9. The Charity Care Policy, COMAR 10.24.10.04A(2), requires that a determination of probable eligibility be made within two business days following a patient's request for charity care. MHE's charity care policy addresses this requirement in section 9.4 on page

eight of the nine page policy at the end of a paragraph that includes as the second sentence the statement that "once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for determination of final eligibility based on SHS guidelines." One of the objectives of this standard is to require that patients seeking charity care be informed of probable eligibility at the earliest possible time. Satisfying the standard requirement for a determination of probable eligibility will require separation of the probable determination process from the final determination process in order to make it clear that the probable determination does not require submission of a complete application.

10. Regarding COMAR 10.24.10.04B(5), Cost Effectiveness, please provide the following information:
    a. Provide a detailed description of the existing campus alternative specifying the amount of new construction and renovation in square feet, the changes in bed capacity and mixes of private and semi-private rooms and the changes in capacity and space allocated to each department;
    b. Submit a site plan of the existing site indicating the location of physical plant expansion(s) that were part of the on-site-alternative. What is the size of the existing site?
    c. Identify the degree to which the on-site alternative (Alternative 1) would solve the concerns expressed about the existing physical plant, especially as detailed in the project description (pages 20 through 24);
    d. Compare the estimated cost of $38,888,000 for the on-site alternative to the cost of the proposed alternative;
    e. Explain why, after a major on-site improvement project, "way-finding" would still rank as poor, as specified in Table 9 on page 61;
    f. Explain why the on-site alternative ranks so low in terms of enhancing physician recruitment,
    g. Why are patient volumes expected to grow faster under the Easton relocation alternative (Alternative 2) and even faster under the northern Talbot County alternative (Alternative 3) than the on-site alternative (Alternative 1)? To the extent such differences in expected growth are associated with the development of new ambulatory care centers (one if the hospital is relocated in Easton, two if it is relocated to northern Talbot County, and none with the on-site alternative), why wouldn't the same ambulatory care centers be developed with each alternative?
    h. Provide a more detailed explanation of the projected high level of ongoing capital budgeting for replacement equipment ($8 million under Alternative 1 and $7 million under Alternatives 2 and 3); and
    i. Explain why SHS assumed pursuit of the northern Talbert County site would be delayed two years, as stated on page 74.

11. Regarding the response to COMAR 10.24.10.04B(7), Hospital Construction Cost, it appears that the inside-the-loop costs identified on page 91 were treated as extraordinary costs and removed from the project costs for comparison to the Marshall Valuation Service ("MVS') benchmark. However, the reason why these costs are not included in the MVS benchmark are not explained on pages 91 and 92. Please explain why the costs identified on the top of page 91 are considered to be extraordinary costs for purposes of comparison with the MVS benchmark, given that the MVS costs include the cost of utilities from the property line to the building.

12. Regarding the response to Standard B(14), Emergency Department Treatment Capacity and Space, while MHE may not be proposing an expansion of treatment capacity, the proposed emergency department will be in new space. Therefore, its treatment capacity and space must be evaluated with respect to the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* as required by this standard. (Commission staff notes that this has been done under the need criterion.)

13. Regarding the response to Standard B(16), Shell Space, since the proposed shell space supports upper floors, your response must address part (c) as follows:
    a. Please specify the additional square footage of each shell space area;
    b. Please specify the most likely use of each area and the likely time frame for using the space. The time frame projected should be accompanied by an explanation of why you expect to use the space as contemplated in the time frame specified; and
    c. Please specify the cost of constructing each shelled area and the practicality and cost of redesigning the building to eliminate such areas.

Obstetrics Plan

It appears that in responding to the Obstetric Plan chapter, the latest version of the plan chapter was not used. The result is that some of the current standards were not addressed and others were addressed out of order. Note that the current plan includes 15 standards. However, because you are proposing the relocation of an existing service, not a new service, you only need to address standards (1) through (6) and standard (15).

With respect to the Charity Care Policy standard, which has been revised in the current plan chapter, but is still standard (3), please document how MHE's charity care policy is consistent with the standard. Explanations with references to documents submitted in response to the Acute Care Hospital Services chapter charity care standard are acceptable where the standards are consistent.

Acute Rehabilitation Plan

14. Concerning the response to the Transfer and Referral Agreements standard, please provide the following clarifications;
    a. Identify the types of rehabilitation cases that exceed MHE's capabilities and the facilities to which such cases are transferred. Specify the number of such cases that have been transferred to each facility in the last three years; and
    b. Identify the other facilities and agencies to which patients are transferred for rehabilitation that could have been provided in MHE's acute medical rehabilitation unit.

Need Criterion, 10.24.01.08G(3)(b)

15. Regarding the need for the number of obstetric post partum beds proposed, please provide the following information:
    a. Explain why an average length of stay (ALOS") of 2.26 days was used to calculate need, as presented on page 127, when the OB ALOS reported in 2010 and 2011 was 2.21 days and the ALOS projected for 2012 is 2.16 days; and
    b. Regarding the assumption that obstetric bed utilization will be distributed in a cumulative normal distribution, discuss and justify the continued validity of this approach, given the growing ability to manage patient census (because of caesarean section deliveries and induction of labor). Also address the appropriateness of using specific minimum occupancy rates, such as those used for pediatric beds.

16. Regarding the need for acute medical rehabilitation beds, please address the following:
    a. Why is Table 23 on page 129 labeled as 2018 and 2020 when the projected days are for 2017? and
    b. Why is an MHE market share of 78.4% used to calculate need when the narrative (page 129, 3rd paragraph) indicates that the market share for CY 2011 was 74%?

17. Regarding the need for emergency department treatment spaces, please respond to the following:
    a. On the Maryland Health Care Commission's Supplemental Survey of Emergency Department Treatment Capacity, MHE reported a total of 34 treatment spaces as of June 1, 2012, but the tables on pages 104 and 130 of the application appear to indicate that the total is currently 32 and the proposed capacity is also 32 spaces, including three pediatric treatment spaces. Please reconcile or explain this apparent discrepancy.
    b. Specify the location of the rapid diagnostic and other triage spaces on the project drawings.

18. Regarding the need for operating rooms, please provide the following information:
    a. Submit a more detailed description of the need methodology that was used including submission of the calculation of the compound annual growth rate from 2008 to 2012 and the projections forward through 2020;
    b. Why do the plans for the replacement hospital appear to call for six ORs when you are projecting the need for eight ORs in 2016 when the replacement hospital would be expected to open based on the current criteria for optimal utilization of 97,920 minutes per year for each OR?
    c. How would additional OR capacity be added when it is needed?

Availability of More Cost-Effective Alternatives

19. Please compare the cost-effectiveness of providing the services affected by the proposed project with the cost effectiveness of providing the services at alternative existing facilities.

Viability of the Proposal, 10.24.01.08G(3)(d)

20. Regarding the response to the Viability criterion:
    a. Please provide the Audited Financial Statement for the year ending June 30, 2012 with the response to this letter or as soon as it becomes available;
    b. Specify the source of the cash contribution and document the current or expected availability of these funds;
    c. Specify the expected terms (interest rate(s), years, etc.) of the proposed bond financing;
    d. Document the likelihood of raising the $28 million in philanthropic funding for the proposed project. Document the experience of MHE and/or Shore Health System in fundraising; and
    e. Identify the type of state grant or appropriation that is expected to supply $2.5 million of the required project funding.

21. Regarding the response to the Viability criterion, please provide the following clarifications and additional information regarding the availability of financial resources to sustain the project:
    a. Provide a detailed description of the calculation of the gross patient revenues as they appear in Table 3 including a detailed explanation of how current rates account for capital cost; how rates would change as a result of the rate increase MHE is requesting; and how the increase in rates is reflected, if it is, in the gross patient revenue projections of Table 3;

b. Specify your assumptions with respect to the projection of allowances for bad debt, contractual allowances and charity care and explain how contractual allowances are calculated given the Total Patient Revenue method or rate regulation being used by MHE;
c. Specify the sources of the non-operating revenue reported in Table 3;
d. Explain the $46,669,784 in other expenses that are only reported for FY 2014;
e. Explain why supply expenses are projected to decline from 2013 through 2016;
f. Explain why current depreciation is reported in 2016 and 2017 after the hospital relocates; and
g. Submit a Table 3 with no increase in rates (revenue?) associated with the proposed project.

Impact on Existing Providers, 10.24.01.08G(3)(f)

22. In responding to this criterion you state that the project will have no negative effect on other providers. However, the criterion requires that the applicant provide information and analysis with respect to the impact (not necessarily negative) of the proposed project on existing health care providers in the service area. Please respond to this requirement with analysis of such impacts especially given the response to the cost effectiveness standard stating that MHE expects its service volume to grow faster under the proposed alternative than under the on-site alternative. Submit the analysis supporting the view that this growth will or will not have an impact on other providers.

23. Regarding Table 5, Manpower, please correct or explain the following apparent discrepancies:
    a. Under Total Direct Care, you report an addition of 25.3 FTEs, but your table indicates an addition of only 24.6 FTEs.
    b. Using the number of additional FTEs reported in Table 5, staff calculates, using the total number of FTEs projected for FY 2017 and the average projected salary of employees after the implementation of the project as:
    c.

	Reported Table 5	Calculated
Total Administration	$17,948,125	$17,944,320.50
Total Direct Care	$58,213,945	$58,156,712.80
Total Support	$7,136,946	$7,139,322.30
Total	$83,299,016	$83,240,355.60

    If a correction is made to the total, please revise Table 3 accordingly.

24. It will be necessary to provide a Table 3 that includes inflation in revenues and expenses for HSCRC's review and comment on the financial feasibility of this project. Provide an

accompanying comprehensive statement of assumptions with all alternative Table 3s provided.

Please submit ten copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt. All information supplementing the application must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, feel free to contact me at (410) 764-5596 or Paul Parker at (410) 764-3261.

Sincerely,

for Joel Riklin

Joel Riklin, Program Manager
Certificate of Need

Attachment
Enclosure

cc: Jack C. Tranter, Esq.
Thomas C. Dame, Esq.
Andrew L. Solberg
Kathleen H. Foster, R.N., Talbot County Health Department
(internal distribution)

ATTACHMENT 1: Actual Physical Bed Capacity Before And After The Project

Hospital: _____ Date:

Location (Floor/Wing)	Before the Project						After Project Completion				
			Room Count			Bed Count		Room Count			Bed Count
	Hospital Service	Licensed July 1, 2012	Total Rooms	Semi-Private	Private	Physical Capacity	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity
			0			0		0			0
			0			0		0			0
			0					0			0
			0			0		0			0
			0			0		0			0
SUBTOTAL	Gen. MSGA		0	0	0	0	Gen. MSGA	0	0	0	0
	ICU/CCU		0			0	ICU/CCU	0			0
TOTAL	MSGA	0	0	0	0	0	MSGA	0	0	0	0
	Obstetrics		0			0	Obstetrics	0			0
	Pediatrics		0			0	Pediatrics	0			0
	Psychiatric		0			0	Psychiatric	0			0
ACUTE TOTAL	Acute Care	0	0	0	0	0	Total Acute	0	0	0	0
Non-Acute Beds											
	Rehabilitation										
Hospital Total											

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough, from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall, but are used to accommodate more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms is semi-private, and the bed capacity is as applicable.

.04 Review Standards

The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving new acute hospital inpatient obstetric services, existing services proposed to be relocated to newly constructed space, and existing services proposed to be located in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to applicants for a new perinatal service. Standard (15) applies only to applicants with an existing obstetric service.

(1) Need. All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

(2) The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

(3) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the admissions office, business office and emergency areas within the hospital

(iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and

(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

(4) Medicaid Access. Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

(5) Staffing. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

(6) Physical Plant Design and New Technology. All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

(7) Nursery. An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

(8) Community Benefit Plan. Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population. This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required. At a minimum, the Community Benefit Plan must include:

(a) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,

(b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and

(c) information on the structure, staffing and funding of the Plan;

(d) documentation of community support and involvement in program planning for the Plan by other agencies, organizations or institutions which will be involved, directly or indirectly, with the Plan;

(e) an implementation scheme for the Community Benefit Plan.

(f) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

(9) Source of Patients. An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

(10) Non-metropolitan Jurisdictions. A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

(11) Designated Bed Capacity. An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

(12) Minimum Volume.

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval, the applicant shall accept a requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two year period.

(13) Impact on the Health Care System.

(a) An application for a new perinatal program will be approved only if its likely impact on the volumes of obstetric discharges at any existing obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetrics patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article §19-120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

(i) from an applicant as to why rules (a) through (c) should not apply to the applicant, or;

(ii) from a very low volume program (fewer than 500 annual obstetric discharges) as to why a lower volume impact should apply.

(14) Financial Feasibility. Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,

(b) the proposed unit rates and/or average charge per case for the perinatal services,

(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and

(d) the written opinions or recommendations of the HSCRC.

(15) Outreach Program. Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

.05 Definitions

(1) Hospital Obstetric Services. DRGs 370 - 379, and 382 - 384.

(2) Metropolitan Areas. For purposes of this plan chapter, metropolitan areas include: Anne Arundel, Baltimore, Calvert, Carroll, Charles, Frederick, Harford, Howard, Montgomery, Prince George's, St. Mary's and Washington counties and Baltimore City.

(3) Non-Metropolitan Areas. For purposes of this plan chapter, non-metropolitan areas include: Allegany, Caroline, Cecil, Dorchester, Garrett, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester counties.

(4) Primary Service Area. Defined in COMAR 10.24.01.01.B.