19-017

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Skin Cancer Surgery Center, LLC
Street Address: 331 Regency Park Drive
City and Zip Code: O'Fallon, Illinois 62269
County: St. Clair Health Service Area: XI Health Planning Area: F-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Jamie L. McGinness, MD / McGinness Properties, LLC
Street Address: 1911 Fortune Blvd., Suite 2
City and Zip Code: Shiloh, Illinois 62269
Name of Registered Agent: Christopher W. Bryon
Registered Agent Street Address: 411 Saint Louis Street
Registered Agent City and Zip Code: Edwardsville, Illinois 62025-1907
Name of Chief Executive Officer: Jamie L. McGinness, MD
CEO Street Address: 1911 Fortune Blvd., Suite 2
CEO City and Zip Code: Shiloh, Illinois 62269
CEO Telephone Number: 618-622-7546

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Jamie L. McGinness, MD
Title: Owner / Sole Corporate Member
Company Name: McGinness Properties
Address: 1911 Fortune Blvd., Suite 2 Shiloh, Illinois 62269
Telephone Number: 618-622-7546
E-mail Address: jmcginness@dermskincancercenter.com
Fax Number: 618-622-7547

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: E.W. Parkhurst, Jr.
Title: Managing Principal
Company Name: PRISM Healthcare Consulting
Address: 800 East Roosevelt Road, Bldg. E, Suite 100, Glen Ellyn, Illinois 60137
Telephone Number: 630-790-5089
E-mail Address: eparkhurst@consultprism.com
Fax Number: 630-790-2696

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name: Jamie L. McGinness, MD
Title: Owner / Sole Corporate Member
Company Name: McGinness Properties LLC
Address: 1911 Fortune Blvd., Suite 2 Shiloh, Illinois 62269
Telephone Number: 618-622-7546
E-mail Address: jmcginness@dermskincancercenter.com
Fax Number: 618-622-7547

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: McGinness Properties LLC
Address of Site Owner: 1911 Fortune Blvd., Suite 2 Shiloh, Illinois 62269
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

(When completed; new healthcare facility ASTC, to be established))

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Skin Cancer Surgery Center, LLC
Address: (to be assigned) 331 Regency Park Drive, O'Fallon, Illinois 62269

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (**http://www.hfsrb.illinois.gov**).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive *

☐ Non-substantive

* "Establish" a new ASTC

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms, NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Jamie L. McGinness MD (Illinois License # 036124865 / NIP# 1447291356) is a Board Certified Dermatologist with sub-specialty training in Dermatologic Surgery and Dermatopathology. Dr. McGinness specializes in Mohs Micrographic Surgery (Mohs or MMS) procedures and, to the best of his knowledge, is the only Fellowship trained Mohs surgeon in the Metro East Illinois region (HSA X1). (See Appendix A)

He is relocating his single-specialty private office practice from Shiloh, Illinois to a new medical office building (MOB) on Regency Park Drive, proximal to the new HSHS St. Elizabeth's Hospital, O'Fallon, Illinois and contiguous to the recently approved HSHS St. Elizabeth's Radiation Oncology Clinic, Part of Lot A, 301 Regency Park Drive, O'Fallon, Illinois. The MOB address is 331 Regency Park Drive, O'Fallon, Illinois. 62269.

This MOB will house Dr. McGinness's solo private practice entitled Metro East Dermatology and Skin Cancer Center and, when completed, will have a shelled area for the proposed single-room, single specialty ASTC for Mohs Surgery reconstruction and repair (to be known as the "Skin Cancer Surgery Center, LLC") as defined in this CON permit application.

An ASTC for Mohs surgery reconstruction procedures is not explicitly defined or included in Section 1110, Appendix A, ASTC Services. These highly complex procedures embrace professional skills associated with general surgery, plastic surgery, pathology / histology analysis (dermatopathology) and dermatology. What is being requested in this permit application is State Agency approval to establish a single-room, single specialty, ASTC to perform Mohs Micrographic Surgery reconstruction / repair procedures. The ASTC will be self-contained and separate, but integral, to Dr. McGinness's private dermatology practice, as required by Medicare CoP's and Illinois ASTC licensing regulations.

The project is classified as substantive because it proposes to establish a non-hospital based ambulatory surgical treatment center (ASTC) by modernizing shelled area in an MOB (see the following pages for support letters and preliminary building plan)..

Support Letters

STATE CAPITOL
SENATE POST OFFICE
SPRINGFIELD, ILLINOIS 62706

STATE OF ILLINOIS
101ST GENERAL ASSEMBLY
ILLINOIS STATE SENATE

RACHELLE AUD CROWE
STATE SENATOR
56TH DISTRICT

March 10, 2019

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield IL 62761

Dear Ms. Avery,

I am writing in support of the CON permit application to establish a single specialty ASTC in O'Fallon. The proposed Skin Cancer Surgery Center, LLC will provide state-of-the-art skin cancer diagnostic and treatment services not readily available, locally, until Dr. McGinness began his practice in 2017. His practice has provided increased access to needed healthcare services.

Metro East is one of the larger population centers in Illinois, outside of Chicago. The proposed Cancer Surgery Center will provide skin cancer procedures on an highly specialized ambulatory basis which is more efficient than in other healthcare settings.

Again, I urge the State Agency to approve the CON permit application for the proposed Skin Cancer Surgery Center.

If you would like additional information, I can be reached at 618-251-9840.

Sincerely,

Rachelle A. Crowe

Rachelle A. Crowe
State Senator – 56th District

RAC/tlc

Springfield Office:
253-S Stratton Office Building
Springfield, IL 62706
(217) 782-8018

District Office:
2105 Vandalia St. #16
Collinsville, IL 62234
(618) 365-6650

Katie Stuart
State Representaive
112th District

Committees:
Appropriations-Elementary & Secondary Education
Consumer Protection
Elementary & Secondary Education: School Curriculum Policies
Higher Education
Labor & Commerce
Museums, Arts, & Cultural Enhancement

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
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Metro East is one of the larger population centers in Illinois, outside of Chicago. The proposed Cancer Surgery Center will provide skin cancer procedures on an highly specialized ambulatory basis which is more efficient than in other healthcare settings.

Again, I urge the State Agency to approve the CON permit application for the proposed Skin Cancer Surgery Center.

If you would like additional information, I can be reached at 618-365-6650 or 217-782-8018.

Sincerely,

Representative Katie Stuart

RONALD (RON) M. & DORIS O. HAWRELAK
2524 GREENBRIAR ROAD
SPRINGFIELD, IL 62704
EMAIL ADDRESS: hawrelak@onemain.com
PHONE NUMBER: (217) 787-9511

"Peace Beyond All Understanding"

February 22, 2019

Jamie L. McGinness, MD
Metro East Dermatology & Skin Cancer Center
1191 Fortune Blvd, STE 2
Shiloh, IL 62269

Dear Doctor McGinness:

I just wanted to drop you a note of thanks for your terrific medical care I was fortunate to receive on a timely basis. It all began January 24, 2019 as one of my most invasive yet most successful surgeries, of any specialty I have experienced in my being.

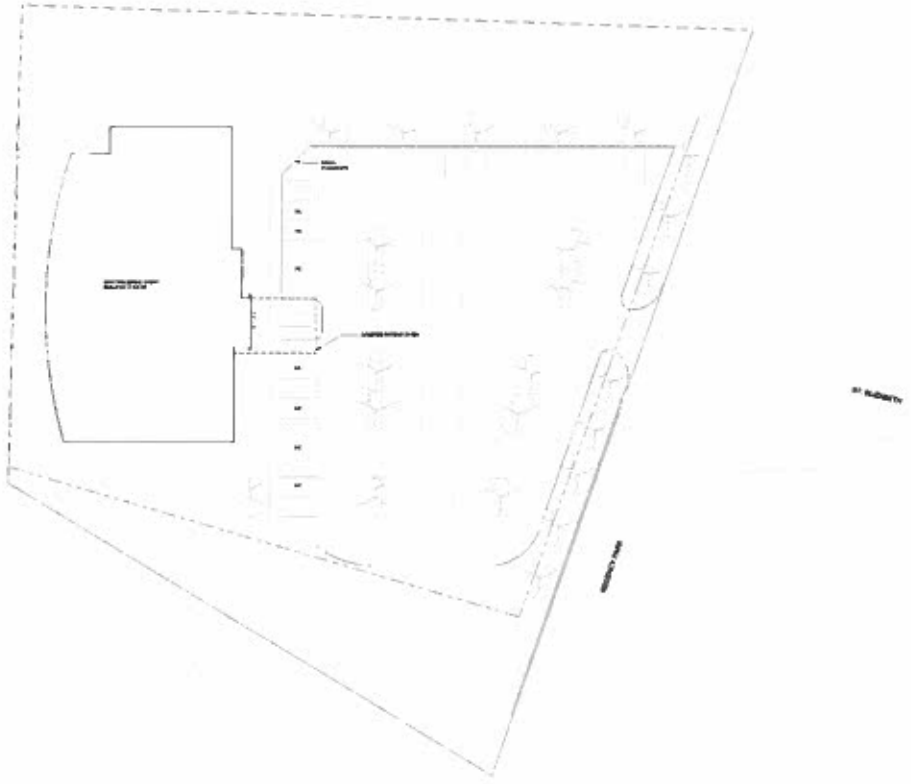
Requiring over a hundred stiches on the left area of my scalp is a WOW moment no matter who the patient may be. While I own that seriousness with its memories, it's your highly effective Mohs surgery which removed the nasty nodular infiltrative basil cell carcinoma. Now with the rapid recovery there is much to be grateful for!

Today my wife Doris and I know why we felt we were at the right clinic at the right time on our first visit. At the time, this was emulated by other patients we observed touched by your specialized and quality standard of skin cancer treatment. By the way, your entire staff is clearly a reflection of your high patient care values, natural respect and compassion. Team work and your leadership at its best!

Keep up that remarkable work you do for all your patients. The high regard your medical peers have for you is well earned and deserved!

Na Zdorovlya!

RMH/



PRELIMINARY, NOT FOR CONSTRUCTION, RECORDING PURPOSES, OR
11/28/2018 10:00:53 AM

ACI BOLAND ARCHITECTS

CIVIL CONSULTANT

STRUCTURAL CONSULTANT

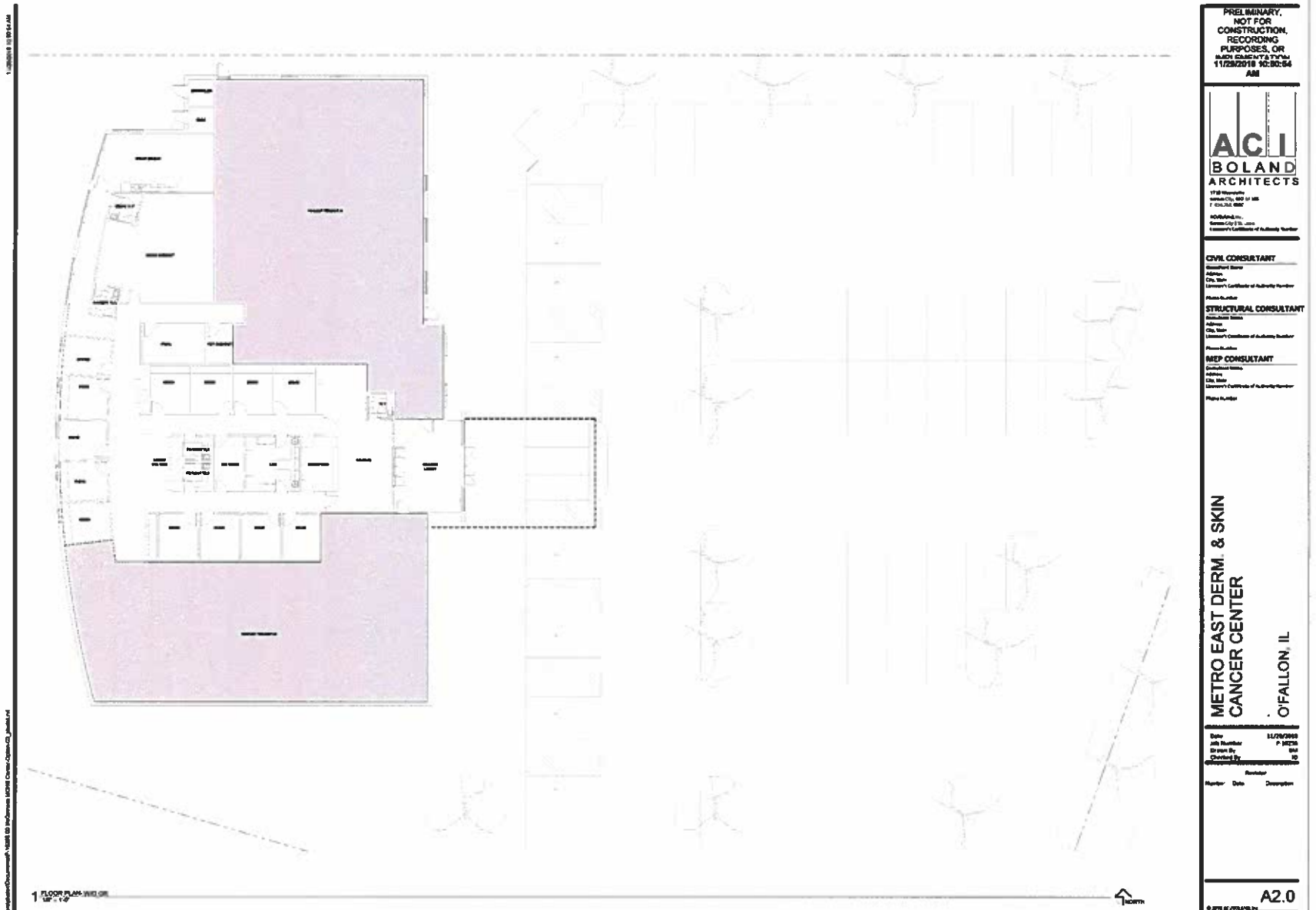
MEP CONSULTANT

METRO EAST DERM. & SKIN CANCER CENTER

O'FALLON, IL

A1.0

SITE PLAN



PRELIMINARY, NOT FOR CONSTRUCTION, RECORDING PURPOSES, OR
11/26/2018 10:30:54 AM

ACI BOLAND ARCHITECTS

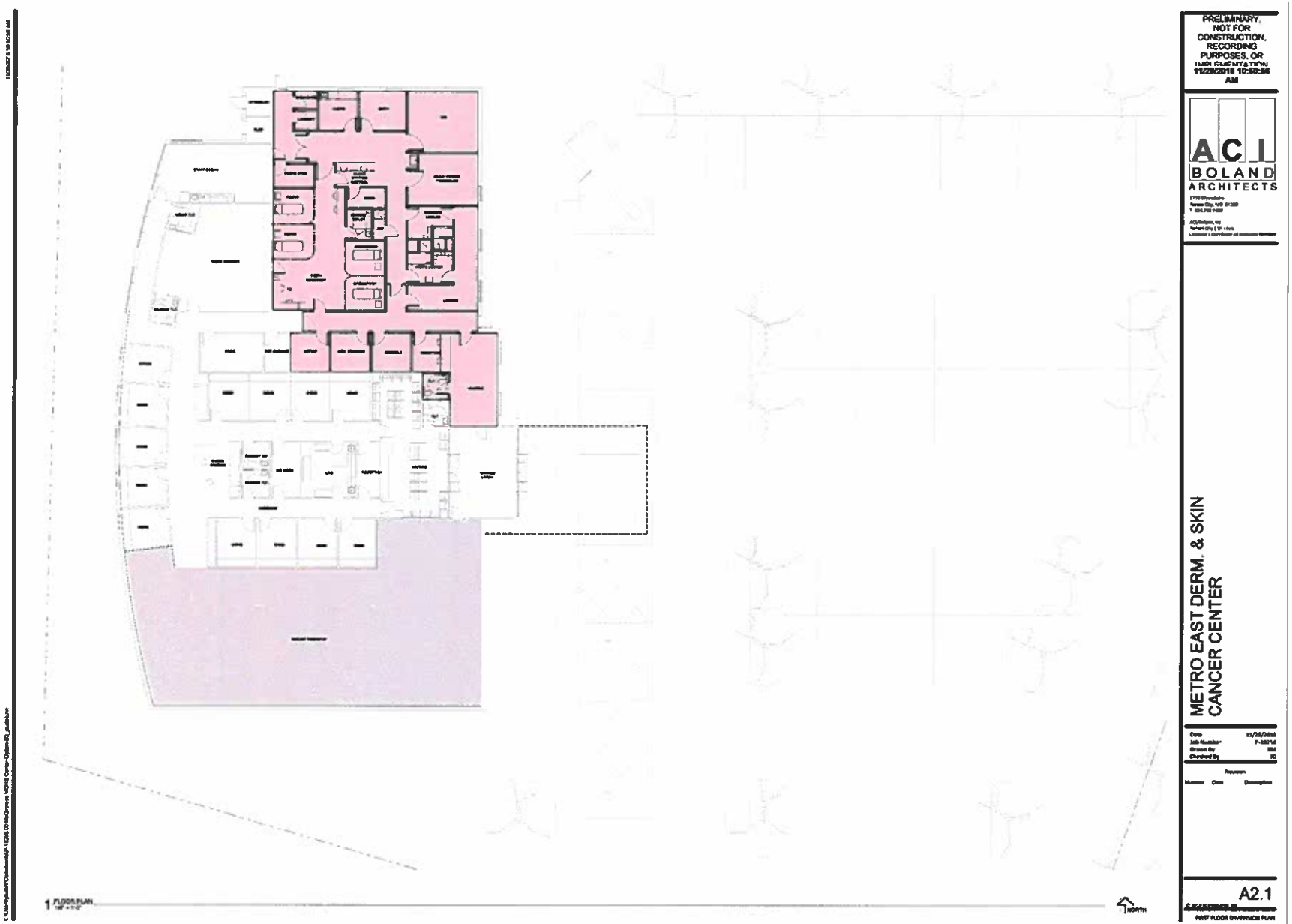
CIVIL CONSULTANT

STRUCTURAL CONSULTANT

MEP CONSULTANT

METRO EAST DERM. & SKIN CANCER CENTER
O'FALLON, IL

A2.0
OVERALL FLOOR PLAN


PRELIMINARY, NOT FOR CONSTRUCTION, RECORDING PURPOSES, OR
11/28/2018 10:50:56 AM
ACI
BOLAND
ARCHITECTS
METRO EAST DERM. & SKIN
CANCER CENTER
A2.1
1
NORTH

Project Costs and Sources of Funds (Under development)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	8,800	2,200	11,000
Site Survey and Soil Investigation	4,000	1,000	5,000
Site Preparation	- 0 -	246,000	- 0 -
Off Site Work	- 0 -	- 0 -	- 0 -
New Construction Contracts	- 0 -	- 0 -	- 0 -
Modernization Contracts	745,000	- 0 -	745,000
Contingencies	80,000	10,000	90,000
Architectural/Engineering Fees	42,400	1,000	43,400
Consulting and Other Fees	49,000	1,000	50,000
Movable or Other Equipment (not in construction contracts)	40,000	10,000	50,000
Bond Issuance Expense (project related)	15,000	3,000	18,000
Net Interest Expense During Construction (project related)	34,000	8,000	42,000
Fair Market Value of Leased Space or Equipment	- 0 -	- 0 -	- 0 -
Other Costs To Be Capitalized	2,500	500	3,000
Acquisition of Building or Other Property (excluding land)	- 0 -	- 0 -	- 0 -
TOTAL USES OF FUNDS	1,020,700	282,700	1,303,400
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages (Construction Loan) *	1,020,700	282,700	1,303,400
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	1,020,700	282,700	1,303,400
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

* To be converted to a mortgage when the project is complete

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ $20,000.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☒ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): June 17, 2021

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☒ Cancer Registry
☐ APORS *
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☐ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

* Not Applicable; proposed establishment of a new ASTC

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.[1]**	**Modernized[2]**	**As Is**	**Vacated Space**
ASTC*	1,020,700	0	4,068	0	1,020,700	0	0
NON REVIEWABLE							
Parking / Site Devl	282,700	0	0	282,700	0	0	0
Total Non-clinical	282,700						
TOTAL	**1,303,400**	**0**	**0**	**282,700**	**1,020,700**	**0**	**0**

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* Sized to meet Illinois Licensing and CoPs criteria (Medicare)

[1] Parking and related site development costs

[2] "Modernization" or Completion / finishing of shelled area in the MOB

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: NA		**CITY: NA**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

(Not Applicable; Proposed establishment of an ASTC)

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Skin Cancer Surgery Center, LLC * **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

Jamie L. McGinness, MD
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26 day of March

Signature of Notary

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

SIGNATURE

Jackie McGinness, FNP
PRINTED NAME

Secretary/Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26 day of March

Signature of Notary

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

*Insert the EXACT legal name of the applicant

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

Attachments

Attachment 1

Applicant Ownership Information

Jamie L. McGinness, M.D. is the sole corporate member of McGinness Properties, LLC., the owner of the subject private practice MOB which contains unfinished area to be modernized for the non-hospital based ambulatory surgery center ASTC) to be known as the Skin Cancer Surgery Center, LLC.

Dr. McGinness will own, operate, manage, and control the subject ASTC in support of his office-based private medical practice.

The Skin Cancer Surgery Center, LLC will apply for and hold an ASTC license from the Illinois Department of Public Health (IDPH. Additionally, a Certificate of Good Standing is attached for the Skin Cancer Surgery Center, LLC.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Jamie L. McGinness, MD / McGinness Properties, LLC
Street Address: 1911 Fortune Blvd., Suite 2
City and Zip Code: Shiloh, Illinois 62269
Name of Registered Agent: Christopher W. Bryon
Registered Agent Street Address: 411 Saint Louis Street
Registered Agent City and Zip Code: Edwardsville, Illinois 62025-1907
Name of Chief Executive Officer: Jamie L. McGinness, MD
CEO Street Address: 1911 Fortune Blvd., Suite 2
CEO City and Zip Code: Shiloh, Illinois 62269
CEO Telephone Number: 618-622-7546

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 0727804-7

STATE OF ILLINOIS

OFFICE OF

THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SKIN CANCER SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 11, 2018, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

SEAL OF THE STATE OF ILLINOIS

AUG. 26TH 1818

Authentication #: 1902200604 verifiable until 01/22/2020

Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 22ND *day of* JANUARY *A.D.* 2019 .

Jesse White

SECRETARY OF STATE

Form LLC-5.5	Illinois Limited Liability Company Act Articles of Organization	FILE # 07278047
Secretary of State Jesse White Department of Business Services Limited Liability Division www.cyberdriveillinois.com	Filing Fee: $150 Approved By: TLB	FILED OCT 11 2018 Jesse White Secretary of State

1. Limited Liability Company Name: SKIN CANCER SURGERY CENTER, LLC

2. Address of Principal Place of Business where records of the company will be kept:
1191 FORTUNE BLVD, SUITE 2

SHILOH, IL 62269

3. The Limited Liability Company has one or more members on the filing date.

4. Registered Agent's Name and Registered Office Address:

CHRISTOPHER W. BYRON
411 SAINT LOUIS ST
EDWARDSVILLE, IL 62025-1907

5. Purpose for which the Limited Liability Company is organized:
"The transaction of any or all lawful business for which Limited Liability Companies may be organized under this Act."

6. The LLC is to have perpetual existence.

7. Name and business addresses of all the managers and any member having the authority of manager:

MCGUINNESS JAMIE
1191 FORTUNE BLVD SUITE 2
SHILOH, IL 62269

8. **Name and Address of Organizer**
I affirm, under penalties of perjury, having authority to sign hereto, that these Articles of Organization are to the best of my knowledge and belief, true, correct and complete.

Dated: OCTOBER 11, 2018

CHRISTOPHER W. BYRON
411 SAINT LOUIS ST
EDWARDSVILLE, IL 62025

This document was generated electronically at www.cyberdriveillinois.com

Attachment 2

Applicant Site Ownership Information

Jamie L. McGinness, M.D. is the sole corporate member of McGinness Properties, LLC., the owner of the subject private practice MOB which contains unfinished area to be modernized for the non-hospital based ambulatory surgery center ASTC) to be known as the Skin Cancer Surgery Center, LLC.

Dr. McGinness will own, operate, manage, and control the subject ASTC in support of his office-based private medical practice.

The Skin Cancer Surgery Center, LLC will apply for and hold an ASTC license from the Illinois Department of Public Health (IDPH). Additionally, a Certificate of Good Standing is attached for the Skin Cancer Surgery Center, LLC. (See Attachment 1, herein)

Dr. McGinness' current practice location address is 1911 Fortune Blvd., Shiloh, Illinois 62269. His practice will be relocating to 331 Regency Park Drive, O'Fallon, Illinois 62269, the location of the proposed Skin Cancer Surgery Center, LLC (ASTC).

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: McGinness Properties LLC
Address of Site Owner: 1911 Fortune Blvd., Suite 2 Shiloh, Illinois 62269
Street Address or Legal Description of the Site:331 Regency Park Drive, O'Fallon, Illinois 62269 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 2

Applicant Site Ownership Attestation

My name is Jamie L. McGinness, M.D. As the sole corporate member of McGinness Properties, LLC. I attest that this respective LLC owns the property known as 331 Regency Park Drive, O'Fallon, Illinois, 62269. McGinness Properties, LLC, proposes to plan, design, construct, and develop a private physician medical office building on the subject property. The respective MOB, to be developed on this site, will contain shell space that will be modernized to accommodate the proposed non-hospital based ambulatory surgical treatment center to be known as the "Skin Cancer Surgery Center, LLC".

Having personal knowledge of the facts attested to, in this sworn affidavit, I attest that all matters herein are truthful to the best of my knowledge and belief.

Attested by: _____

Jamie L. McGinness, M.D.
McGinness Properties, LLC.

Notarization:

Subscribed and sworn to before me
this 26 day of March

Jenna Condron
Signature of Notary

Jenna Condron
Printed Name

Seal

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

Form **LLC-5.5**	Illinois Limited Liability Company Act **Articles of Organization**	FILE # 07278047
Secretary of State Jesse White Department of Business Services Limited Liability Division www.cyberdriveillinois.com	**Filing Fee:** $150 **Approved By:** TLB	**FILED** **OCT 11 2018** **Jesse White** **Secretary of State**

1. Limited Liability Company Name: SKIN CANCER SURGERY CENTER, LLC

2. Address of Principal Place of Business where records of the company will be kept:
1191 FORTUNE BLVD, SUITE 2

SHILOH, IL 62269

3. The Limited Liability Company has one or more members on the filing date.

4. Registered Agent's Name and Registered Office Address:

CHRISTOPHER W. BYRON
411 SAINT LOUIS ST
EDWARDSVILLE, IL 62025-1907

5. Purpose for which the Limited Liability Company is organized:
"The transaction of any or all lawful business for which Limited Liability Companies may be organized under this Act."

6. The LLC is to have perpetual existence.

7. Name and business addresses of all the managers and any member having the authority of manager:

MCGINNESS, JAMIE
1191 FORTUNE BLVD. SUITE 2
SHILOH, IL 62269

8. **Name and Address of Organizer**
I affirm, under penalties of perjury, having authority to sign hereto, that these Articles of Organization are to the best of my knowledge and belief, true, correct and complete.

Dated: OCTOBER 11, 2018

CHRISTOPHER W. BYRON
411 SAINT LOUIS ST
EDWARDSVILLE, IL 62025

This document was generated electronically at www.cyberdriveillinois.com

ATTORNEYS' TITLE GUARANTY FUND, INC.

ATG® COMMITMENT FORM – SCHEDULE A

Transaction Identification Data for reference only:

Commitment No.: 180470200106
Issuing Agent: Edwardsville Title & Escrow, LLC
Issuing Office's ALTA® Registry ID:
Property Address: 300 Regency Park, O'Fallon, IL 62269
ATG licenses: Illinois: TU.0000002 Wisconsin: 000-51560

1. Commitment Date: November 15, 2018
2. Policy or policies to be issued:
   a. [X] 2006 ALTA Owner's Policy
      Proposed Insured: Jamie McGinness
      Proposed Policy Amount: $816,750.00
   b. [ ] 2006 ALTA Loan Policy
      Proposed Insured:
      Proposed Policy Amount: To Come
3. The estate or interest in the Land described or referred to in this Commitment: is a Fee Simple
4. The Title is, at the Commitment Date, vested in:
   Darrell G. Shelton, Trustee of the Darrell G. Shelton Revocable Trust dated December 4, 1997
5. The Land is described as follows:

PART OF THE NORTHEAST QUARTER OF SECTION 36, TOWNSHIP 2 NORTH, RANGE 8 WEST OF THE THIRD PRINCIPAL MERIDIAN, ST CLAIR COUNTY, ILLINOIS, DESCRIBED AS FOLLOWS

COMMENCING AT THE NORTHEAST CORNER OF SAID NORTHEAST QUARTER OF SECTION 36, THENCE, NORTH 89 DEGREES 33 MINUTES 15 SECONDS WEST, (BEARING ASSUMED), ALONG THE NORTH LINE OF SAID NORTHEAST QUARTER OF SECTION 36, 1857 35 FEET, THENCE, NORTH 00 DEGREES 10 MINUTES 48 SECONDS WEST, COLLINEAR WITH THE EAST LINE OF GLENVIEW SUBDIVISION AS RECORDED IN PLAT BOOK 2, PAGE 34, OF THE ST CLAIR COUNTY, ILLINOIS RECORDS, 25 00 FEET TO THE SOUTH LINE OF CARR STREET, THENCE, NORTH 89 DEGREES 33 MINUTES 15 SECONDS WEST, PARALLEL WITH AND 25 FEET NORTH OF SAID NORTH LINE OF THE NORTHEAST QUARTER OF SECTION 36, 783 60 FEET TO THE EAST R O W LINE OF F A I ROUTE 64, THENCE ALONG SAID EAST R O W LINE AS FOLLOWS SOUTH 30 DEGREES 21 MINUTES 34 SECONDS EAST, 58 21 FEET, SOUTH 89 DEGREES 33 MINUTES 15 SECONDS EAST, 11 25 FEET, SOUTH 30 DEGREES 25 MINUTES 36 SECONDS EAST, 282 20 FEET, SOUTH 59 DEGREES 38 MINUTES 26 SECONDS WEST, 10 00 FEET, SOUTH 30 DEGREES 25 MINUTES 36 SECONDS EAST, 667 26 FEET TO THE POINT OF BEGINNING, THENCE, CONTINUING SOUTH 30 DEGREES 25 MINUTES 36 SECONDS EAST, 232 74 FEET, NORTH 59 DEGREES 38 MINUTES 26 SECONDS EAST, 15 00 FEET, SOUTH 30

Edwardsville Title & Escrow, LLC
411 St. Louis Street
Edwardsville, IL 62025
618-655-0600

4702
Member No.

Signature of Member or Authorized Signatory

DEGREES 25 MINUTES 36 SECONDS EAST, 336 78 FEET TO A POINT ON THE SOUTH LINE OF THE NORTHWEST QUARTER OF SAID NORTHEAST QUARTER, THENCE, SOUTH 89 DEGREES 36 MINUTES 32 SECONDS EAST, ALONG SAID SOUTH LINE, 276 17 FEET, THENCE, ALONG A CURVE HAVING A RADIUS POINT TO THE EAST, A RADIAL DISTANCE OF 330 00 FEET, A CHORD BEARING, NORTH 16 DEGREES 30 MINUTES 59 SECONDS WEST, AND A CHORD DISTANCE OF 53 96 FEET, THENCE, NORTH 11 DEGREES 49 MINUTES 36 SECONDS WEST, 461 51 FEET, THENCE, ALONG A CURVE HAVING A RADIUS POINT TO THE WEST, A RADIAL DISTANCE OF 300 00 FEET, A CHORD BEARING, NORTH 21 DEGREES 07 MINUTES 36 SECONDS WEST, A CHORD DISTANCE OF 96 96 FEET, THENCE, NORTH 30 DEGREES 25 MINUTES 36 SECONDS WEST, 125 55 FEET, THENCE, SOUTH 59 DEGREES 34 MINUTES 24 SECONDS WEST, 428 02 FEET TO THE POINT OF BEGINNING

EXCEPT ANY INTEREST IN THE COAL, OIL, GAS AND OTHER MINERALS UNDERLYING THE LAND WHICH HAVE BEEN HERETOFORE CONVEYED OR RESERVED IN PRIOR CONVEYANCES, AND ALL RIGHTS AND EASEMENTS IN FAVOR OF THE ESTATE OF SAID COAL, OIL, GAS AND OTHER MINERALS, IF ANY

SITUATED IN ST CLAIR COUNTY, ILLINOIS

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Operating Identity/Licensee (When completed; new facility)
[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Skin Cancer Surgery Center, LLC (See also Attachment 1 herein)

Address: 331 Regency Park Drive, O'Fallon, Illinois 62269

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 0727804-7

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

SKIN CANCER SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 11, 2018, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 22ND *day of* JANUARY *A.D.* 2019 .

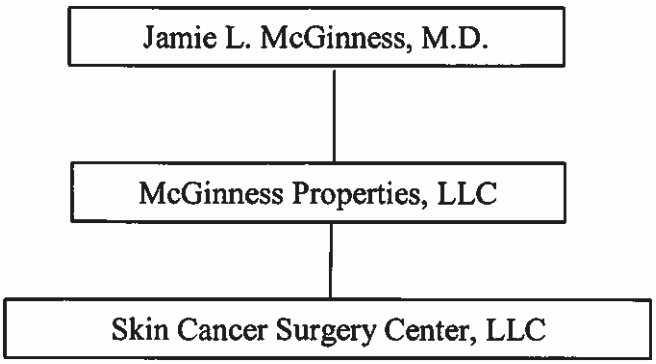
Authentication # 1902200604 verifiable until 01/22/2020
Authenticate at http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.


Jamie L. McGinness, M.D.
McGinness Properties, LLC
Skin Cancer Surgery Center, LLC

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (**http://www.hfsrb.illinois.gov**).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See Attached

- Attestation Statement
- Flood Plain Map

Attachment 5

Flood Plain Attestation

My name is Jamie L. McGinness, M.D. As the sole corporate member of McGinness Properties, LLC, I attest , to the best of my knowledge, the property known as 331 Regency Park Drive, O'Fallon, Illinois, 62269, is not in a flood plain and the location of the proposed Skin Cancer Surgery Center, LLC., complies with the Flood Plain Rule under Illinois Executive Order #2006-5.

Attested by: _____

Jamie L. McGinness, M.D.
McGinness Properties, LLC.

Notarization:

Subscribed and sworn to before me
this 26 day of March

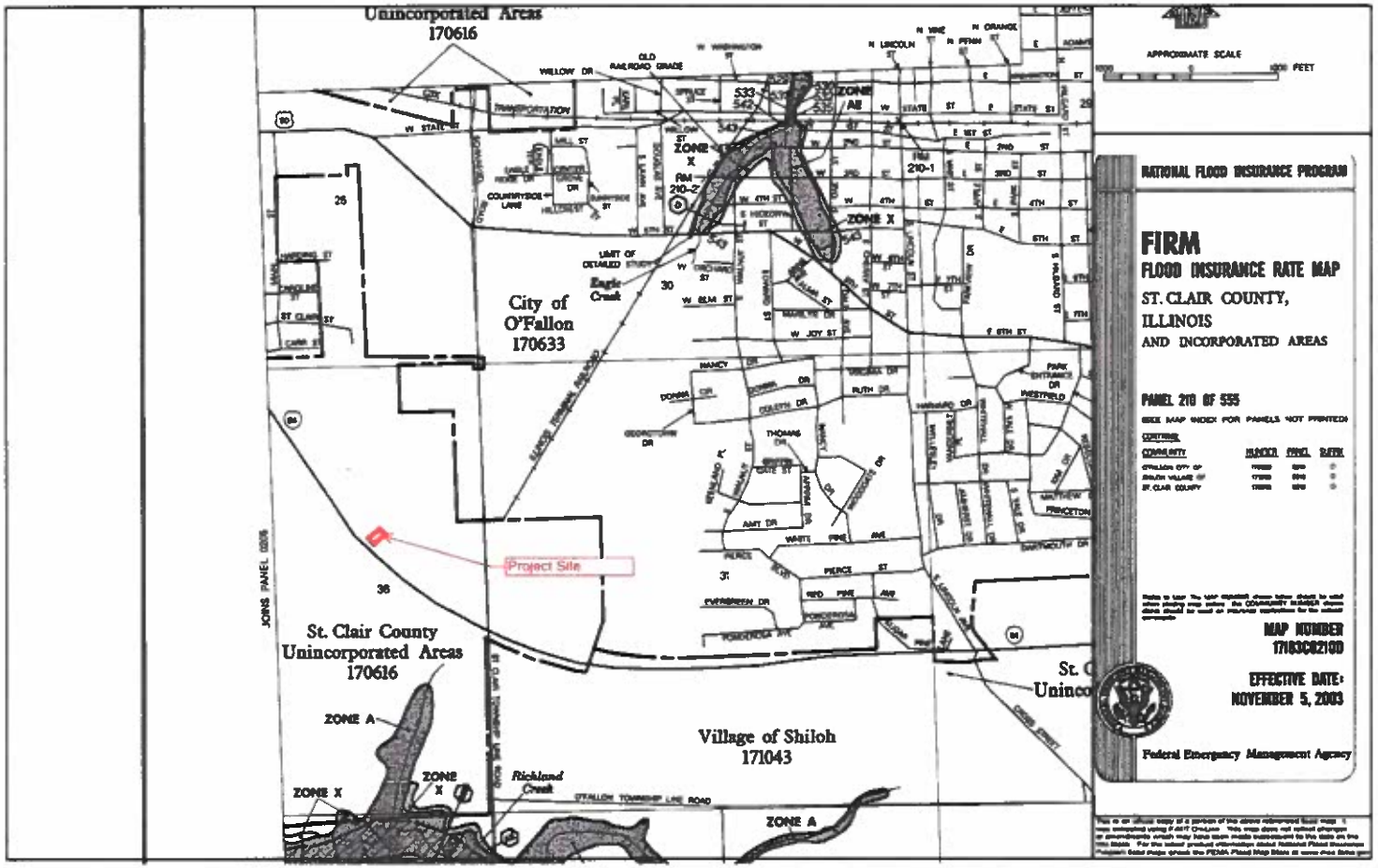
_____
Signature of Notary

Jenna Condron
Printed Name

Seal

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022


Unincorporated Areas
170616
City of
O'Fallon
170633
Eagle
Creek
Project Site
St. Clair County
Unincorporated Areas
170616
Village of Shiloh
171043
Richland
Creek
ZONE A
ZONE X
ZONE AE
ZONE X
ZONE A
NATIONAL FLOOD INSURANCE PROGRAM
FIRM
FLOOD INSURANCE RATE MAP
ST. CLAIR COUNTY,
ILLINOIS
AND INCORPORATED AREAS
PANEL 210 OF 535
MAP NUMBER
17163C0210D
EFFECTIVE DATE:
NOVEMBER 5, 2003
Federal Emergency Management Agency

Historic Resources Preservation Act Requirements
[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.
APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See following letter dated November 9, 2018 indicating required compliance with the Illinois Historic Resources Preservation Act.

ILLINOIS

Illinois Department of Natural Resources

One Natural Resources Way · Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Bruce Rauner, Governor
Wayne A. Rosenthal, Director

St. Clair County
O'Fallon
300 Block of Regency Park, Section 36,Township 2N Range 6W
IEPA
New construction, Office building

PLEASE REFER TO: SHPO LOG #002101518

November 9, 2018

Trinity Lopez
Millennia Professional Services of IL, Ltd
11 Executive Drive, Suite 12
Fairview Heights, IL 62208

Dear Ms. Lopez,

The Illinois State Historic Preservation Office is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural or archaeological resources are located within the proposed project area.

According to the information you have provided concerning your proposed project, apparently there is no federal involvement in your project. However, please note that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits, use federal property, or involve assistance from a federal agency, then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This clearance remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the IL Human Skeletal Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

If further assistance is needed please contact Jeff Kruchten, Chief Archaeologist at 217/785-1279 or Jeffery.Kruchten@illinois.gov.

Sincerely,

Robert F. Appleman
Deputy State Historic
Preservation Officer

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	8,800	2,200	11,000
Site Survey and Soil Investigation	4,000	1,000	5,000
Site Preparation	- 0 -	246,000	- 0 -
Off Site Work	- 0 -	- 0 -	- 0 -
New Construction Contracts	- 0 -	- 0 -	- 0 -
Modernization Contracts	745,000	- 0 -	745,000
Contingencies	80,000	10,000	90,000
Architectural/Engineering Fees	42,400	1,000	43,400
Consulting and Other Fees	49,000	1,000	50,000
Movable or Other Equipment (not in construction contracts)	40,000	10,000	50,000
Bond Issuance Expense (project related)	15,000	3,000	18,000
Net Interest Expense During Construction (project related)	34,000	8,000	42,000
Fair Market Value of Leased Space or Equipment	- 0 -	- 0 -	- 0 -
Other Costs To Be Capitalized	2,500	500	3,000
Acquisition of Building or Other Property (excluding land)	- 0 -	- 0 -	- 0 -
TOTAL USES OF FUNDS	1,020,700	282,700	1,303,400
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages (Construction Loan) *	1,020,700	282,700	1,303,400
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	1,020,700	282,700	1,303,400
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

* To be converted to a mortgage when the project is complete

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

- ☐ None or not applicable
- ☒ Preliminary
- ☐ Schematics
- ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): June 17, 2021

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

- ☐ Purchase orders, leases or contracts pertaining to the project have been executed.
- ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
- ☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Please see following page for the detail.

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.[1]	Modernized[2]	As Is	Vacated Space
ASTC*	1,020,700	0	4,068	0	1,020,700	0	0
NON REVIEWABLE							
Parking / Site Devl	282,700	0	0	282,700		0	0
Total Non-clinical	282,700						
TOTAL	1,303,400	0	0	282,700	1,020,700	0	0

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* Sized to meet Illinois Licensing and CoPs criteria (Medicare)

[1] Parking and related site development costs

[2] "Modernization" or Completion / finishing of shelled area in the MOB

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

(See Appendix A; Dr. McGinness's Resume)

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110 (A) Applicant Background

1. This criteria is not-applicable. The applicant, Jamie L. McGinness, MD, is the sole corporate member of "Skin Cancer Surgery Center, LLC," a newly formed corporation which will own and operate the proposed single-specialty single room ASTC, when established, post State Agency approval(see also Attachments 1 and 2, herein) . No other health care facilities are owned or operated by the applicant or its officers.

2. See the foregoing response, above; the proposed new ASTC requires State Agency approval to be developed and operated, once licensed by IDPH "establishment" will occur. There are no other owners.

3. a. No adverse actions have been taken against the applicant.

3. b. There are no incidences to report or certify with respect to this criteria.

3. c. There are no incidences to report or certify with respect to this criteria.

3. d. There are no incidences to report or certify with respect to this criteria.

3. e. There are no incidences to report or certify with respect to this criteria.

4. See the included attestation letter which follows pertinent to Criterion 1110.110 (a)

5. Not Applicable

Attestation Statement (draft)
Attachment 11
Criterion 1110.110 (a) (1) (2) (3) (4)

My name is Jamie L. McGinness, MD, President and Sole Corporate Member of the Skin Cancer Surgery Center, LLC., a newly formed Illinois Limited Liability Corporation which proposes to establish a limited specialty, single-room ASTC in O'Fallon, Illinois. I certify and attest to the following relevant to establishing the proposed non-hospital based Ambulatory Surgery Center (ASTC) Category of Service in response to the Illinois Health Facilities and Services Review Board (State Agency) criterion 1110.110 (a) (1) (2) (3) (4).

1. The applicant does not own or operate any other health care facilities, as defined by the State Agency.
2. There have been no adverse actions taken against the applicant or its officers during the three (3) years prior to filing this specific permit application which proposed to "establish" an ASTC
3. The Skin Cancer Surgery Center, LLC and its sole corporate member, Jamie L. McGinness, MD authorizes the Illinois Department of Public Health (IDPH) and the Illinois Health Facilities and Services Review Board (IHFSRB) to access any documents necessary to verify the information submitted, including, but not limited to, official records of the DPH or other State Agencies; the licensing and certifications of other states, where applicable, and the records of nationally recognized accreditation organizations.

Attested by: _____
Jamie L. McGinness, MD

Notarization:

Subscribed and sworn to before me
this 26 day of March

_____
Signature of Notary

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

Criterion 1110.110 (b) & (d)

Project Purpose

1. To the applicants best knowledge there are no other Board Certified Mohs/MMS surgeons in the defined Geographic Service Area (GSA) nor is there a licensed ASTC whose specialty is skin cancer treatment within the GSA (IDPH).

   More individuals are diagnosed with skin cancer in the United States than all other cancers combined. (Source: Cancer Facts and Figures, 2018, American Cancer Society) Through "establishing" the proposed Skin Cancer Surgery Center, LLC single-specialty ASTC, this new service, by definition, will improve health care within the market. (See also Attachment 24)

2. The primary and secondary geographic service areas are defined in Attachment 24. Based on Dr. McGinness' current regional patient origin, it is primarily HSA XI, Planning Area F-01.

3. Mohs/MMS Surgery has several components unique to the respective procedure as identified in Appendices B through F, inclusive, herein. Some portions of the Mohs surgical process are conducted in the office-based setting. However, lesions with infiltrate horizontally require reconstruction which is best performed in the ASTC setting to ensure the highest quality level with respect to environmental conditions, in particular, sterility to mitigate any potential infections. Thus, the problem to be resolved is to provide an optimal surgical setting to perform reconstruction, post MMD procedures which remove the cancerous lesion. An ASTC meets this requirement.

4. Documentation is provided in Appendices B, through G, inclusive from such sources as, Mayo Clinic, American College of Mohs Surgery, and AMA, (Medicare Population).

5. The project will improve care by providing an optimal surgery setting for reconstruction procedures as required by select Mohs/MMS surgical procedures which require both a physician office setting and surgical suite setting (Appendices C, D, and E)

6. The applicants over-arching goal is to provide optimal services and an optimal setting for those skin cancer patients serviced by Dr. McGinness's private practice which focuses primarily on skin cancer. To the best of his knowledge, he is the only Board Certified Mohs physician within the defined planning area

7. The proposed project with finish or "modernize" a shelled area in a newly constructed MOB at 331 Regency Park Drive, O'Fallon, Illinois, 62269 which will house Dr. McGinness' private practice. As identified herein; the private practice office and separate ASTC are inextricably linked due to implementing the optimum Mohs surgical procedures. The proposed ASTC, as required by IDPH and Medicare CoPs, will be separately identifiable. Unfinished space will be "upgraded" or modernized to a surgical quality finished area to establish the subject ASTC.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Alternatives

The applicant understands the criterion as defined by the State Agency. However, the criterion requirements, in this respective case, are judged to not apply.

The proposed single-specialty, single room, ASTC; to be known as the "Skin Cancer Surgery Center, LLC", is integral to Dr. McGinness' solo private practice. As outlined by the documentation in Appendices B through E, inclusive e, one can better understand how the proposed ASTC is integral to a private specialty physician practice. Hence, there is but one alternative to consider and that is modernizing the associated shell space, contiguous to the applicants new private practice office / MOB, Metro East Dermatology and Skin Cancer Center, which is relocating from Shiloh to O'Fallon, Illinois.

As Dr. McGinness is a solo-practitioner, a joint-venture with another physician practice was not judged feasible. As well, Dr. McGinness' private practice is not hospital-based, so again, such an arrangement, including a hospital, was judged to be not feasible in the context of potential alternatives and the Mohs procedure, itself.

The project cost for the chosen alternative is estimated to be $1,303,400.00 (Attachment 7)..

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Skin Cancer Surgery Center LLC	4,068	2,750	1,328	No

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The proposed ASTC's space is required due to the fact, by IDPH licensing requirements and Medicare Conditions of Participation, the separately contained ASTC includes both required clinical and non-clinical area. (Reference 2 (d) above).

PROJECT SERVICES UTILIZATION:
This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

	UTILIZATION				
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION** *	**STATE STANDARD** **	**MEET STANDARD?** **
YEAR 1	ASTC	0	550	--	--
YEAR 2	ASTC	0	880	--	--

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* See Attachment 24

** There is no applicable standard. The current and projected utilization demonstrates or justifies the need for a single room non-hospital-based ASTC in support of Dr. McGinness's office-based specialty practice.

UNFINISHED OR SHELL SPACE:)

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Not applicable to this permit application, there is no shell space involved. See also Attachment #17 which indicates the intent to modernize shell space in an MOB to establish the proposed single specialty, single-room ASTC.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See attestation letter, which follows:

Attachment 17

Shell Space Attestation

My name is Jamie L. McGinness, M.D. The proposed non-hospital based ambulatory surgical treatment center (ASTC) will be established by modernizing unfinished area in the newly developed MOB at 331 Regency Park Drive, O'Fallon, Illinois, 62269. The ASTC will be known as the Skin Cancer Surgery Center, LLC, and it will not contain any shell space upon completion / modernization.

Attested by: _____

Jamie L. McGinness, M.D.
McGinness Properties, LLC.

Notarization:

Subscribed and sworn to before me
this 26 day of March

_____
Signature of Notary

Jenna Condron
Printed Name

Seal

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ **Cardiovascular**
☐ **Colon and Rectal Surgery**
☐ **Dermatology**
☐ **General Dentistry**
☐ **General Surgery**
☐ **Gastroenterology**
☐ **Neurological Surgery**
☐ **Nuclear Medicine**
☐ **Obstetrics/Gynecology**
☐ **Ophthalmology**
☐ **Oral/Maxillofacial Surgery**
☐ **Orthopedic Surgery**
☐ **Otolaryngology**
☐ **Pain Management**
☐ **Physical Medicine and Rehabilitation**
☐ **Plastic Surgery**
☐ **Podiatric Surgery**
☐ **Radiology**
☐ **Thoracic Surgery**
☐ **Urology**
☒ **Other** Skin Cancer Surgery Center, LLC

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service	X	(NA)
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Non-Hospital Based

Ambulatory Surgery Section

1110.235

Introduction

Mohs Micrographic Surgery was originally developed in the 1930s and has been refined into the most advanced, precise, and effective treatment for an increasing variety of skin cancer types. Using Mohs surgery, physicians can accurately and precisely identify and remove an entire tumor while leaving surrounding healthy tissue unharmed. Mohs surgery offers the highest cure rates of any treatment approaching 99% for basal cell carcinomas. This complex procedure is considered the gold standard of care for treating high-risk non-melanoma skin cancers. "Mohs Micrographic Surgery (MMS) has the highest cure rates, spares the maximum amount of normal tissue, and is cost-effective in the treatment of cutaneous malignancies". (Source: Mayo Clinic Proceedings, August 2017) (See also Appendix B)

For patients who have had a cutaneous growth removed, reconstructive surgical procedures performed by Mohs surgeons provide a way to regain functional structures and aesthetic appearances that may have been compromised during removal of a cancerous or benign growth. Advanced reconstructive techniques to repair surgical defects may be required based on the location and depth of the removed growth, the amount of removed skin, and/or the lack of adjacent skin available (i.e. nose, mouth, ear), to close a defect. In these latter cases, skin grafts, flaps, or other advanced reconstructive techniques may be needed to restore both the functional and cosmetic features apparent before growth removal. (Appendices C through F, inclusive)

To ensure the highest quality care, MMS reconstruction surgery procedures are best performed in a surgical setting. (Appendices B through E, inclusive) Peer reviewed surgical centers can offer a higher quality of care and a higher standard for surgical procedures for patients. Therefore, based on underlying legislation, this CON permit application submission is to establish the proposed single specialty, single-room, Ambulatory Surgical Treatment Center (ASTC) to be known as the Skin Cancer Surgery Center, LLC, O'Fallon, Illinois.

This establishment request is primarily based on the clinical procedures associated with Mohs surgery and optimal, efficient and the high quality delivery of MMS clinical practice services. Office based practice and related procedures performed in this setting are inextricably linked to those procedures best performed in a surgical setting which, by necessity, leads to developing a contiguous physical relationship between the physician's private office, and the separately identified ASTC, for reconstructive / repair procedures.

(Note: The basic Mohs Surgery procedural steps follow, on the next page).)

The basic procedural steps are best summarized as:

Physician Office Based Setting

1. The tumor is first marked with a margin.
2. Mohs surgery then removes or debulks any obvious visible tumor.
3. A thin layer of normal tissue is then removed around this area to obtain a margin around the tumor.
4. The tissue is then removed.
5. The tissue is precisely inked and a map drawn to track exactly where residual tumor may remain.
6. In the CLIA certified laboratory within the physician's office, the tissue is embedded for horizontal sections. The sections are cut and put on slides that are stained.
7. In the CLIA certified laboratory in the physician's office, the Mohs surgeon meticulously examines 100% of the surgical margin under the microscope and maps out any remaining cancer.
8. If residual malignant tumor is noted, it is precisely mapped and the Mohs surgeon returns to the patient and removes additional tissue precisely from the involved area and the above steps are repeated until no additional tumor remains. Mohs surgery targets removal of only cancerous skin, therefore, healthy tissue is spared.
9. At this point in the process, when tumor extirpation is considered complete, the Mohs surgeon discusses reconstructive options. If possible, depending on the surgical defect, the surgical site is allowed to heal without necessitating reconstruction and the patient is discharged from the physician office setting. If reconstruction / repair is necessary due to the lesion location and/or excision depth, the patient will be directed to the self-contained ASTC setting for surgical reconstruction procedures.
10. The majority of reconstruction of Mohs surgical defects occurs on the same day as removal of the tumor in the office practice setting. The following generally outlines the ASTC setting process.

ASTC for MMS Reconstruction Setting

1. Within the ASTC setting, the patient is prepped for surgery and anesthetized with the most appropriate anesthetic which is typically a local anesthetic.

2. The patient is transported to the surgical suite where the reconstruction procedure(s) occur.
3. The patient is recovered and discharged from the ASTC setting for follow-up in the physician office setting at a future date.

It **is** standard to have several (between 8 – 10) Mohs cases occurring simultaneously on Mohs surgical days. It **is not** typical to start and finish Mohs and reconstruction on a single patient prior to starting an additional case. All cases are started early and sequentially. As first layers of cancerous tissue are removed, patients are bandaged and wait in a sub-waiting room for results. Several patients typically wait for results at the same time. If further tissue removal is necessary, the individual patient is re-prepped and anesthetized for further excisions. This process could be occurring simultaneously while another patient, deemed clear of tumor, is being prepped for closure. This allows the physician to remove additional tissue and prepare it in the histopathological lab and then immediately return to the ASTC to prep, repair, and discharge a patient and then return back to the office setting to continue examining microscopically removed tissue from other patients. This integral, efficient, and unique clinical delivery process, demonstrates the necessity of physically locating the physician office practice adjacent to the self-contained ASTC practice component, not only for the highest quality patient care, but also to optimize care delivery, efficiency, and convenience for the patient.

Section 1110.235 Non Hospital-Based Ambulatory Surgical Treatment Center Services

a) Projects not Subject to this Section

This permit application is not a hospital project and is not subject to the Illinois Hospital Licensing Act. Once approved, the proposed single-specialty ASTC will require an ASTC license to operate which will be issued by IDPH

b) Recognition (b) (1) (2) (3) (4)

This permit application seeks authorization to "establish" a new single-specialty, single-room ASTC (Skin Cancer Surgery Center, LLC) for MMS reconstruction surgery procedures integral with, yet self-contained as required by various regulations, a private physician office practice (Metro East Dermatology and Skin Cancer Center). Hence, there are no existing services to be recognized.

c) Review Criteria

1) Introduction

A) This permit application is being submitted to comply with this requirement. It seeks approval to establish a non-hospital based single-specialty, single-room ASTC integral with a private physician office.

B) This permit application, if approved by the State Agency, will establish a new single-specialty, single-room, separately identifiable ASTC contiguous to, and integrated, with a private physicians' office practice. (Skin Cancer Surgery Center, LLC)

Hence, a CON permit is being requested as required by statute. The facility, once approved, will be non-hospital based and a component of a physician's private office.

C) Required Review Criteria (Establishment)

The "establishment" review criteria will be addressed herein (Attachment 24) as follows:

D) Applicant Indications

i) Services

The proposed ASTC services will include those procedures associated with Mohs / MMS reconstructive surgery which embraces general, plastic, and dermatologic surgical techniques. However, the applicant requests approval for single specialty recognition as indicated in the permit request narrative which most likely falls under the "Other" category (Section 1110, Appendix A, ASTC Services)

ii) Rooms

One (1) operating room (OR) is being proposed in the single room, single specialty Mohs surgery reconstruction ASTC (Skin Cancer Surgery Center, LLC). This single room is justified based on Dr. McGinness's historical clinical practice utilization.

iii) Unspecified Services

Please reference D i and ii, above in compliance with this criteria.
Dr. McGinness is a Board-Certified dermatologist with sub-specialties in dermatologic surgery and dermatopathology. He is licensed as a physician and surgeon in Illinois (License # 036124865). The proposed non-hospital based ASTC will have one (1) operating room. (See Appendix A for his résumé).

E) Transition Period

Not applicable; this permit application proposes to establish a new, non-hospital based ASTC. Hence, there is no transition to document.

F) Sanctions and Penalties

Not applicable in that there is no ASTC established at this point.

2) Geographic Service Area Need (Formula Calculation)

A) The State Agency has no formula need determination for the number of ASTC's or the number of surgical / treatment rooms in a particular geographic area. Need will be established as outlined in Attachment 24.

B) Service to Geographic Service Area Residents (GSA)((c) (2) (B) (i) + (ii)

Dr. McGinness, a solo practitioner, moved his practice from Springfield, Illinois, to the O'Fallon / Shiloh Illinois region in September 2017. He currently does Mohs 3 - days per week and excisions and clinic 2 - days per week. He also has a nurse practitioner who sees patients. In the first full operational year (2018), the practice had a total of 4,004 distinct patients (Table A) which follows on the next page, associated with 6,320 patient encounters. The first stage of Mohs surgery was billed out 1,101 times (patient encounters) (practice records) and the subsequent stages were billed 325 times (patient encounters). When put together this was 1,426 times a Mohs stage procedure was performed in the first operational year. The surgical repairs performed in his practice for both standard excisions and Mohs cases were as follows: 941 intermediate layered closures, 185 complex layered closures, 89 flaps, 92 grafts, and 19 cartilage grafts for a total of 1,326 surgical repairs optimally performed in an ASTC vs office practice environment. If put together this equates to 2,752 surgical procedures performed (practice data).

The patients primarily originated in HSA XI as identified in Table A, which follows herein. The practices' patient origin primarily encompasses the counties defined by HSA XI including the counties of St. Clair, Madison, Clinton and Monroe. (Table A, and Attachment 24, Exhibit B) The 21 mile radii distance criteria from the proposed ASTC location touches on portions of Bond, Washington, and Randolph Counties. The practices' patient origin is also regional with patients originating in Bond, Marion, Jefferson, Perry, Randolph, Montgomery, Macoupin, Jersey, Green, and Calhoun, (Exhibits 24-B and 24-E,) Geographic Service Areas.

As previously noted, Dr. McGinness's private practice had 4,004 distinct patients and 6,320 patient encounters in its first operational year, January 2018 through December 2018. Greater than fifty percent of these visits originated in the following geographic service area, as noted in Table A, which follows. This table is derived from Attachment 24, Exhibit 24-A.

Table A

Metro East Dermatology and Skin Cancer Center (C.Y. 2018)

Zip Code	Visits	Location (Primary City)	County
62269	603	O'Fallon	St. Clair
62221	315	Belleville/Shiloh/Rentchler	St. Clair
62226	253	Swansea/Belleville/Shiloh	St. Clair
62208	163	Fairview Heights/O'Fallon	St. Clair
62234	163	Collinsville/Others	Madison
62223	156	Belleville/Swansea/Briar Hill	St. Clair
62025	167	Edwardsville/Others	Madison
62040	139	Granite City/Others	Madison
62220	132	Belleville/Others	St. Clair
62249	155	Highland/Grantfork	Madison
62258	108	Muscotah/Fayetteville	St. Clair
62294	123	Troy/	Madison
Sub-total	2,477	(61.9%)	
Other	1,527	(38.1%)	
Grand Total	4004	(100.00%)	

Source: Practice Records

3) Service Demand – Establishment(c) (3) (A) + (B) or (C) (C not applicable in this case)

A) Historical Referrals (c) (3) (A)

Dr. McGinness currently provides the proposed Mohs surgery reconstruction procedures in his private office, in Shiloh, Illinois, which will relocate to his new private office (MOB) in O'Fallon. These procedures are currently performed in sub-optimal conditions, hence this permit application to establish a single room, single specialty ASTC with an appropriate surgical setting (ASTC) for select patients who require repair and reconstruction procedures.

There are no "referrals" to document in that his private practice is "self-contained". As such, this criterion is not applicable.

B) Projected Service Demand (c) (3) (B)

B) i) Physician referral letters are not applicable, in this instance, because Dr. McGinness will not be referring patients to others nor will other physicians utilize the proposed ASTC. The single-room, single specialty ASTC will solely support his private practice. Hence, the utilization will be based on "self-referred" MMS patients within his existing practice requiring reconstructive surgical procedures post-Mohs surgical intervention. Historical patient origin by zip code is documented in Exhibit 24-A.

B) ii) Please refer to criterion / Section 1110.235 (3) (A) Historical Referrals, above, for documentation pertaining to patient volume originating within the GSA. (Table A and Exhibit 24-A) This documentation is consistent with subsections 1110.235 (c) (2) (B).

B) iii) Historically, in the first year of Dr. McGinness' private practice in Shiloh, he performed 1,101 first stage Mohs procedures and an additional 325 second stage Mohs procedures based on internal practice data, not all of which originated in Illinois. The estimated

United States incidence of skin cancer is calculated in Exhibit 24-C and Illinois in 24-D. Skin cancer cases within the defined GSA is provided in Exhibit 24-D and indicates potentially 14,935 skin cancer cases in the primary and secondary GSA's. Based on Illinois rates and population, Exhibits 24-E, F.1, and F.2 focus on the PGSA and SGSA population. This additional analysis indicates potentially 13,026 skin cancer cases. Hence, the range is from 13,026 to 14,395 potential skin cancer cases, on the average (Exhibit 24.F.1).

B) iv) Not applicable, the proposed ASTC will solely support Dr. McGinness's private practice.

B) v) Not applicable, no external physician letters pertain to this respective CON permit application.

B) vi) In that the proposed ASTC will support Dr. McGinness' private practice, and that there have been no out-referrals since his practice was established in Shiloh, the current and anticipated utilization will not impact on any existing ASTC nor has the practice's historical utilization been documented to support another pending or approved CON permit application.

C) Projected Service Demand – Rapid Population Growth

Introduction

Not applicable to this defined GSA or ASTC Permit Application.
See Exhibit 24-E for the estimated population for both the defined Primary (PGSA) and Secondary (SGSA) geographic service areas. The total population is stable within these two geographic service areas.
(Exhibit 24-E)

4) Service Demand – Expansion of Existing ASTC Services (c) (4)

This criterion is judged to be not applicable to this specific permit application which proposes to establish a single-specialty, single operating room MMS / Mohs cancer reconstruction ASTC in support of the specialty physician practice, (Jamie L. McGinness, MD).

5) Treatment Room Need Assessment (c) (5) (A) + (B)

5) A) One procedure room is being requested based on the current historical practice experience. Hence, the anticipated 1,500 hours of use will not be exceeded based on current and projected utilization. In its first year of private practice in Shiloh, Dr. McGinness performed 1,101 first stage Mohs procedures, 50 to 80 percent of which will be eligible for reconstruction based on his practice experience and national estimates. The utilization will vary by year depending on the patient's clinical condition. Thus, the projected number of ASTC based procedures is between 550 to 880, conservatively, on an annual basis based on an estimated 4 to 7 % market share. This number is anticipated to continue to grow as Dr. McGinness's practice is new to the region and is continuing to grow.

5) B) Based on Dr. McGinness' current practice, the average amount of time varies widely depending on the extent of the tumor and related necessary reconstruction surgical procedures. Some Mohs patients will require a full-day for the Mohs procedure which requires initial excision and subsequent reconstruction. Some portion of the respective procedure will typically be done in the practice office with repair and reconstruction in the self- contained ASTC. On the average, reconstruction will require less than two (2) hours.

6) Service Accessibility (c) (6)

6) A) Not Applicable; other non-hospital based ASCT's exist in the defined GSA's but do not specialize in skin cancer reconstruction surgery. (See also Exhibit 24-G)

6) B) Not Applicable; there is excessive market capacity as noted in exhibits 24-G, H, and I. However, none are dedicated to skin cancer repair and reconstruction surgery and the reported AHQ data does not document such cases in publicly available information.

6) C) To the best of Dr. McGinness's knowledge, the applicant, he is not aware if there is another Mohs Board-Certified physician in the HSA XI or within the 21-mile defined geographic service area (GSA) within Illinois.

Hence, it is unknown if other physicians may be providing this complex cutaneous surgical intervention for skin cancer. In addition, the proposed skin cancer reconstruction ASTC is integral to Dr. McGinness' private office practice consistent with optimal MMS / Mohs procedures. (See Appendix B through E, inclusive)

6) D) Not applicable. The proposed ASTC establishment is not a joint venture.

7) Unnecessary Duplication / Maldistribution (c) (7) (A) through (C)

7) (A) (i) Total GSA Population

Exhibit 24-E profiles the estimated population for both the PGSA and SGSA for the period 2018 through 2023. The population is essentially stable with minimal population growth.

7) (A) (ii) Clinical Services

To the best of the applicant's knowledge, there are no other physicians within the defined service areas that are Board-Certified and fellowship trained to perform MMS/Mohs surgical procedures. In addition, there is no publicly available information to document or compare to the clinical skin cancer reconstruction procedures proposed for the single-room, single specialty ASTC.

7) (B) (i) Maldistribution

7) i) Operating Room Ratio

The defined GSA's have a total projected population estimated at approximately 742,242 persons (Exhibit 24-E). The number of operating rooms available in this area is 65 with 11 being in ASTC settings and 54 in hospital-based settings (Exhibits 24-G, H, and I) for a ratio of 0.088 OR's / 1,000 GSA population. The State ratio is based on 1,917 total operating rooms in ASTC and hospital settings for an Illinois ratio of 0.0059 / 1,000 population. The defined GSA ratio is then 14.92 times the state average.

7) ii) Historical Utilization

Exhibits 24-G, 24-H, and 24-I profile the historical utilization for non-hospital based ASTC's and hospital based operating room utilization within the 21-mile travel radius.

There is excess surgical capacity within the market. However, this market based capacity is not relevant when one considers the proposed ASTC is integral to the physicians' private practice. Please reference appendices B through E, inclusive, with respect to optimal MMS/Mohs surgery procedures / clinical practice. The surgery room market supply "excess" is not clinically supportive, and although theoretically "available", these existing OR's are irrelevant to Dr. McGinness' specialty and the proposed ASTC due to optimum clinical practice patterns and the necessity to integrate the subject ASTC into the office practice.

7) iii) Caseload

Exhibits 24-C, D, F.1 and F.2, derive the estimated number of skin cancer cases within the PGSA and SGSA. The total derived number is 13,026 cases of which 20 to 30 percent will conservatively require reconstruction in an ASTC environment, when appropriately treated. The estimated number is, therefore, minimally between 2,600 and 3,900 estimated ASTC-based cases, annually. Dr. McGinness' current practice, after just one operational year, estimates the practice's potential ASTC utilization to be between 550 to 880 cases based on national data and 1,326 surgical repairs based on practice data. Thus, there is sufficient population and resulting caseload to support the proposed single-room Skin Cancer Surgery Treatment Center.

7) (C) (5)(A)(B) Treatment Room Need Assessment)

7) (c) (i) (ii) Impact on Utilization

Due to the fact the proposed single room, single specialty ASTC will solely support and be associated with a current private practice based in

the Metro East Dermatology and Skin Cancer Center, as well, Dr. McGinness does not practice in any local hospital or ASTC. Hence, the utilization of other in-market providers will not be impacted in any way. He is a new specialty provider in the market and just after one operational year his practice is substantial indicating, in part, the need for this clinical specialty.

8) Staffing (c) (8) (A) + (B)A)

8) A) Availability

The current staff in the applicant's private practice office (Dr. McGinness) will be available to staff the proposed single specialty single room ASTC. These individuals, in addition to Dr. McGinness are, as of March 2019;

Individual	Profession *	License or Certificate
J.M.	R.N.	# 041419581
	NP	# 209014474
C.K.	MA	#2595250 (AMT ID)
J.H.	MA	# B3D3J5WS (NHA Certified)
E.S.	MA	# 2644586 (AMT ID)
J.M.	MA	#N2Q3R8J9 (NHA Certified)
	H.T.	Registered for certifying exam
M.G.	H.T	#11248 (ASCP Certification)
	HTL	#2343 (ASCP Certification)
A.C.	MA	Certification in process
C.H.	MA	Certification in process
J.F.	MA	Certification in process

Proposed additional staff for the new ASTC include an RN and also an ASTC Center Manager (RN)

* Note:

R.N. Registered Nurse

N.P. Nurse Practitioner

M.A. Medical Assistant

H.T. Histology Assistant

H.T.L. Histotechologist

8) Medical Director –

See Appendix A for Dr. McGinness' biography. He will be the Medical Director for the proposed ASTC.

9) Charge Commitment (c) (9)

See the following attestation statement

10) Assurances (c) (10) (A) + (B)

See the following attestation statement

Attachment 24
Charge Commitment and Assurances
Section 1110.235(c) (9) (10) (A) & (B)

My name is Jamie L. McGinness, M.D. the sole practitioner proposing to establish the non-hospital based ambulatory surgical treatment center (ASTC) to be known as the "Skin Cancer Surgery Center, LLC". As this newly proposed healthcare facility is not yet approved, established, licensed, or in operation, there are no current charges that can be stated. However, once established, the ASTC charges will be based on the then current Medicare payment rates for Ambulatory Surgery Centers (ASC), approved HCPCS codes, and payment rates. These charges will not increase for the first two (2) years of operation, except on the Medicare payment rates, at that time, may vary.

As a physician, I certify that I am Board Certified by the American Board of Dermatology (ABD) holding a sub-specialty certification in Micrographic Dermatologic Surgery (MDS). The ABD is one of twenty-four (24) medical specialty boards making up the American Board of Medical Specialties (ABMS). I further certify my intent to maintain Board Certification which includes continuing medical education (CME) credits, as well as peer review; thereby, complying with the peer review program required under this criterion.

As further outlined in this respective CON Permit Application, Section 1110.235, Attachment 24, there is sufficient annual utilization to justify one, single specialty, skin cancer surgery operating room; hence, the Section 1110, Appendix B criterion utilization standard will be met.

Attested by: _____

Jamie L. McGinness, M.D.
McGinness Properties, LLC.

Notarization:

Subscribed and sworn to before me
this 26 day of March

_____
Signature of Notary

Jenna Condron
Printed Name

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

Exhibit 24-A

Metro East Dermatology and Skin Cancer Center

C.Y 2018 Patient Origin Profile (First Operational Year)

Patient Zip	Patient Count	Patient Zip	Patient Count	Patient Zip	Patient Count
62269	603	62286	9	63105	2
62221	315	62246	8	63131	2
62226	253	62012	8	62295	2
62025	167	62239	8	62262	2
62234	163	62471	7	62022	2
62208	163	62086	7	62016	2
62223	156	62067	6	62712	2
62249	155	62255	6	62808	2
62040	139	62052	6	62814	2
62220	132	62204	6	62084	2
62294	123	62205	6	62898	2
62258	108	62888	5	62018	2
62034	83	62207	5	62817	2
62243	81	62088	5	62288	2
62225	74	62097	5	62048	2
62254	65	62268	5	62242	2
62232	58	62289	5	62890	2
62260	57	62046	5	63135	2
62062	49	62244	5	62056	2
62285	43	62274	5	63110	2
62265	43	62240	4	62846	2
62230	40	62014	4	62021	2
62298	36	62219	4	62711	2
62264	36	62872	4	63103	1
62293	31	63101	4	29579	1
62281	28	62297	4	77399	1
62257	26	62222	4	32548	1
62216	26	62816	4	46321	1
62215	26	62859	3	22407	1
62206	26	62060	3	62704	1
62231	24	62201	3	34241	1
62864	23	62881	3	63123	1
62010	23	62803	3	63304	1
62236	23	62882	3	63129	1
62002	21	62812	3	62221-4603	1
62263	21	62870	3	62293-1752	1
62801	18	62884	3	65202-5474	1
62001	18	62810	3	56401	1
62095	17	62277	3	63664	1
62278	16	62895	3	62959	1
62061	14	62253	3	34974	1
62035	13	62685	3	62907	1
62245	13	62218	3	62924	1
62271	13	62292	3	47112	1
62275	12	63031	3	63119	1
62024	11	62047	3	62837	1
62237	11	62037	3	63401	1
62203	11	62087	3	62243-4045	1
62214	10	62074	3	63044	1

Exhibit 24-A (Continued)

Metro East Dermatology and Skin Cancer Center

C.Y 2018 Patient Origin Profile (First Operational Year)

Patient Zip	Patient Count	Patient Zip	Patient Count
622856222	1	62221-3477	1
62893	1	63017-8053	1
62273	1	62269-1813	1
62807	1	62234-2945	1
43055	1	63010-4108	1
62626	1	60610-3072	1
62896	1	62254-2336	1
62250	1	62889	1
62034-1223	1	62891	1
62298-1121	1	62265-1931	1
62231-2244	1	62234-6002	1
63116	1	63035	1
62897	1	63379	1
62241	1	62229	1
62243-2731	1	62064	1
62220-2542	1	62028	1
63501	1	62892	1
62208-1207	1	62269-0118	1
62831	1	62232-1727	1
62202	1	62467-3430	1
62269-4126	1	620404722	1
63028	1	62034-0075	1
62848	1	62876	1
62819	1	622697083	1
622690000	1	84106-1340	1
63863	1	62272	1
62062-8531	1	62269-3036	1
62812-1100	1	62248	1
62568	1	62068	1
48313-5079	1	96797	1
62243-1425	1	63026	1
62351	1	622983171	1
62269-7618	1	613421103	1
80122	1	62995	1
65401	1	63126	1
33411-5812	1	62045	1
63033	1	620405405	1
62254-1344	1	63056	1
62906	1	62849	1
12045	1	62217	1
63052	1	620952277	1
62822	1	62063	1
62294-1632	1	62053	1
62221-3391	1	62839	1
65725	1	620255141	1
63139	1	63332	1
63138	1	63118	1
62205-2850	1	622215112	1
62221-3477	1	62103	1

Exhibit 24-B

Metro East Dermatology and
Skin Cancer Center Patient
Origin by Geographic Density

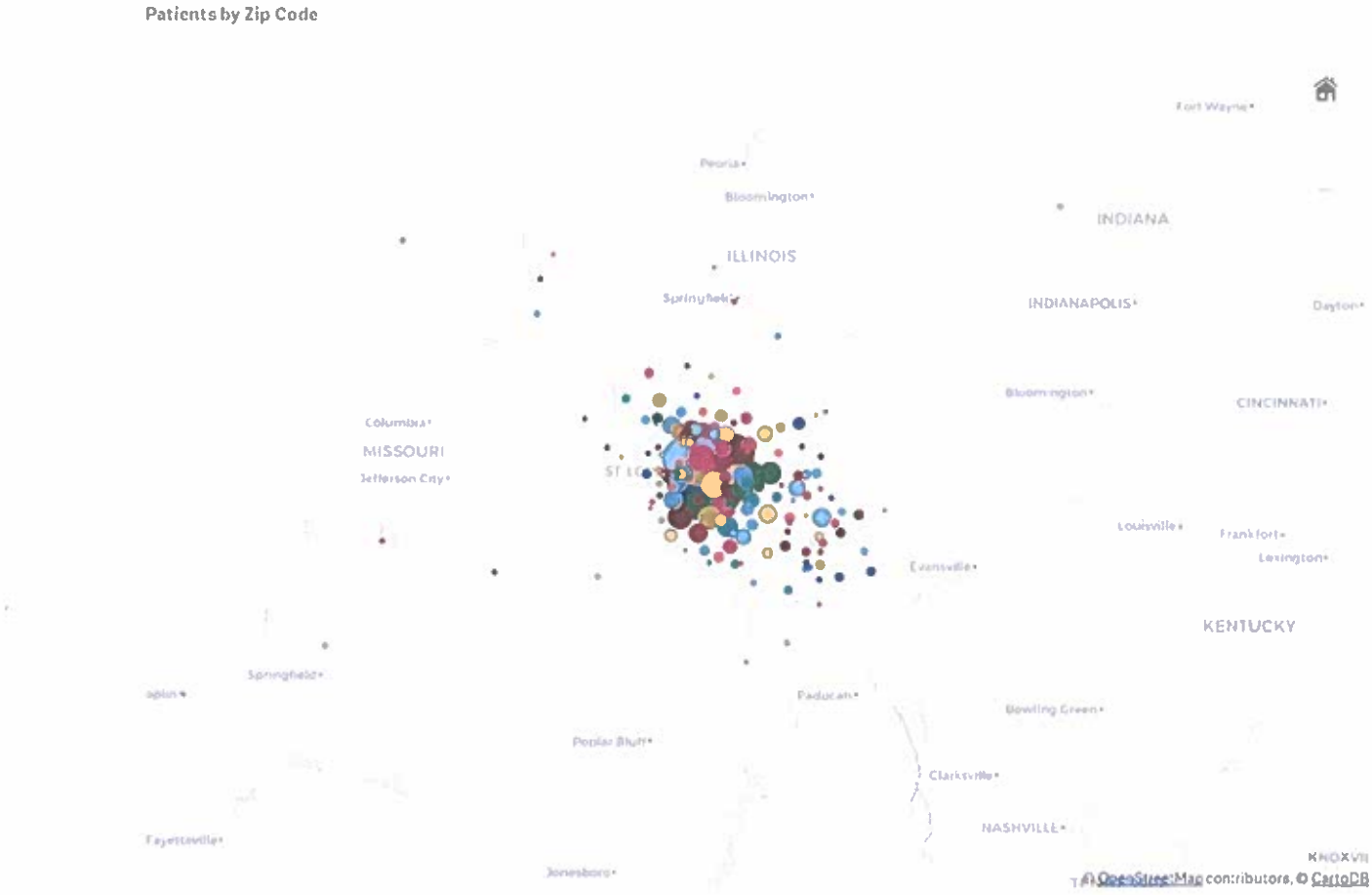


Exhibit 24-B (Continued)

Metro East Dermatology and
Skin Cancer Center Patient
Origin by Geographic Density

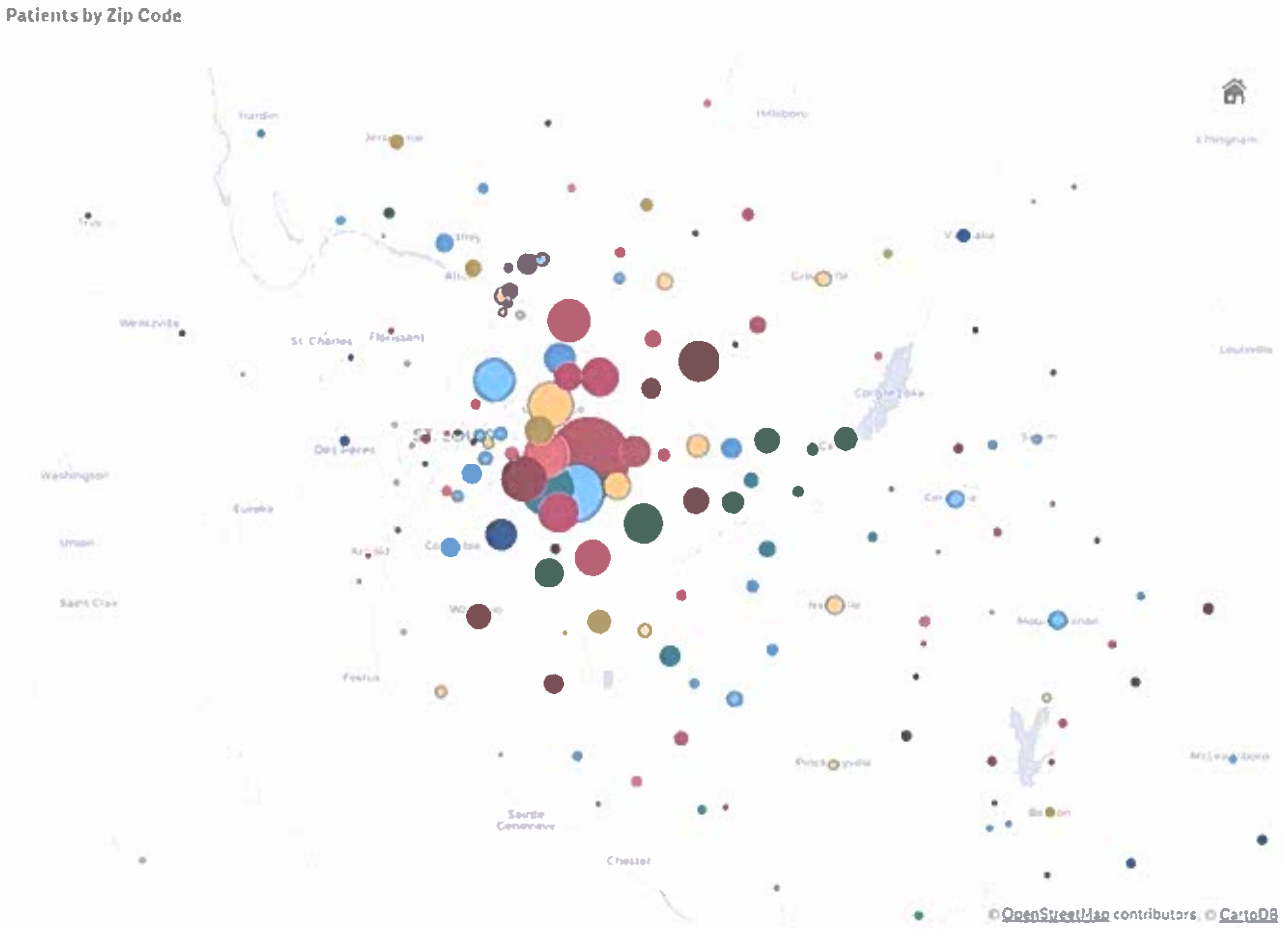


Exhibit 24-C

United States Skin Cancer Incidence Rates
2018 Estimates

Skin Cancer Types	Calculated Rates 100,000 people	
Non-Melanoma Skin Cancers		
• Basal Cell Carcinoma (BCC)	1320.2	(75.1%)
Based on 4,300,000 cases		
• Squamous Cell Carcinoma (SCC)	383.8	(21.8%)
Based on 1,250,000 cases		
Sub-total Non-Melanoma Skin Cancer	1704.0	(96.9%)
Melanoma Related Skin Cancers		
• Non-Invasive (in situ))	26.8	(1.5%)
Based on 87,290 cases		
• Invasive	28.0	(1.6%)
Based on 91,270 cases		
Sub-total Melanoma Related Skin Cancer	54.8	(3.1%)
Grand-total Skin Cancer Incidence Rate	1758.9	(100%)

Based on (5,728,560 est. new cases)

Note: Rate based on US Population of 325,700,000 people

Errors due to rounding

Source: The Skin Cancer Foundation, American Cancer Society, National Cancer Institute, SEER Based Data

Compiled by: PRISM Healthcare Consulting

Exhibit 24-D

Skin Cancer in Illinois
And
Defined Geographic Service Areas
Derived from Skin Cancer in Illinois, 2017
Illinois Department of Public Health, Springfield, Illinois; May, 2017

Melanomas of the Skin (Cases) (See Page 5, incidence rates)

State of Illinois	Cases
Men	1,523
Women	1,144
Total	2,667 Cases of Melanoma

If: Melanoma is ± 1% of all skin cancers (Page 7)

Then: There are approximately 266,700 new skin cancer cases diagnosed annually (derived)

Hence, If: the PGSA approximates 615,562 people (Exhibit 24-E), and

SGSA approximates 126,608 people (Exhibit 24-E), then

The population served is 742,170 people (Exhibit 24-E), or

Approximately 5.6% of the projected Illinois population in 2023 (13,156,118 people)

Therefore: On the average, the PGSA and SGSA will have, on a calculated basis, 14,935 skin cancer cases based on a proportion of the state population.

Based on incidence rates, the calculated number of skin cancer cases (Exhibit 24-F) 1,513,026.

Thus, there is a derived / calculated range of between 13,026 and 14,935 skin cancer cases in the defined GSA's.

Exhibit 24-E

Estimated Population by County

Primary Geographic Service Area (PGSA) (HSA XI / Planning Area F-01)

	2018	2019	2020	2021	2022	2023
Saint Clair	267,627	267,447	267,267	267,087	266,907	266,727
Madison	271,061	271,374	271,687	272,000	272,313	272,626
Clinton	38,309	38,406	38,503	38,600	38,697	38,794
Monroe	35,705	36,047	36,389	36,731	37,073	37,415
Sub-total PGSA	612,702	613,274	613,846	614,418	614,990	615,562

Secondary Geographic Service Area (SGSA)

	2018	2019	2020	2021	2022	2023
Bond	18,215	18,285	18,355	18,425	18,495	18,565
Clinton	38,502	38,599	38,696	38,793	38,890	38,987
Washington	14,395	14,362	14,329	14,296	14,263	16,230
Perry	22,457	22,476	22,495	22,514	22,533	22,552
Randolph	32,679	32,598	32,517	32,436	32,355	32,274
Sub-total SGSA	126,248	126,320	126,392	126,464	126,536	126,680

Source: IDPH; IHFSRB, CON Population Projections, 2014 (Extrapolated)
Compiled By: PRISM Healthcare Consulting

Exhibit 24-F.1

Estimated Total Skin Cancer Cases
By County
Based on 2018 United States Incidence Rates

Primary Geographic Service Area (PGSA) (HSA XI / Planning Area F-01)

	2018	2019	2020	2021	2022	2023
Saint Clair	4,707	4,704	4,701	4,698	4,695	4,692
Madison	4,768	4,773	4,779	4,784	4,790	4,795
Clinton	674	676	677	679	681	683
Monroe	628	634	640	646	652	658
Sub-total PGSA	10,777	10,787	10,797	10,807	10,818	10,828

6-year Average 10,802 Cases

Secondaary Geographic Service Area (SGSA)

	2018	2019	2020	2021	2022	2023
Bond	320	322	323	324	325	327
Clinton	677	679	681	682	684	686
Washington	253	253	252	252	251	250
Perry	395	395	396	396	396	397
Randolph	575	573	572	571	569	568
Sub-total SGSA	2,220	2,222	2,224	2,225	2,225	2,228

6-year Average 2,224 Cases

Grand Total Estimated Cases	12,997	13,009	13,021	13,032	13,043	13,056

Derived Total — 6-year Average: 13,026 Cases

Source: Derived from Exhibits 24-D and 24-E
Compiled By: PRISM Healthcare Consulting

Exhibit 24-F.2

Estimated Skin Cancer Cases
By Cancer Type
Primary (PGSA) and Secondary Geographic Service Area (SGSA)

Estimated Total Cases (Exhibit 24-F.1)	PGSA	SGSA	Total
	10.802	2.224	13.026
Skin Cancer Types			
Non-Melanoma Skin Cancers			
• Basal Cell Carcinoma (BCC)			
@ 75.1%	8,112	1,670	9,782
• Squamous Cell Carcinoma (SCC)			
@ 21.8%	2,355	485	2,840
Sub-total Non-Melanoma Skin Cancers	10,467	2,155	12,622
Melanoma Related Skin Cancers			
• Non-Invasive (in situ))			
@ 1.5%	162	33	195
• Invasive			
@ 1.6%	173	36	209
Sub-total Melanoma Related Skin Cancers	335	69	404
Grand-total Skin Cancer Cases	10.802	2.224	13.026

Source: Exhibits 24-C, 24-D, 24-E, and 24-F.1
Compiled by: PRISM Healthcare Consulting

Exhibit 24-G
Non-Hospital Based Ambulatory Surgery Centers Licensed
ASTC-Based Surgical Suite Operating Room Capacity
Within a 21-mile radius of the proposed single specialty ASTC site

ASTC	Type	Operating Rooms	Surgical Hours	Justified ** Room	Excess / Variance
Anderson Surgery Center, LLC * (Edwardsville)	Multi-Specialty	2	1,875	2	0
Bel-Clair ASTC (Belleville)	Single Specialty / Gastro	2	833.12	1	1
Belleville Surgery Center, LTD*** (Belleville)	Multi-Specialty	0	0	0	0
Belleville Surgery Center, LTD (d/b/a Physicians Surgery Center, LTD	Multi-Specialty / Gastro and Oral Maxillofacial	1	1,980	2	(1)
Edwardsville ASTC, LLC (Glen Carbon)	Multi-Specialty	2	1,123	1	1
Eye Surgery Center, LLC (Belleville)	Single Specialty / Opthalmology	2	1,975	2	0
Metro-East Endoscopic Surgery Center (Fairview Heights)	Single Specialty / Gastro	0 (1 procedure room / no OR)	0		
Monroe County Surgical Center (Waterloo)	Multi-Specialty	2	795.5	1	1
Nova Med Eye Surgery Center (Maryville)	Single Specialty / Opthalmology	0 (2 procedure rooms / no OR's)	0	0	0
Hope Clinic for Women (Granite City)	Single Specialty Elective Termination	0 (2 procedure rooms / no OR's)	0	0	0
Total		11	8,581.62	9	2

* Approved 12/4/2018 by IHFSRB for 2 OR's and 1 procedure room; utilization of both justifies the rooms
** Based on 1,500 Surgical hours / operating room excludes procedure rooms / utilization
*** Discontinued per Exemption application E-003-19, as approved March 5, 2019
Note: One (1) of the calculated five (5) excess ASTC operating rooms is in a single-specialty facility (Gastroenterology) which indicates four (4) potential excess ASTC-based operating rooms within 21-miles

Source: 2017 Annual Hospital Questionaire, IDPH, Health System Development and State Agency meeting 12/4/2018

Compiled by: PRISM Healthcare Consulting

Exhibit 24-H
Hospital-Based Surgical Suite Capacity Analysis
Within a 21-mile radius of the proposed single specialty ASTC site

Hospitals	HPA	HSA	Location	Operating Rooms	Total Cases	Surgical Hours	Justified * Rooms	Excess / Variance
Anderson Hospital	F-01	XI	Maryville	9	7,149	11,615	8	1
Gateway Regional	F-01	XI	Granite City	7	2,251	2,612	2	5
Memorial East	F-01	XI	Shiloh	4	1,970	2,364	2	2
Memorial	F-01	XI	Belleville	18	8,830	12,771	9	9
St. Elizabeth's	F-01	XI	O'Fallon	10	4,128	11,366	8	2
Touchette Regional	F-01	XI	Centerville	6	1,034	1,134	1	5
Total / Average				54	25,362	41,862	30	24

Source: 2017 Annual Hospital Questionnaire, IDPH, Health Systems Development

Compiled by: PRISM Healthcare Consulting

* Based on 1,500 surgical hours / OR … excludes reported procedure room utilization

Exhibit 24-I
Hospital-Based Surgical Suite Capacity
Within a 21-mile radius from the Proposed Single Specialty ASTC Site

Hospitals	Location	Miles (MapQuest Travel Distance)	Calculated * Excess OR's
Anderson Hospital	Maryville	14.5 or 17.4	1
Gateway Regional	Granite City	20.7	5
Memorial East	Shiloh	3.6 or 3.7	2
Memorial	Belleville	7.6 or 9.0	9
St. Elizabeth's	O'Fallon	< 1.0	2
Touchette Regional	Centerville	13.1 or 13.7	5
			24

Source: MapQuest and IDPH Data (Calculated excess OR's; See Exhibit 24-H)

Compiled by: PRISM Healthcare Consulting

* Based on 1,500 surgical hours / OR … excludes reported procedure rooms / utilization

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VI. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
1,303,400	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance

_____	accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
1,303,400	**TOTAL FUNDS AVAILABLE**

See enclosed commitment letter from Carrolton Bank dated January 25, 2019

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

CARROLLTON BANK

February 25, 2019

Dr. Jamie McGinness
37 Kennerly Manor Dr.
St. Louis, MO 63128

Re: Metro East Dermatology & Skin Cancer Center
Tenant #1 – CO#1
Regency Park & St. Elizabeth
O'Fallon, IL 62269
St. Clair County

To whom it may concern:

Carrollton Bank has pre-approved financing for Dr. Jamie McGinness and/or a related entity to build out the ASTC finished product relative to the above referenced project. Our pre-approval is for an amount up to $1,380,900. Dr. Jamie McGinness is a valued client of Carrollton Bank. This pre-approval is based on his current financial statement and excellent historic performance.

Borrower:	An entity to be formed, Jamie and Jackie McGinness
Loan Amount:	$1,380,900
Interest Rate:	Floating at National Prime + 0%, which is currently 5.50%
Construction Fee:	$3,500
Term:	18 months
Collateral:	Mortgage on the subject property and a UCC filing on the assets of the company

The pre-approval is subject to a complete financial analysis, proper due diligence relative to a construction project and occupancy due diligence. This pre-approval letter will expire on 01/31/20, however, can be considered for extension with additional due diligence.

Sincerely,

Mark Vance
Senior Vice President

2135 Wabash • Springfield, IL 62704
217-793-8696 • fax 217-793-4056 • www.carrolltonbanking.com
Alton • Belleville/O'Fallon • Carrollton • Jerseyville • Springfield • St. Charles • St. Louis

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Not Applicable

"Skin Cancer Surgery Center, LLC", the proposed ASTC to be established based on this respective CON Permit Application, is a new legal entity (Attachment 1) with no operational history and therefore unable to demonstrate a bond rating.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical * 3 Years			Projected
Enter Historical and/or Projected Years:	NA	NA	NA	2021
Current Ratio				1.3 X
Net Margin Percentage				28.0%
Percent Debt to Total Capitalization				91.0%
Projected Debt Service Coverage				1.57 X
Days Cash on Hand				227
Cushion Ratio				.04 X

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* As a newly established legal entity, "Skin Cancer Surgery Center, LLC" has no operational history to disclose.

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements (See Attached Attestation)

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ASTC	0	$183.14	0	--	4,068	--	--	745,000	745,000
Contingency	0	19.66	0	--	4,068	--	--	80,000	80,000
TOTALS		202.80	0	--	4,068	--	--	825,000	825,000
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs *

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs *

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* Not applicable, the proposed new healthcare facility (single specialty ASTC) will not have an "equivalent patient day" in that it is not a hospital; in addition, "effect on capital cost / equivalent patient day, is not applicable.

Attachment 36
Attestation of Financing Arrangements
Section VIII 1120.140 (A)
Reasonableness of Financing Arrangements
(See also Attachment 2, herein)

The proposed non-hospital based ambulatory surgical treatment center (ASTC) is to be known as the "Skin Cancer Surgery Center, LLC".

My name is Jamie L. McGinness, M.D. I attest that the estimated project costs, and related costs, for the "Skin Cancer Surgery Center, LLC" will be funded in total by borrowing in that it is less costly than the liquidation of existing investments. As well, the selected form of debt financing will be at the lowest net cost available. The funding will be available through Carrollton Bank as documented in Attachment 33 included within this respective permit application.

Attested by:

Jamie L. McGinness, M.D.
McGinness Properties, LLC.

Notarization:

Subscribed and sworn to before me
this 26 day of March

Signature of Notary

Jenna Condron
Printed Name

Seal

Seal

OFFICIAL SEAL
JENNA A. CONDRON
Notary Public - State of Illinois
My Commission Expires 3/15/2022

SECTION IX. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Safety Net Impact Statement

The proposed newly established non-hospital based ASTC, "Skin Cancer Surgery Center, LLC" utilization is based solely on Dr. McGinness's private dermatology office practice. This practice was recently opened in Shiloh, Illinois and will be moving to his new MOB in O'Fallon, Illinois. Due to the fact this is a new specialty physician office practice in the market, as the applicant understands it, there has been no nor will there be any adverse impact on existing safety net services nor any cross-subsidization.

Safety Net Information per PA 96-0031			
CHARITY CARE(Not Applicable)			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

Not Applicable, see previous page

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE *			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* Not applicable, See following page

Not Applicable

"Skin Cancer Surgery Center , LLC" is a new legal entity to be housed integral with a private physician MOB which will, therefore, "establish" the single specialty, single-room, ASTC. It has no historical operating history; as such, there is no Charity Care or Medicaid information to disclose.

CHARITY CARE			
	Year	**Year**	**Year**
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

Not applicable, see previous page

Jamie L. McGinness

1191 Fortune Blvd, Suite 2
Shiloh, IL. 62269
Work: (618) 622-7546
Home: (573) 268-6330
E-mail: jmcginness@dermskincancercenter.com

EDUCATION:

- ***Doctorate of Medicine, University of Missouri—Columbia School of Medicine***
  Columbia, Missouri
  August 1998 – May 2002

- ***Bachelor of Science, University of Missouri—Columbia***
  Columbia, Missouri
  August 1994 – May 1998
  Major: Biochemistry, College of Agriculture, Food, and Natural Resources
  Magna Cum Laude, G.P.A.: 3.86

- ***Potosi High School***
  Potosi, Missouri
  August 1990 – May 1994
  Valedictorian, G.P.A.: 3.98

TRAINING:

- ***Northwest Diagnostic Clinic***
  Advanced Mohs Micrographic Surgery, Reconstructive Surgery, and vein therapy training with Dr. Tri Nguyen
  July 2011 – October 2012

- ***Dermatopathology Training, University of Cincinnati***
  Cincinnati, Ohio
  July 2010 – June 2011

- ***Fellowship, Dermatology & Skin Cancer Center; Mohs Micrographic Surgery***
  Leawood, Kansas and Lee's Missouri
  July 2006 – June 2007

- ***Residency, University of Virginia; Dermatology***
  Charlottesville, Virginia
  July 2003 – June 2006
  Chief Resident
  July 2005 – June 2006

- ***Internship, University of Missouri—Columbia; Internal Medicine***
  Columbia, Missouri
  July 2002 – July 2003

WORK EXPERIENCE:

- ***Metro East Dermatology & Skin Cancer Center***
  Shiloh, IL, Mohs surgery and general dermatology
  September 2017—present

- ***Springfield Clinic***
  Springfield, IL, Mohs surgery
  November 2012 — 2017

- ***Sadler Clinic***
  Kingwood, TX, general dermatology moonlighting one day a week during training
  July 2011 – 2012

- ***University of Cincinnati***
  Cincinnati, Ohio, general dermatology one day a week during training
  October 2010 – June 2011

- ***Riverside Dermatology***
  Hannibal, Missouri
  August 2009 – May 2010

- ***Dermatology & Skin Cancer Center***
  Leawood, Kansas and Lee's Summit, Missouri
  July 2007 – May 2009

CERTIFICATION:

- ***Diplomate of the American Board of Dermatology***
- ***Fellow American College of Mohs Surgery***
- ***Missouri Medical License***
- ***Illinois Medical License***
- ***United States Medical Licensing Examination***

Step I:	July 2000	255, 99%
Step II:	March 2002	256, 97%
Step III:	September 2003	233, 94%

HONORS AND AWARDS:

- ***Graduate:***
  - ***ASDS Dermatologic Surgery Preceptorship Award***
  - ***Alpha Omega Alpha***
  - ***Dermatology clerkship student award***
  - ***Surgery Club President and Founder, University of Missouri SOM***
  - ***University of Missouri Summer Research Fellowship Program***
  - ***Honors Internal Medicine***
  - ***Honors Family Practice***
  - ***Honors Surgery***
  - ***Honors Psychiatry/Neurology***
- ***Undergraduate:***
  - ***Magna Cum Laude Honors Scholar***
  - ***University of Missouri freshman football academic award***
  - ***Curator's Scholar***

PROFESSIONAL MEMBERSHIPS:

- ***Alpha Omega Alpha***
- ***American College of Mohs Surgery***
- ***American Academy of Dermatology***
- ***American Society for Dermatologic Surgery***

VOLUNTEER ACTIVITIES:

- ***Mohs observation at MD Anderson, November 2008***
- ***Facial plastic surgery observation at the University of Kansas 2008-2009***
- ***Charlottesville Free Clinic, general dermatology 2004-2006***
- ***Skin Cancer Screening Volunteer***

PUBLICATIONS:

- *Janet Y. Li, MD, Silapunt, Sirunya, MD, Michael Migden, MD,* ***Jamie McGinness, MD,*** *Tri Nguyen, MD.* Mohs mapping fidelity: optimizing orientation, accuracy, and tissue identification in Mohs Surgery. Dermatol Surg. 2018 Jan.

- **McGinness JL,** Spicknall K, Mutasim D. Azathioprine induced EBV positive mucocutaneous ulcer. J Cutan Pathol. 2012 Mar.

- **McGinness JL,** Goldstein G. The Value of Preoperative Biopsy Site Photography for Identifying Cutaneous Lesions. Dermatol Surg. 2009 Dec.

- **McGinness JL,** Bivens M, Greer K, Patterson J, Saulsbury F. Immune Dysregulation, Polyendocrinopathy, Enteropathy, X-linked Syndrome(IPEX) associated with Pemphigoid Nodularis: A Case Report and Review of the Literature. J Am Acad Dermatol. 2006 Jul;55(1):143-8.

- **McGinness JL,** Wilson B. Tinea Incognito Masquerading as Granulomatous Periorificial Dermatitis. Cutis. 2006 May;77(5):293-6.

- **McGinness JL,** Greer K. Malignant Acanthosis Nigricans and Tripe Palms Associated with Pancreatic Adenocarcinoma. Cutis. 2006 Jul;78(1):37-40.

- **McGinness JL,** Parlette HL 3rd. A Novel Technique Using a Rotation Flap for Repairing Adjacent Surgical Defects. Dermatol Surg. 2006 Feb;32(2):272-5.

- **McGinness JL,** Parlette HL 3rd. Versatile Sterile Field for Nail Surgery Using a Sterile Glove. Dermatol Online J. 2005 Dec 1;11(3):10.

- **McGinness JL,** Russell M. Surgical Pearl: A Technique for Placement of Buried Sutures. J Am Acad Dermatol. 2006 Jul;55(1):123-4.

PRESENTATIONS:

- **McGinness JL**, Variations in Mohs Surgery. *Oral presentation at the 2016 ACMS meeting in Orlando Florida.*

- **McGinness JL**, Goodman C, Chiang M, Farnsworth N, Migden M, Phung T, Nguyen TH. Optimizing Mohs Frozen Section: Clini-RF Rapid Freeze Histology. *Oral presentation at the 2012 ACMS meeting in Chicago.*

- **McGinness JL**, Nguyen TH. Prolonging the Primary Pivoting Point: Mathematical Effect of Prolonging the Primary Burow's Triangle on Trilobed Transposition Flap Rotation. *Oral presentation at the 2012 ACMS meeting in Chicago.*

- **McGinness JL**, Nguyen TH. Prolonging the Primary Pivoting Point: Mathematical Effect of Lengthening the Primary Burow's Triangle on the Bilobed Flap. *Poster presentation at the 2011 ACMS meeting in Las Vegas.*

- **McGinness JL**, Kerith S, Mutasim D. EBV Associated Mucocutaneous Ulceration Secondary to Azathioprine. *Poster presentation at the 2010 American Society of Dermatopathology Meeting.*

- **McGinness JL**, Goldstein G. The Value of Preoperative Biopsy Site Photography for Identifying Cutaneous Lesions. *Oral presentation at the 2008 ACMS meeting in Vancouver.*

- **McGinness JL**, Bivens M, Greer K, Patterson J, Saulsbury F. Immune Dysregulation, Polyendocrinopathy, Enteropathy, X-linked Syndrome (IPEX) associated with Pemphigoid Nodularis. *Presentation at the Residents and Fellows Symposium at the 2006 American Academy of Dermatology Meeting.*

- **McGinness JL**, Heath C, Nichols GR, Wilson B. Blue Rubber Bleb Nevus Syndrome Treated Successfully with the 595-nm Pulsed Dye Laser. *Poster presentation at the 2006 American Academy of Dermatology Meeting.*

- **McGinness JL**, Parlette H. A Novel Technique Using a Rotation Flap for Repairing Adjacent Surgical Defects. *Poster presentation and special oral discussion session entitled "Poster Discussion on Mohs Surgery" at the 2005 ASDS-ACMMSCO Combined Annual Meeting.*

- **McGinness JL**, Bivens M, Greer K, Patterson J, Saulsbury F. Immune Dysregulation, Polyendocrinopathy, Enteropathy, X-linked Syndrome(IPEX) associated with Pemphigoid Nodularis. *Presentation at the Gross and Microscopic Dermatology Symposium at the 2006 American Academy of Dermatology Meeting.*

- Nichols GR, Hopkins R, **McGinness JL**, Wilson B. Nephrogenic Fibrosing Dermopathy Presenting as Sclerodactyly. *Poster presentation at the 2006 American Academy of Dermatology Meeting.*

- **McGinness JL.** Spongiotic and Psoriasiform Dermatitis. Presented to the University of Cincinnati Department of Pathology. 2010.

- **McGinness JL.** Benign Epidermal Neoplasms and Cysts. Presented to the University of Cincinnati Department of Pathology. 2010.

- **McGinness JL.** Lichenoid Tissue Reactions. Presented to the University of Cincinnati Department of Pathology. 2010.

- **McGinness JL.** Sedation and Pain Control for the Dermatologic Surgeon. Presented to the University of Virginia Department of Dermatology. 2003, 2004, 2005.

- **McGinness JL.** Arthropods in Dermatology. Presented to the University of Virginia Department of Dermatology. 2004, 2005.

- **McGinness JL.** Dermatomyositis. Presented to the University of Virginia Department of Dermatology. 2004, 2005.

- **McGinness JL.** Autoantibodies in Autoimmune Connective Tissue Disease. Presented to the University of Virginia Department of Dermatology. 2003, 2004, 2005.

- **McGinness JL.** The Basic Science of Hair. Presented to the University of Virginia Department of Dermatology. 2003, 2004, 2005.

- **McGinness JL.** Review of Oral Antifungal Medications. Presented to the University of Virginia Department of Dermatology. 2003, 2004, 2005.

- **McGinness JL.** Basic Science of Phototherapy. Presented to the University of Virginia Department of Dermatology. 2003, 2004, 2005.
- **McGinness JL.** Skin: Structure, Function, and Description of Cutaneous Signs. Presented to the University of Virginia Department of Dermatology. 2004.

- **McGinness JL.** Medium Depth Chemical Peels. Presented to the University of Virginia Department of Dermatology 2005.

- **McGinness JL.** Microdermabrasion and Dermabrasion. Presented to the University of Virginia Department of Dermatology 2006.

- **McGinness JL.** Clostridium Perfringens Gas Gangrene Secondary to Acute Paronychia in an Immunosuppressed Patient. Morning Report at the University of Missouri—Columbia. 2003.

- Prakash S, **McGinness JL** (Curtis JJ, sponsor). Can dobutamine stress echocardiography identify patients with poor ventricular function who will have a successful outcome after coronary artery bypass? Proceedings of the MU School of Medicine Annual Student Research Day, November 11, 1999.

PERSONAL INTERESTS:

- *Golf, biking, football, skiing, basketball, tennis, movies, dining out, and spending time with my wife, daughter, and three sons.*

MAYO CLINIC

REVIEW

Understanding Mohs Micrographic Surgery: A Review and Practical Guide for the Nondermatologist

Stanislav N. Tolkachjov, MD; David G. Brodland, MD; Brett M. Coldiron, MD; Michael J. Fazio, MD; George J. Hruza, MD; Randall K. Roenigk, MD; Howard W. Rogers, MD; John A. Zitelli, MD; Daniel S. Winchester, MD; and Christopher B. Harmon, MD

Abstract

The incidence and diagnosis of cutaneous malignancies are steadily rising. In addition, with the aging population and increasing use of organ transplant and immunosuppressive medications, subsets of patients are now more susceptible to skin cancer. Mohs micrographic surgery (MMS) has become the standard of care for the treatment of high-risk nonmelanoma skin cancers and is increasingly used to treat melanoma. Mohs micrographic surgery has the highest cure rates, spares the maximal amount of normal tissue, and is cost-effective for the treatment of cutaneous malignancies. As in other medical fields, appropriate use criteria were developed for MMS and have become an evolving guideline for determining which patients and tumors are appropriate for referral to MMS. Patients with cutaneous malignancies often require multidisciplinary care. With the changing landscape of medicine and the rapidly increasing incidence of skin cancer, primary care providers and specialists who do not commonly manage cutaneous malignancies will need to have an understanding of MMS and its role in patient care. This review better familiarizes the medical community with the practice of MMS, its utilization and capabilities, differences from wide excision and vertical section pathology, and cost-effectiveness, and it guides practitioners in the process of appropriately evaluating and determining when patients with skin cancer might be appropriate candidates for MMS.

 ■ Mayo Clin Proc. 2017;92(8):1261-1271

A 57-year-old man with a history of renal transplant and chronic lymphocytic leukemia presents with a recurrent squamous cell carcinoma (SCC) of the lower vermillion lip. The tumor was excised 6 months earlier, and the middle portion of the scar has now ulcerated. A 32-year-old woman with a history of tanning bed use develops a basal cell carcinoma (BCC) on the nasal tip. These patients may be encountered in a primary care office, a transplant or oncology clinic, an obstetrics and gynecology center, or a walk-in urgent care facility.

To better equip a wide range of primary care physicians and specialists to treat patients with skin malignancies with a multidisciplinary approach, we present a guide for nondermatologists to Mohs micrographic surgery (MMS) and its use in skin cancer management. Mohs micrographic surgery has become the gold standard of treatment of cutaneous malignancy, with a focus on tumor eradication and tissue sparing. The aim of this report is to better explain the utility and advantages of MMS and guide medical professionals on the appropriate management of patients with skin cancer.

Among the authors, more than 312,000 MMS procedures have been performed at more than 10 different institutions, including private practices, hospital settings, academic departments, and tertiary referral centers.

Nonmelanoma skin cancer (NMSC) is the most common malignancy in the United States and European countries, with substantial associated morbidity and cost, as well as relatively low but significant mortality. The NMSCs are increasing in incidence and diagnosis.[1,2]

From the Surgical Dermatology Group, Birmingham, AL (S.N.T., C.B.H.); Department of Dermatology (D.G.B., J.A.Z.), Department of Plastic Surgery (D.G.B., J.A.Z.), and Department of Otolaryngology (D.G.B., J.A.Z.), University of Pittsburgh Medical Center, Pittsburgh, PA; Zitelli & Brodland, P.C., Pittsburgh, PA (D.G.B., J.A.Z.); The Skin Cancer Center, Cincinnati, OH (B.M.C.); Department of Dermatology, University of Cincinnati, Cincinnati, OH (B.M.C.); Skin Cancer

Affiliations continued at the end of this article

ARTICLE HIGHLIGHTS

- Mohs micrographic surgery has become the standard of care for the treatment of high-risk nonmelanoma skin cancers and is increasingly used to treat melanoma.
- Mohs micrographic surgery has the highest cure rates, spares the maximal amount of normal tissue, and is cost-effective for the treatment of cutaneous malignancies.
- Patients with cutaneous malignancies, including patients with organ transplant, with hematologic malignancies, and who are pharmacologically immunosuppressed, often require multidisciplinary care.
- Primary care providers and nondermatology specialists should be aware of the possible role of Mohs micrographic surgery in the care of patients with cutaneous malignancies and how to best expedite this care.

Approximately 80% of all NMSCs are BCC, whereas cutaneous SCC (cSCC) represents approximately 20%, and the remaining rare NMSCs represent 1%.[2,9,10] Mohs micrographic surgery is the standard of care for select BCCs and SCCs.[11-13]

The incidence of melanoma (MM) is steadily rising.[14] Recent data and projections show that in the US white population, annual new cases of MM are projected to rise from approximately 70,000 in 2007-2011 to 116,000 in 2026-2031, with 79% of the increase attributable to rising age-specific rates and 21% to population growth and aging.[15] Similar projections have been made about the United Kingdom, Sweden, Norway, Australia, and New Zealand.[15] Melanoma is also the most common cancer in the adolescent and young adult population.[16] The incidence of MM of all thicknesses is rising; however, although the prognosis of MM worsened with increasing stages, most deaths resulted from MMs that were diagnosed at the T1 stage (thin MM).[17] In addition, the long-term risk of subsequent invasive MM increases in patients with melanoma in situ (MIS).[18,19] It is prudent to diagnose and treat MM at an early stage and continue to monitor these patients for subsequent skin malignancies.[18,20] Mohs micrographic surgery has been used with success to treat MIS as well as invasive MM.[21-23]

MMS TECHNIQUE, ADVANTAGES, AND DIFFERENCES FROM TRADITIONAL WIDE LOCAL EXCISION

A complete description of MMS is out of the scope of this article, and some technique variability is seen among surgeons. Basically, the technique involves surgically removing the minimal amount of tissue to eradicate cancerous tissue with precise mapping of the entire surgical margin while preserving normal skin.

The surgical site is clearly marked and infiltrated with local anesthetic. Typically, tumor debulking is done to remove clinically evident tumor with either a blade (sharp debulking) or a curette. A saucerized layer of tissue is excised, with tissue nicks or suture placement for orientation and creation of a corresponding tissue map. The tissue is precisely labeled with ink at nicked edges and transposed to a cryostat chuck with the cut surface flattened.[24] The entire horizontal section of tissue is frozen, cut, and stained, allowing for lateral and deep margin visualization and precise orientation (Figure 1A).[25] Using microscopic examination, the surgeon visualizes the absence or presence of tumor.[26] Once tumor is fully removed, either the site is allowed to heal by second intention (granulation) or an appropriate reconstruction is performed.[25,27] If tumor is still present, a second or subsequent layer is taken only from the represented tumor site on the map corresponding to both the tissue and the patient's defect. This is repeated until tumor is no longer present.[28-30]

The major difference between MMS and wide local excision (WLE) is the fresh frozen technique with horizontal sections, allowing complete margin visualization.[26] In contrast to the complete margin control of MMS, classic histopathology uses a "breadloafing" technique in which tissue is sectioned in a vertical orientation at several intervals (Figure 1B). The amount of tissue visualized depends on the number of sections read. Typically, less than 1% to 2% of the specimen margin is evaluated. Sampling error will occur if the intervals of the sections miss extensions of tumor, which may penetrate between the sampled sections (Figure 1B). Mohs micrographic surgery does not rely on the intervals of sampled margins, instead allowing for microscopic control of 100% of the margin,

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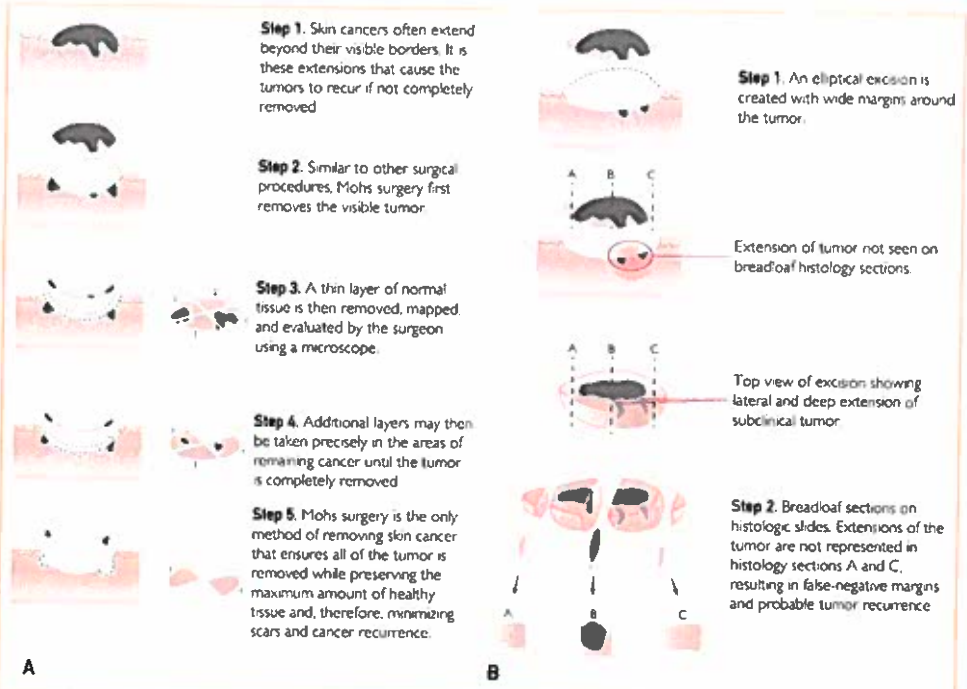

FIGURE 1. A, Mohs micrographic surgery technique. B, Standard technique for wide local excision with breadloaf histology.

translating to both superior cure rates and sparing of normal tissue.[25,26] Tissue sparing with precise mapping allows for potentially more reconstructive options and less disfigurement, especially in cosmetically sensitive areas such as the nose, eyelids, ears, lips, digits, and genitalia.[31,32]

Histopathologic examination is key to the high cure rates achieved with MMS. Most tumors are very effectively examined with hematoxylin and eosin staining. Certain tumors, such as extramammary Paget disease, can better be examined using periodic acid–Schiff staining or cytokeratin 7 immunostaining.[33] Dermatofibrosarcoma protuberans can be further delineated with CD34 immunostaining.[34] Intraepidermal MM cells can be highlighted effectively with Mart-1 or Melan-A immunoperoxidase staining and spindle cell MM with S100.[34] Immunostains can now be done rapidly and efficiently in the MMS laboratory on frozen sections, allowing the surgery to be completed within a few hours rather than days.[35]

THE SYNERGY OF MICROGRAPHIC SURGERY AND RECONSTRUCTION

Micrographic surgery is synergistic with cutaneous reconstruction in several ways. First and foremost, no reconstruction is performed until the margins are confirmed to be histologically tumor free. This is beneficial to both the reconstructive surgeon and the patient because at the time of reconstruction the statuses of the margins are not in doubt. This obviates any need for reoperating at a later date based on subsequent pathology findings. The certainty of clear margins is increased by virtue of the 100% peripheral margin evaluation and the microscopically guided excision afforded by micrographic surgery.

Another synergy associated with micrographic surgery is the reconstruction of the smallest possible wound. Excision using microscopic surgery begins at the narrowest clinically tumor-free margin. Because clinically occult tumor extension exists in approximately 30% to 35% of the tumors, additional excision is necessary for those patients. However, that means that up to 70% of patients achieve histologically tumor-free margins with the narrowest of excision, thereby conserving uninvolved surrounding tissue. Standard excision is based on margin identification using visual inspection only. From that margin, a predetermined, agreed-on by convention, and sometimes clinically verified "safe" margin of normal-appearing skin is removed. These margins range from 4 to 10 mm in NMSC and from 5 to 20 mm of normal-appearing skin in MM. Other less common cutaneous malignancy's margins range from 5 mm to 2 cm depending on the tumor and location.

The depth of excision is also more customized to the actual extent of the tumor using micrographic surgery. With same-day, intraoperative histologic margin evaluation, the fact that more than 95% of cutaneous malignancies are limited to the epidermis and dermis enables the micrographic surgeon to safely preserve underlying soft tissue, including not only subcutaneous fat but also muscles, nerves, and other important structures (Figure 2). Preservation of these tissues simplifies flaps and grafts and improves long-term aesthetic and functional results.

There are times (<1% of cases) when cutaneous malignancies invade beyond the integument into deeper structures such as muscles, tendons, and bone. In these cases, or in cases in which highly complex reconstructions are needed and would be better performed using a multidisciplinary approach, the micrographic surgeon embraces interdisciplinary cooperation.[16] Often, deep structure involvement cannot be anticipated preoperatively. In these cases, the micrographic surgeon can extirpate the entire tumor except that which extends beyond the integument. Residual tumor can be precisely mapped using the micrographic surgical technique and can facilitate subsequent accurate and complete removal of residual malignancy. When a multidisciplinary approach can be anticipated preoperatively, the micrographic surgeon may be instrumental in using intraoperative MMS, allowing for margin control of large tumors, leaving the residual tumor to be excised under general anesthesia.[17] Again, residual tumor can be precisely located using the mapping techniques, which may be useful for subsequent removal. This may allow for simultaneous reconstruction instead of having to withhold reconstruction to observe for recurrence or for confirmation of clearance by permanent sections, which may prevent potential patient morbidity and psychosocial detriment.[16]

FIGURE 2. A, Post–Mohs micrographic surgery (MMS) defect demonstrating preservation of cranial nerve 7 after perineural extension of squamous cell carcinoma. B, Reconstruction immediately after MMS with a bilobed transposition flap over a subcutaneous flap from the jowl covering the nerve. C, Three-year follow-up with no recurrence, and aesthetic outcome.

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TUMORS TREATED BY MMS AND THEIR CURE RATES

Nonmelanoma Skin Malignancies

Basal cell carcinoma is the most common malignancy in the United States, and although it rarely metastasizes, untreated BCC may continue to grow, with local destruction.[9] Mohs micrographic surgery has been used successfully to treat primary and recurrent BCCs.[11,12] The tumor-free recurrence rates for primary and recurrent BCCs treated with WLE and MMS are outlined in Table 1. Mohs micrographic surgery has been shown to have superior cure rates in primary and recurrent BCCs.[11,12,38] It is also an efficient and cost-effective procedure as the treatment of choice for high-risk BCCs and for those in cosmetically sensitive locations.[9]

Cutaneous SCC makes up a smaller proportion of NMSCs. However, it is estimated that in the United States, 186,157 to 419,543 white individuals were given a diagnosis of cSCC, 5604 to 12,572 developed nodal metastasis, and 3932 to 8791 died of cSCC in 2012.[63] This morality burden is on par with renal and oropharyngeal carcinomas and MM.[63] Treatment of cSCC with MMS has shown superior cure rates to WLE, and local recurrences occur less frequently when cSCC is treated by MMS.[40] In addition, high-risk cSCCs have been better defined by Mohs surgeons working in multidisciplinary settings, which has led to the emergence of sentinel lymph node biopsy and adjuvant radiation considerations in treating this subset of cSCC.[13,63,64]

The concept of margin control with MMS extends beyond common tumors. Almost all types of cutaneous malignancies have been treated by MMS over the decades, all with superior results to WLE (Table 1).[11,12,23,59-62] Although these tumors vary in anatomical structure of origin, they all share 1 crucial aspect: they are contiguous tumors, often with subclinical extension underneath the skin surface, rendering the surgeon's subjective measurement of the tumor margins less efficacious than a micrographic surgeon's ability to assess the margin microscopically.

MMS in the Treatment of Melanoma

Mohs micrographic surgery is a useful technique for cutaneous MM, and its value is highly evidence based. Current surgical margin guidelines for the excision of MM result in recurrences due to inadequate excision, resulting in true local recurrence rates of 9% to 15% on the head and neck and 3% on the trunk and proximal extremities.[22,41] These recurrences may adversely affect prognosis and survival because it has been shown that true local recurrences of MIS appear as invasive MM in 23% of cases.[70] Similarly, true local recurrences of inadequately excised invasive MM appear as more deeply invasive MM in 33% of patients.[43] Therefore, the goal of surgical excision is complete removal with histologically negative margins.

The usual methods of pathology processing of excised MM tissue allow examination of only less than 1% to 2% of the margin. More careful processing is rarely performed but may include methods of en face sectioning to examine a higher percentage of the margin. Mohs micrographic surgery is a method of examining 100% of the margin and allows for mapping the precise location of a positive margin so that reexcision is complete. Mart-1 or other immunoperoxidase stains increase the accuracy of margin examination. The

TABLE 1. Cure Rates (5 Years) for Selected Cutaneous Malignancies

Tumor	Cure rates (%)	
	Mohs micrographic surgery	Wide local excision
Basal cell carcinoma[11,12,38]	99 (primary) 90-93 (recurrent)	87-96 (primary) 83 (recurrent)
Squamous cell carcinoma[38-40]	92-99 (primary) 90 (recurrent)	92-95 (primary) 76 (recurrent)
Melanoma in situ[41,42]	98	83-85
Melanoma (invasive)[23,43]	98.7[a]	97[a,b]
Dermatofibrosarcoma protuberans[44,45]	98-100	80-88
Atypical fibroxanthoma[46]	93-100	88
Merkel cell carcinoma[47]	84-95	68-77
Microcystic adnexal carcinoma[48-50]	90	50-70
Sebaceous carcinoma[51,52]	90-93	63-86
Extramammary Paget disease[53]	92	78
Leiomyosarcoma[54,55]	87-100	55-86
Hidradenocarcinoma[56]	100	50
Trichilemmal carcinoma[57,58]	100	90
Mucinous carcinoma[59]	96	66-71
Porocarcinoma[60-62]	100	80

[a]Same study to correct for bias or operator differences.
[b]Of these 3% of tumors without cure, 33% will reappear with deeper thickness than the original primary tumor.

result of detailed margin examination is published local recurrence rates of 0.2% for head and neck MMs and 0.5% for the trunk and proximal extremities, and metastatic rates and MM-specific survival rates as good as wide excision.[71]

Mohs micrographic surgery can be particularly valuable for most head and neck MMs, hand and feet MMs, genital MMs, and any MM with poorly defined clinical margins, including amelanotic, desmoplastic, and recurrent MMs.

Recurrences from MMS may be tumor related, including aggressive pathology, multifocal tumor, recurrent tumor, and high-risk anatomical location; patient related, such as immunosuppression; surgeon related, such as incorrect margin resected; or laboratory related. Two retrospective studies looked at possible reasons for tumor recurrence and found that possible errors could account for 77% to 78% of tumor recurrences, including tumor on the final margin, missing epidermis or dermis, dense inflammation possibly hiding tumor, and incorrect additional margin resected (mapping error).[72-74] A case-control study found that after multivariate analysis, only tumor on final margin, missing epidermis or dermis, and aggressive tumor type were significantly more frequent in recurrent cases than in controls.[75] These findings suggest that continued quality improvement activities can further improve the already excellent MMS cure rates.[76]

APPROPRIATE USE OF MMS

The utilization of MMS has markedly increased during the past 2 decades, and its use has grown disproportionately compared with all other treatment modalities. Some argue that this is an expected finding given the almost epidemic-like increase in skin cancer and the marked increased number of trained Mohs surgeons in the same time frame. Yet, the concern of overutilization or misuse of MMS brought on greater scrutiny by the Centers for Medicare and Medicaid Services and other insurance carriers and eventually lead to consideration of heavy restrictions, including potentially complete elimination of coverage for MMS. To avert these regulatory actions, and to help define the clinical scenarios that are best treated by MMS, the American Academy of Dermatology (AAD) formed an ad hoc task force to develop appropriate use criteria (AUC) for MMS.[77] The AUC process was based on a well-established method developed by the Rand Corp/UCLA and has been successfully applied in the fields of cardiology and radiology. The Mohs AUC are the first AUC developed in dermatology. This was a collaborative effort between the AAD, the American College of Mohs Surgery, the American Society for Dermatologic Surgery, and the American Society for Mohs Surgery. Nearly 80 dermatologists were involved representing all different types of practice and geographic locations. To eliminate potential conflicts of interest or perceived conflicts, most rating panel experts were not Mohs surgeons. More than 400 peer-reviewed articles were presented to the panel, and 161 were identified and analyzed to support the evidence-based tables supporting the MMS AUC.[77] This collaboration of dermatologists developed AUC for 270 clinical scenarios of skin cancer based on cancer and patient characteristics.[78] The 17-member ratings panel ranked each clinical situation into appropriate, inappropriate, or uncertain categories from evidence-based medicine, clinical expertise, and expert judgment.[78] After consensus was achieved in all 270 scenarios, 200 (74.1%) were deemed appropriate, 24 (8.9%) as inappropriate, and 46 (17.0%) as uncertain.[78] These results were jointly published in the *Journal of the American Academy of Dermatology* and *Dermatologic Surgery* in October of 2012. The AAD subsequently developed a telephone application of the MMS AUC for greater availability in the practice setting.

There are a few caveats to the AUC on MMS. First, they are designed to be a guideline of care and not to define the standard of care. The final decision in patient care should reside in the physician's expert judgment. Second, these are not comparative AUC, and, thus, no conclusions can be drawn about the efficacy of MMS compared with that of other treatment modalities. Third, cost was considered only as an additional factor (implicit), not as a primary factor (explicit). Therefore, no conclusions can be drawn regarding the cost-effectiveness of MMS compared with that of other modalities. Finally, these guidelines are considered to be a living revisable

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document, such that as our experience and knowledge changes so will the Mohs AUC.

COST ANALYSIS OF MMS

The US skin cancer epidemic is associated with substantial costs to the health care system. Skin cancer (including MM) is the fifth most costly malignancy to treat in the United States.[7,8,82] A recent report estimates that the average annual cost of treating skin cancer in the United States increased 125% to $8.1 billion in 2007-2011 from $3.6 billion in 2002-2006.[1] Moreover, the direct reimbursements from Medicare to physicians for treatment procedures for cutaneous malignancies increased by 137% from 1996 to 2008.[83] As health care systems struggle to reduce overall expenditure and promote cost-effective treatment, understanding the costs of skin cancer treatments, including MMS, will be critical.

In evaluating health care system expenditures for skin cancer treatment, numerous cost contributors must be considered, including reimbursement for the treatment procedure itself, pathologic evaluation, repair/reconstruction of the resulting defect, anesthesia, facility charges, materials/supply charges, pharmaceuticals, and any additional treatment procedures to re-treat a skin cancer after inadequate initial treatment or positive margins. Moreover, when reviewing studies that evaluate the relative costs of medical treatments, the distinction between cost comparison and cost-effectiveness is critical.[82] Cost comparison can be defined as the evaluation of the cost of one procedure vs a different procedure(s) and the variables that may affect that cost.[82] In contrast, cost-effectiveness analysis compares the relative costs and outcomes of 2 or more medical interventions.[82]

Comparative cost analysis of NMSC treatment options in the US health care system has been evaluated in 4 recent publications.[83-86] These studies report the payments by insurers to treat NMSC using a range of modalities, including MMS, traditional surgical excision, local destructive surgery, radiation therapy, and topical immunomodulatory cream (imiquimod) treatment. The effect of histologic margin control in excisional modalities (permanent vs frozen section pathology) and the site of service (office based, ambulatory surgical center, or hospital-based operating room) on the ultimate cost of the procedure are also calculated.[82] The results of cost comparison studies are summarized in Table 2.[83,86]

These studies show that MMS is cost comparable to office-based surgical excision and clearly less expensive than facility-based excision or radiation therapy. Mohs micrographic surgery is more expensive than local destruction or imiquimod therapy. However, the latter treatments have substantial drawbacks. Imiquimod is approved by the Food and Drug Administration for superficial BCC of the trunk and extremities only, and the National Comprehensive Cancer Network guidelines limit the use of local destructions in

TABLE 2. Estimated Costs of Varied Nonmelanoma Skin Cancer Treatment Modalities and Sites of Service Based on Published Cost Comparison Studies[a]

Treatment and site	Estimated costs ($)				
	Ravitsky et al[83] 2012	Bialy et al,[84] 2004	Rogers and Coldiron,[85] 2009	Wilson et al,[86] 2012	Mean
MMS	804	937-956	1197	2085	1258
Exc/Perm/Office	1025	944-1029[b]	1088	1222[b]	1081
Exc/Froz/Office	1199	1399[b]			1299
Exc/Froz/ASC	2507		2267		2387
Exc/Froz/OR			2883		288
Local destructive surgery (ED&C)			432	463	447
Radiation			2575-3446		3011
Imiquimod			945		945

[a]ASC = ambulatory surgery center; ED&C = electrodessication and curettage destruction; Exc = traditional surgical excision; Froz = frozen section margin control; Imiquimod = topical 5% imiquimod therapy (6 weeks); MMS = Mohs micrographic surgery; Office = office-based surgical setting; OR = hospital-based operating room setting; Perm = formalin permanent section margin control; Radiation = radiation therapy treatment based on 12 to 17 fractions.
[b]Mixed site of service that may include some facility-based treatment.

cutaneous malignancies that are large, aggressive, or in high-risk locations.

The cost-effectiveness of MMS compared with traditional surgical excision has also been evaluated. Seidler et al[87] used a "time trade off" model based on the surgical defect size and likelihood of tumor recurrence. In this study, MMS had an average cost of $957 with a projected quality-adjusted life expectancy of 15.67 quality-adjusted life-years.[82] Traditional surgical excision with a combination of permanent and frozen section margin control costs $1248 and has a projected quality-adjusted life expectancy of 15.61 quality-adjusted life-years.[82]

A more conventional cost-effectiveness evaluation of cost per cancer cure has also been calculated using costs from US studies and historical outcome rates, resulting in US-specific cost-effectiveness ratios.[83] With a difference of $177 in average cost between MMS and office-based excision with permanent sections for NMSC of the face, and taking into account the previously published higher recurrence rates of excisions for NMSC, the cost to prevent a recurrence is $1967. This $1967 is almost twice the cost of a Mohs case.[82]

Thus, given its better effectiveness and lower price tag, MMS is clearly cost-effective compared with any treatment rendered in an inpatient or outpatient facility setting. Moreover, in evaluations with office-based surgical excision with permanent sections,[82] MMS is more effective, with higher cure rates and smaller defects, and also costs less in some studies, but on average, MMS is no more than 15% more expensive.

There is a misperception in the medical community that MMS is a very expensive procedure. It has drawn substantial attention from insurers and regulators as a possibly overused and misvalued procedure, and MMS's cost-effectiveness has been questioned.[84] Mohs micrographic surgery is the only procedure that includes all surgery,

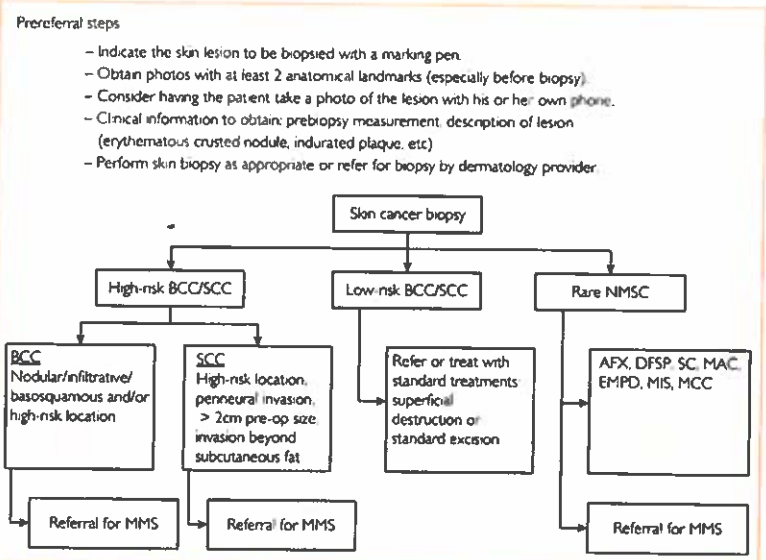

FIGURE 3. Referral steps in the management of cutaneous malignancy for nonmelanoma skin cancer (NMSC). AFX = atypical fibroxanthoma; BCC = basal cell carcinoma; DFSP = dermatofibrosarcoma protuberans; EMPD = extramammary Paget disease; MAC = microcystic adnexal carcinoma; MCC = Merkel cell carcinoma; MIS = melanoma in situ; MMS = Mohs micrographic surgery; SC= sebaceous carcinoma; SCC = squamous cell carcinoma.

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pathology, anesthesia, and supply expenses in the payment for the primary code(s). With MMS, a single payment is made to a single provider. When a patient is treated for skin cancer by facility-based excision, insurer payments are spread out over charges for the operating room, surgeon, anesthesiologist, pathologist, all supplies, and laboratory. The result is that when analyzing facility-based excision, it is easy to solely report payment for the surgical excision and ignore all the mandatory attendant costs. This makes surgical excision seem to be much lower in cost than MMS and more difficult for insurers to track.

As patients become more savvy consumers of health care, many are seeking the best value and quality for their health care dollar. It seems that MMS is an outstanding example of a procedure that is not only cost-effective but also enhances quality of care and adds great value for the patient with skin cancer.[16] As health care costs rise, and insurers and payers attempt to contain costs, there will be increased calls for transparency in charges. Any office-based procedure, but in particular MMS, will become obvious as the most affordable option.

REFERRING PATIENTS FOR MMS

Referring patients to the micrographic surgeon necessitates some critical steps (Figure 3). These steps will assist the surgeon and his or her team in correctly identifying the tumor type and tumor site. Commonly, after a skin biopsy is performed, new skin will grow over the biopsy site. If enough time has passed, this biopsy site may not be readily noticeable, especially if the patient has had previous biopsies, cryotherapy, or multiple concurrent biopsy sites. It is essential to ensure that the site is marked with a tissue-marking pen before taking a photograph that shows at least 2 anatomical landmarks to put the site in context

CONCLUSION

In our experience, MMS is a safe, effective, and cost-efficient treatment modality for cutaneous malignancies. It allows for the highest cure rates while preserving the maximum amount of normal tissue, allowing for immediate reconstruction. As the incidence and diagnosis of skin cancer increases, the demand for cutaneous surgery will continue to evolve. Communication between nondermatology providers and general dermatologists and Mohs surgeons will aid in appropriate and efficient care for patients with skin cancer.

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Abbreviations and Acronyms: **AAD** = American Academy of Dermatology; **AFX** = atypical fibroxanthoma; **ASC** = ambulatory surgery center; **AUC** = appropriate use criteria; **BCC** = basal cell carcinoma; **cSCC** = cutaneous squamous cell carcinoma; **DFSP** = dermatofibrosarcoma protuberans; **ED&C** = electrodessication and curettage destruction; **EMPD** = extramammary Paget disease; **MAC** = microcystic adnexal carcinoma; **MCC** = Merkel cell carcinoma; **MIS** = melanoma in situ; **MM** = melanoma; **MMS** = Mohs micrographic surgery; **NMSC** = nonmelanoma skin cancer; **SC** = sebaceous carcinoma; **SCC** = squamous cell carcinoma; **WLE** = wide local excision

Affiliations (Continued from the first page of this article): Surgery Center, Sacramento, CA (MJF); Department of Dermatology, St Louis University, St Louis, MO (GJH); Laser & Dermatologic Surgery Center, Chesterfield, MO (GJH); Department of Dermatology (RKR, DSW) and Division of Dermatologic Surgery (RKR, DSW), Mayo Clinic, Rochester, MN; and Advanced Dermatology, Norwich, CT (HWR).

Correspondence: Address to Stanislav N. Tolkachjov, MD, Surgical Dermatology Group, 2000 Stonegate Trail, Ste 112, Birmingham, AL 35242 (Stan.tolkachjov@gmail.com)

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Mohs surgery

Overview

Mohs surgery is a precise surgical technique used to treat skin cancer. During Mohs surgery, thin layers of cancer-containing skin are progressively removed and examined until only cancer-free tissue remains. Mohs surgery is also known as Mohs micrographic surgery.

The goal of Mohs surgery is to remove as much of the skin cancer as possible, while doing minimal damage to surrounding healthy tissue. Mohs surgery is usually done on an outpatient basis using a local anesthetic.

Mohs surgery is an improvement to standard surgery (local excision), which involves removing the visible cancer and a small margin of surrounding healthy tissue all at once. Mohs surgery allows surgeons to verify that all cancer cells have been removed

at the time of surgery. This increases the chance of a cure and reduces the need for additional treatments or additional surgery.

Mayo Clinic's approach

Why it's done

Mohs surgery is used to treat the most common skin cancers, basal cell carcinoma and squamous cell carcinoma, as well as some kinds of melanoma and other more unusual skin cancers.

Mohs surgery is especially useful for skin cancers that:

- Have a high risk of recurrence or that have recurred after previous treatment
- Are located in areas where you want to preserve as much healthy tissue as possible, such as around the eyes, ears, nose, mouth, hands, feet and genitals
- Have borders that are hard to define
- Are large or aggressive

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Risks

As with any surgical procedure, Mohs surgery carries the risk of:

- Bleeding
- Pain or tenderness around the surgical site
- Infection

Other complications that may result from Mohs surgery are uncommon but may include:

- Temporary or permanent numbness surrounding the surgical area, if small nerve endings are cut
- Temporary or permanent weakness of the surgical area, if the tumor is large and a muscle nerve is severed
- Itching or shooting pain in the affected area
- An enlarged scar (keloid)

How you prepare

Selecting a Mohs surgeon

Mohs surgery can be technically challenging. Many skin doctors (dermatologists) can perform Mohs surgery, since dermatologists learn about Mohs surgery in their medical training. Some Mohs surgeons have undergone specialized training — called a fellowship — to learn more about the procedure and become more proficient in Mohs surgery.

Ask your doctor about his or her qualifications and experience performing Mohs surgery.

Preparing for surgery

Your surgeon may recommend ways you can prepare for your surgery. You may be asked to:

- **Stop taking certain medications.** Let your surgeon know of any medications or supplements you're taking, including any blood-thinning medications. Some supplements may affect your chances of bleeding after surgery, so make sure your surgeon knows about those, too. Continue taking any prescription medications as instructed unless your surgeon tells you otherwise.
- **Clear your schedule for the day.** It's not possible to predict how long Mohs surgery will take. For most people, the procedure takes less than four hours. But your surgeon may advise you to plan as though surgery will take all day, since there's a very small chance it could take that long.
- **Wear comfortable clothing.** Wear casual clothes that are comfortable. Dress in layers so you can easily adapt if the room is warm or cold.
- **Bring something to help pass the time.** Expect some waiting time during your Mohs surgery. Plan ahead by bringing a book, magazine or other activity to help you pass the time.

What you can expect

Mohs surgery is done on an outpatient basis in an operating room or procedure room that has a nearby laboratory that allows the surgeon to examine the tissue after it's removed.

In most cases, the procedure lasts a few hours. But since it can be difficult to tell how extensive a skin tumor is just by looking at its surface, doctors often advise reserving the whole day for the procedure.

You likely won't have to change into a surgical gown unless the location of the tumor requires it. To prepare you for surgery, your surgeon or a nurse cleanses the area to be operated on, outlines it with a special pen and injects the area with a local anesthetic. The anesthetic numbs the skin, so you won't feel any discomfort during the procedure.

During the procedure

Once the anesthetic has taken effect, your surgeon uses a scalpel to remove the visible portion of the cancer along with a thin, underlying layer of tissue that's slightly larger than the visible tumor. A temporary bandage is placed on your incision. This takes only a few minutes.

The surgeon then takes this tissue to the laboratory for analysis. This portion of the procedure typically takes the longest amount of time.

Expect to wait about an hour or so in a waiting room for the surgeon to return. It may help to bring a book or magazine to pass the time. You'll be able to use the restroom or have a snack, if you need to, but you won't be able to leave the surgeon's office until the procedure is complete.

While you're waiting, the surgeon or technician cuts the tissue sample into sections and examines them with a microscope. Your surgeon takes great care to keep track of the exact spot where each piece of tissue was removed by making a map. That way, if a small area of cancer is found in one piece of tissue, the surgeon knows precisely where to continue with the surgery.

If cancer remains, your Mohs surgery will continue. Your surgeon removes an additional layer of tissue from the affected area, taking care to remove tissue that contains cancer while leaving as much healthy tissue as possible intact. Again, you'll wait while the surgeon examines the tissue in the laboratory.

The process is repeated until the last tissue sample removed is cancer-free. Local anesthetic can be re-administered as necessary.

After the procedure

After all of the cancer has been removed, you and your surgeon can decide on how to repair the wound. Depending on the extent of the operation, this might include:

- Letting the wound heal on its own (healing by second intention)
- Using stitches to close the wound (primary closure)
- Shifting skin from an adjacent area (skin flap) to cover the wound
- Using a skin graft from another part of the body, such as behind the ear, to cover the wound

If the surgical area is extensive or complex, your surgeon may temporarily close your wound and then refer you to another surgeon for reconstructive surgery to repair the wound.

Results

One of the advantages of Mohs surgery is that you know your results right away, and you usually don't leave your appointment until all of the skin cancer has been removed. You may have a follow-up visit with your surgeon or referring doctor to monitor your recovery to make sure your wound is healing properly.

Follow-up exams to look for additional skin cancer

Though Mohs surgery has a high rate of cure for skin cancer, you will always have a small risk of cancer recurrence or of developing another skin cancer.

People who have been diagnosed with skin cancer have an increased risk of developing skin cancer again, compared with people who have never had skin cancer. As many as half the people diagnosed with the most common types of skin cancer will develop another skin cancer again within five years.

Plan to undergo regular follow-up visits with your dermatologist or family doctor to spot any new skin cancer. Ask your dermatologist to create a follow-up schedule for you. How often you'll undergo follow-up skin exams depends on your diagnosis. Expect to have skin exams at least once or twice a year, and more often if your cancer was aggressive or is more likely to recur.

Clinical trials

Explore Mayo Clinic studies testing new treatments, interventions and tests as a means to prevent, detect, treat or manage this disease.

By Mayo Clinic Staff

Mohs surgery care at Mayo Clinic

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What is Mohs surgery?

Also called Mohs micrographic surgery

Used to treat skin cancer, this surgery has a unique benefit. During surgery, the surgeon can see where the cancer stops. This isn't possible with other types of treatment for skin cancer.

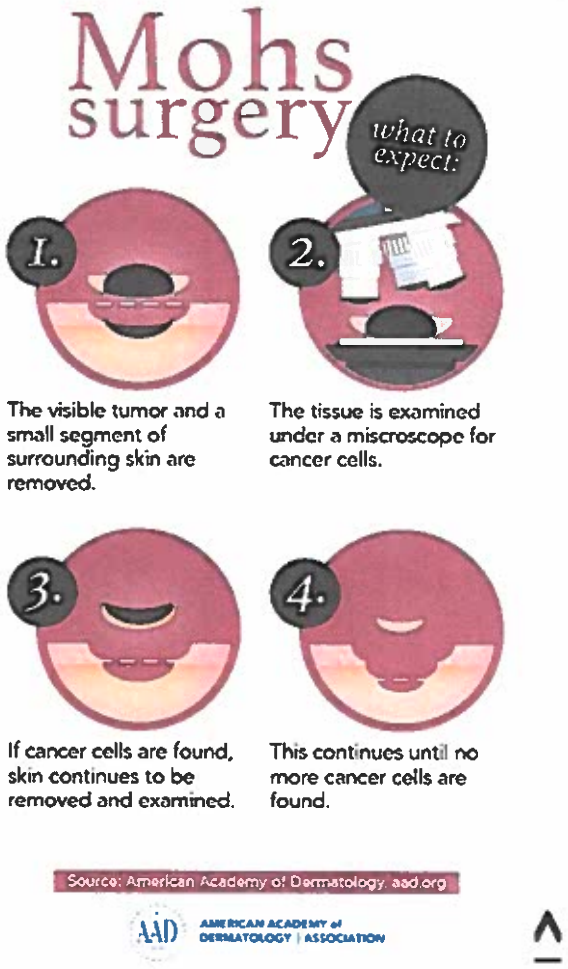
The ability to see where the cancer stops gives Mohs (pronounced Moes) two important advantages:

1. Mohs has a high cure rate.

2. Mohs allows you to keep as much healthy skin as possible because the surgeon only removes the skin with cancer cells. This is especially important when skin cancer develops in an area with little tissue beneath (e.g., eyelid, ear, or hand).

What is it like to have Mohs surgery?

If you have Mohs surgery, you'll see a doctor who is a trained Mohs surgeon. Most Mohs surgeons are dermatologists who have completed extensive training in Mohs surgery.



During Mohs surgery, most patients remain awake and alert. This means Mohs can safely be performed in a medical office or surgical suite. Only if extensive surgery is necessary would you be admitted to a hospital.

On the day of the surgery, your surgeon will first examine the area to be treated. You'll then be prepped for surgery. This includes giving you an injection of anesthetic. This injection only numbs the area that will be operated on, so you'll be awake during the surgery.

Once the anesthetic takes effect, the surgery can begin. The surgeon starts by first cutting out the visible skin cancer. Next, the surgeon removes a thin layer of surrounding skin. You're then bandaged so that you can wait comfortably.

While you wait, the Mohs surgeon looks at the removed skin under a microscope. The surgeon is looking for cancer cells. If cancer cells are found, you'll need another layer of skin removed.

Some wounds heal without stitches.
A: The Mohs surgeon didn't stitch the wound on this man's lip. B: 6 weeks later, the wound has healed on its own.

This process of removing a thin layer of skin and looking at it under a microscope continues until the surgeon no longer sees cancer cells.

Once cancer cells are no longer seen, your surgeon will decide whether to treat your wound. Some wounds heal nicely without stitches. Others need stitches. To minimize the scar and help the area heal, some patients require a skin graft or other type of surgery.

If you need wound treatment, your Mohs surgeon may treat the wound that same day. Some patients with a large wound are referred to another surgeon for wound treatment.

When is Mohs surgery recommended?

Most Mohs patients have a common type of skin cancer like basal cell carcinoma (/public/diseases/skin-cancer/basal-cell-carcinoma) (BCC) or squamous cell carcinoma (/public/diseases/skin-cancer/squamous-cell-carcinoma) (SCC). Mohs is usually recommended when a BCC or SCC:

- Is aggressive or large
- Appears in an area with little tissue beneath it (e.g., eyelid, nose, ear, scalp, genitals, hand, or foot)
- Was treated and has returned

Mohs is also used to treat some rare skin cancers like DFSP (/public/diseases/skin-cancer/dermatofibrosarcoma-protuberans), extramammary Paget's disease, and Merkel cell carcinoma (/public/diseases/skin-cancer/merkel-cell-carcinoma).

Can Mohs treat melanoma?

Yes, dermatologists occasionally recommend Mohs for treating melanoma (/public/diseases/skin-cancer/melanoma), the most serious type of skin cancer. Mohs is only used to treat an early melanoma, and it must be a type of melanoma called lentigo malignant melanoma. This type of melanoma stays close to the surface of the skin for a while.

When treating melanoma, the surgeon uses a modified type of Mohs surgery called slow Mohs. It's called slow because the patient must wait longer for the results. It's not possible for the surgeon to look at the removed skin and know right away whether it contains cancer cells. More time is needed.

If you have slow Mohs, the surgeon will remove the visible skin cancer and a bit of normal-looking skin around it. You'll then be bandaged and sent home.

Most patients return the next day. It's then that the patient learns whether more skin must be removed or the wound can be closed. Again, some wounds are left to heal on their own.

Who is Mohs recommend for?

No matter what type of skin cancer you have, Mohs is only recommended for certain patients. You must have one skin cancer or a few skin cancers that are very close together.

Mohs patients have good results

Having any type of surgery can be scary. If your dermatologist recommends Mohs, you can take comfort in knowing a few facts. Mohs has a high cure rate. Your surgeon will remove the least amount of skin needed to treat the cancer.

Image used with permission of Journal of the American Academy of Dermatology: J Am Acad Dermatol. 2007;

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The Mohs Procedure....Mohs Surgery Patient Education (American College of Mohs Surgery)

ACMS Mohs Surgery Patient Education by American College of Mohs Surgery

The Mohs Procedure

It's helpful to know what to expect before you undergo any surgical procedure. Because the Mohs surgery procedure for skin cancer removal is somewhat complex, it can be reassuring to become familiar with the treatment process ahead of time. Here, you can learn what to expect before, during, and after your procedure.

Mohs surgery is the most effective treatment for most types of skin cancer. To learn more about your options, find a fellowship trained Mohs surgeon in your area.

Before Your Surgery

When you meet with a surgeon certified by the American College of Mohs Surgery (ACMS) for a consultation, you determine together whether a Mohs surgical procedure is the best course of action for your cancer. Once you have set an appointment for surgery, you receive a detailed list of instructions to follow beforehand. You may be asked to:

- Temporarily stop the use of certain medications, including some over-the-counter pain relievers, supplements, and other medicines
- Stop consuming certain foods or beverages a number of hours before your procedure
- Stop smoking
- Clear a full day for your procedure, because it is difficult to predict how long it may take

Your ACMS surgeon and his or her team will give you more information about these and other considerations before your surgery, and it's important to follow this advice as closely as you can to ensure a successful outcome.

Your Mohs Procedure

Surgeons usually perform Mohs skin cancer surgery as an outpatient procedure in the office, which has an on-site surgical suite and a laboratory for microscopic examination of tissue. Typically, surgery starts early in the morning and is completed the same day, depending on the extent of the tumor and the amount of reconstruction necessary.

You receive local anesthesia around the area of the tumor, so you are awake during the entire procedure. The use of local anesthesia versus general anesthesia provides numerous benefits, including preventing a lengthy recovery and possible side effects from general anesthesia. You are completely numb in the area of the surgery, though, so the procedure is comfortable.

After the area has been numbed, your ACMS surgeon removes the visible tumor, along with a thin layer of surrounding tissue. A technician then prepares this tissue and puts it on slides for your surgeon to examine under a microscope. If the surgeon sees evidence of cancer around the outer edges of the removed tissue, he or she takes another layer of tissue from the area where the cancer was detected. This ensures that only cancerous tissue is removed during the procedure, minimizing the loss of healthy tissue. Your surgeon repeats these steps until all samples are free of cancer. Although there are always exceptions to the rule, most tumors require 1 to 3 stages for complete removal.

To get a better picture of how this process takes place, please view our guide, The Mohs Step-by-Step Process.

After Your Surgery

When your surgery is complete, your Mohs surgeon assesses the wound and discusses your options for ideal functional and cosmetic reconstruction. ACMS surgeons understand that a good cosmetic result is an important part of the recovery process, and that's why they work so hard to leave as little tissue damage as possible. If reconstruction is necessary, the Mohs surgeon usually repairs the area the same day as the tumor removal.

Learn more about Mohs surgery recovery, your reconstruction options, and post-operative care.

Last updated: August 28, 2016

American College of Mohs Surgery
555 East Wells Street, Suite 1100
Milwaukee, WI 53202-3823
Phone: (414) 347-1103 or (800) 500-7224

The American College of Mohs Surgery promotes and continues to set the highest standards of patient care relating to management of skin cancer through Mohs micrographic surgery.

Mohs Surgery Patient Education
by American College of Mohs Surgery

The Mohs Step-by-Step Process

The Mohs surgery procedure seems simple: the surgeon removes the cancer, carefully checks to be sure the he or she got it all, then repairs the wound. American College of Mohs Surgery members, however, train in and practice the complex nuances of this process for years so they are prepared to handle any situation they may encounter. This page describes the steps they follow for each Mohs surgical procedure.

Mohs skin cancer surgery is the most effective treatment for most types of skin cancer. To learn more about your options, find a fellowship trained Mohs surgeon in your area.

Step 1

The roots of a skin cancer may extend beyond the visible portion of the tumor. If these roots are not removed, the cancer will recur. A surgery starts with the American College of Mohs Surgery (ACMS) specialist examining the visible lesion and planning what tissue to remove. The patient then receives local anesthesia, and the Mohs surgery begins.

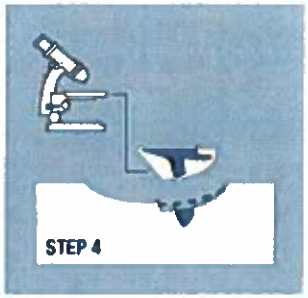
Step 2

The surgeon removes the visible portion of the tumor using careful surgical techniques.

Step 3

The ACMS surgeon next removes a deeper layer of skin and divides it into sections. With the help of technicians, the surgeon then color-codes each of these sections with dyes and makes reference marks on the skin to show the source of the sections. A map of the surgical site is then drawn to track exactly where each small portion of tissue originated.

Step 4



In a laboratory, the surgeon uses a microscope to examine the undersurface and edges of each section of tissue in search of evidence of remaining cancer.

Step 5

If the surgeon finds cancer cells under the microscope, he or she marks their location on the "map" and returns to the patient to remove another deeper layer of skin — but only from precisely where the cancer cells originated. This method ensures that the Mohs surgery results in the smallest scar possible.

Step 6

The removal process stops when there is no longer any evidence of cancer in the surgical site. Because Mohs surgey removes only tissue containing cancer, it ensures that the maximum amount of healthy tissue is kept intact.

https://www.skincancermohssurgery.org/about-mohs-surgery/the-mohs-step-by-step-process 3/16/2019

At this point, the surgeon discusses reconstruction options, should they be required, and then post-operative care. Mohs surgery recovery tends to be easily manageable because of the use of local anesthesia and the careful surgical techniques.

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American College of Mohs Surgery
555 East Wells Street, Suite 1100
Milwaukee, WI 53202-3823
Phone: (414) 347-1103 or (800) 500-7224

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What Happens During Post-Mohs Reconstructive Surgery?

Your Mohs Reconstructive Surgery for Skin Cancer

By Natalie Kita
Updated May 15, 2018

What happens during your post-Mohs reconstructive surgery for skin cancer?

What Is Mohs Reconstructive Surgery?

After having Mohs surgery to remove a skin cancer lesion, your surgeon may perform a simple closure himself or you may recommend post-Mohs reconstructive surgery. This type of reconstructive plastic surgery can be performed immediately after any skin cancer lesions are removed.

Your Options for Post-Mohs Reconstruction

It is important to understand that there is no one "formula" for performing post-Mohs reconstructive surgery since the locations, amounts, and types of tissues affected are different from person to person. However, certain techniques which are commonly used include:

- Flap techniques (The most commonly used technique in post skin cancer facial reconstruction.)
- Bone grafting (Bone is most often taken from the skull and shaped to be placed into the excision site.)
- Cartilage grafting (The most common donor site for cartilage in the ear, but rib cartilage is also used.)
- Tissue expansion (Tissue expanders are used for a small percentage of people.)
- Skin grafts (Skin grafts are used infrequently for facial reconstruction.)

Post-Mohs Reconstructive Surgery - How It's Done

There are a few steps that are common for most people having post-Mohs reconstructive surgery. Prior to beginning the surgery or administering anesthesia, your surgeon will make sure you thoroughly understand the goals of the procedure as well as the possible risks. You will be asked to sign an informed consent form stating that you understand the reason for the procedure, as well as possible complications which could occur. You will also be given information on what you should do prior to the procedure. This may include avoiding any food or drink for a period of time, and sometimes your surgeon may have you shower the night before using a special soap. On the day of the procedure, your skin cancer may be removed either by a dermatologist or by the plastic surgery who is performing your post-Mohs reconstruction. Then:

Anesthesia is given. Skin cancer reconstruction may be performed under local anesthesia, intravenous sedation (also known as managed anesthesia care (MAC) or "twilight sleep"), or general anesthesia. Your doctor will recommend the best choice for you, based on what tends to work well for the procedure you are having, as well as any other medical conditions you may have. If your plastic surgeon is the one excising the lesion, it will be done at this stage. A small lesion with well-defined borders may be removed with a simpler surgical process called excision.

The lesion is removed. This step may have already been completed in a separate procedure unless your plastic surgeon is also the one removing your lesion or is working with your dermatological surgeon as a team in a single procedure. *Note: If your lesion was small with well-defined borders, a simple surgical process called excision may have been used to remove it. If it was larger without well-defined borders, Mohs surgery was probably required.*

The wound is closed. If your procedure has been a simple excision, this is a relatively straightforward process. If, however, more complex Mohs surgery was required, there are a number of options to repair the resulting defect left behind after removal of the lesion.

Regardless of the techniques used, your plastic surgeon will take care whenever possible to ensure that the resulting suture line is positioned to follow the natural creases and curves of your face, in order to minimize the appearance of your scar.

After surgery. You will be observed for a while after your surgery has been completed, and then given instructions for returning home. Some people, especially those who have a flap procedure, may be given a prescription for antibiotics to take at

home. It is important to talk to your surgeon about symptoms of infection and when to call. Most often your surgeon will ask you to call if you develop a fever over 101F, increasing redness, pain, or discharge. If you're given antibiotics to take, make sure to finish all of these. One of the most important things you can do to reduce your chance of infection is to refrain from smoking, as smoking interferes with healing after plastic surgery.

After Post-Mohs Reconstructive Surgery

It is important to note here that for approximately 15 percent of people, reconstruction after skin cancer excision must be performed in at least two stages. This is true mostly when certain types of flap techniques are used. The first stage creates and repositions the flap, and the second stage "sections" or separates the flap from its original location and blood supply. Therefore, once you have recovered and blood supply to the wound has been sufficiently established, a second surgery may need to be scheduled to complete reconstruction.

Surgeries other than a flap technique may also require further procedures in order to get the desired cosmetic effect. It can be helpful to talk to your surgeon prior to your surgery about her expectations, and whether she believes the entire reconstruction can be done in one procedure, or if she expects that you will need more than one procedure.

Learn More About Reconstructive Surgery After Skin Cancer

If you want to find out more about reconstructive surgery after skin cancer removal, including how it's done, your options, and what happens after surgery. Take some time to read about facial reconstruction after skin cancer surgery. You may also wish to take a look at some before and after photos of reconstruction after skin cancer. If you have a weak stomach when it comes to looking at medical photos, you may wish to skip this step, yet many people find it encouraging and comforting to see just how well facial features can be restored, even after significantly large skin cancers are removed.

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STUDY

Mohs Micrographic Surgery and Surgical Excision for Nonmelanoma Skin Cancer Treatment in the Medicare Population

Kate V. Viola, MD, MHS; Mamta B. Jhaveri, MD, MS; Pamela R. Soulos, MPH; Ryan B. Turner, MD; Whitney L. Tolpinrud, MD; Daven Doshi, MD; Cary P. Gross, MD, MPH

Objectives: To identify Medicare use rates of Mohs micrographic surgery (MMS) and surgical excision for the treatment of nonmelanoma skin cancer (NMSC) and to identify patient, lesion, and geographic characteristics associated with treatment type.

Design: A retrospective analysis of Medicare beneficiaries.

Setting: Surveillance, Epidemiology, and End Results database.

Patients: Patients undergoing MMS or other surgical intervention for the treatment of NMSC from January 1, 2001, through December 31, 2006.

Main Outcome Measures: Surgical treatment, patient, and lesion characteristics.

Results: A total of 26 931 operations were performed for the treatment of NMSC from 2001 through 2006, of which 36.4% were MMS. Although the rate of surgical excision slightly increased during this period (1.8 vs 2.1 per 100 Medicare beneficiaries), the rate of MMS doubled (0.75 vs 1.5 per 100 Medicare beneficiaries). In 46.9% of facial lesions, MMS was performed, whereas MMS was used to treat 14.7% of total body lesions. Atlanta, Georgia, had the highest proportion of patients treated with MMS (45.1%); Louisiana had the lowest (11.0%). Age, race, lesion location, and area of country for patient treatment were significantly associated with MMS use (all $P<.001$).

Conclusions: Surgical treatment of NMSC increased substantially from 2001 through 2006, primarily because of a doubling in the rate of MMS procedures. Significant differences in surgical rates, depending on patient age, race, lesion location, and geographic region, of treatment were found.

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Author Affiliations: Department of Dermatology, Albert Einstein College of Medicine, Bronx, New York (Drs Viola, Turner, and Doshi); Department of Medicine, University of Maryland School of Medicine, Baltimore (Dr Jhaveri); Department of Medicine, Yale University School of Medicine (Drs Tolpinrud and Gross and Ms Soulos), and Cancer Outcomes, Policy, and Effectiveness Research Center, Yale Comprehensive Cancer Center (Dr Gross and Ms Soulos), New Haven, Connecticut.

More than 3 million nonmelanoma skin cancers (NMSCs) are diagnosed annually in the United States; 1 in 5 Americans will develop skin cancer during their lifetime.[1,2] The NMSC treatment options include electrodessication and curettage, cryosurgery, photodynamic therapy, laser therapy, radiation, medical therapy, surgical excision, and Mohs micrographic surgery (MMS).[3] Surgical excision is effective for most primary basal cell carcinomas, but cure rates are higher with MMS in patients with recurrent, infiltrative, and high-risk anatomical site (face) cancers; MMS examines 100% of the surgical margin, which ensures definitive tumor removal and minimal loss of surrounding normal tissue.[3,4]

In 1995, the American Academy of Dermatology set forth guidelines for the use of MMS in patients with skin cancer, for which adequate excision and negative margins are essential, particularly in lesions at high risk of local recurrence and/or metastasis or located in anatomical locations that require tissue preservation, such as the face.[5] The National Comprehensive Cancer Network has identified key characteristics that support treatment of NMSC using MMS and similar criteria for surgical excision.[6] Research from both surgical (otolaryngology) and dermatology

See Practice Gaps at end of article

journals reports optimal outcomes with MMS for NMSC, particularly when determining recurrence rates in basal cell carcinomas over time.[7-9] Recent literature has favored the use of MMS for tissue preservation in recurrent skin cancers, particularly on the neck and face, and optimal cosmetic outcomes and increased patient satisfaction, yet there is ongoing debate on the efficacy of surgical treatment (MMS vs surgical excision) for primary NMSC and

the cost-efficacy of MMS.[10-20] In addition, there has also been research examining variation in surgical treatment environment (private vs academic setting) in addition to anatomical location and type of skin cancer (primary vs recurrent) in MMS use.

Despite the evolving recommendations concerning treatment options, there is a paucity of data examining actual patterns of care for NMSC at the population level. It is particularly important to understand the approach to treating NMSC in the Medicare population because older patients have a higher prevalence of this skin cancer type. Population-level studies can help to identify health system factors that may be barriers to the dissemination of treatment modalities. We therefore studied trends in the approach to 2 types of accepted surgical treatment of Medicare beneficiaries with NMSC to identify patient and regional factors associated with the use of MMS and surgical excision over time. This study represents, to our knowledge, the first longitudinal, population-based analysis of surgical excision and MMS use in the United States.

METHODS

DATA SOURCE

A retrospective analysis of Medicare beneficiaries receiving surgical intervention (MMS vs surgical excision) for the treatment of NMSC from January 1, 2001, through December 31, 2006, using a 5% sample of all Medicare beneficiaries with claims data from the Surveillance, Epidemiology, and End Results (SEER) database was performed. Because the SEER registry does not track NMSC, we were able to use this database to identify a random sample of Medicare beneficiaries living within each SEER registry. This approach enabled us to assess regional variation because each SEER region is represented proportionate to the number of Medicare beneficiaries in that region, regardless of how specific conditions, such as NMSC, are managed. The geographic areas that comprise the SEER regions represent approximately 26% of the US population. Our claims data set captured 1 666 604 patients from 2001 through 2006, of whom 1.6% (n = 26 931) had a diagnosis of NMSC.

Patients included in the study sample were at least 67 years of age and were continuously enrolled in fee-for-service Medicare with Part B coverage for 24 months before entry into the study. Because the SEER registry does not track NMSC, this database was used to identify solely a random sample of persons. Patients included had *International Classification of Diseases, Ninth Revision* (*ICD-9*) diagnosis codes for NMSC and *Current Procedural Terminology* (*CPT*) codes for surgical treatment of NMSC, including MMS, wide excision, and simple excision of lesion. The *ICD-9* codes for basal cell carcinoma and squamous cell carcinoma (173.X, where X is the location) were used. The *CPT* codes were used for type of surgical treatment, including MMS (17304-17310), wide excision (26117), and simple excision of malignant lesion (11600-11646). Simple and wide excision codes were combined to delineate all surgical excision from MMS. Therefore, our dependent variable of interest was procedure type, characterized into surgical excision vs MMS; to avoid confusion, we did not delineate the number of surgical treatments performed per patient (cases in which patients may have had multiple lesions) but rather focused on the overall number of surgical procedures by type.

Variables were characterized into patient (sex, sex, and race), lesion (location), and regional (area of country where surgery was performed, delineated by SEER site) characteristics. To accurately identify treatment trends within our patient population, we determined the number of Medicare beneficiaries from the Centers for Medicare and Medicaid Services for 2004 by state; this year was chosen as the optimal midpoint of our SEER data, which span 2001 through 2006.

STATISTICAL ANALYSIS

The unit of analysis was procedure. A bivariate comparison between our dependent variable (surgical procedure type) and our independent variables (age, sex, race, location of lesion, and area of country treatment was given) was performed using χ^2 analysis. All statistical analyses were performed with the SAS statistical software package (version 9.2; SAS Institute, Inc).

GEOGRAPHIC ANALYSIS

Our initial geographic area of analysis was the SEER registry. Within each registry, we calculated the percentage of patients in our sample who were treated with MMS. The registries were then ranked according to the MMS percentage. Because Utah was the registry with the median percentage of MMS performed, it was selected as the reference for subsequent analyses of geographic variation. The percentages of MMS performed in other registries were compared with the percentage of MMS performed in the Utah registry using logistic regression. The number of surgical treatments for NMSC from 2001 through 2006 in each SEER registry was also estimated. The number of MMS procedures was then divided by the total Medicare beneficiaries within each respective region in 2004 to determine MMS treatment.

RESULTS

PATIENT CHARACTERISTICS

A total of 26 931 patients with NMSC were surgically treated from 2001 through 2006 in our 5% sample of Medicare beneficiaries (**Table 1**). Of all operations performed, 9802 (36.4%) were MMS and 17 129 (63.6%) were surgical excisions. Of all procedures undergone by men, 5603 (36.9%) were MMS, similar to the proportion for women (35.8%, P = .07). A total of 40.6% of procedures received by patients 67 to 69 years old were MMS, which decreased to 33.5% among patients 85 years and older. As a result, there was an increase in the number of procedures that used surgical excision with age (59.4% for those 67-69 years old vs 66.5% for those >85 years old, $P < .001$).

Of all procedures performed on patients identified as white, 9708 (36.5%) were MMS compared with 23.1% for black patients and 28.7% for patients identified as other races. In our bivariate analysis, age ($P < .001$), race ($P = .005$), and location ($P < .001$) were significantly associated with MMS for NMSC treatment.

LESION CHARACTERISTICS

When compared with surgical excision, MMS was more likely to be performed on lesions located on the lip (60.1% vs 39.9%) and eyelid (57.2% vs 42.8%) (Table 1). There was a similar proportion of patients with NMSC treated with MMS vs surgical excision in periocular lesions and those unspecified on the face. In contrast, most malig-

Table 1. Characteristics of Surgical Intervention for 26 931 Patients With NMSC, 2001-2006

Characteristic	No. (%) of Surgical Excisions for NMSC	No. (%) of MMS Procedures for NMSC	*P* Values[a]
Total	17 129 (63.6)	9802 (36.4)	
Sex			
Male	9594 (63.1)	5603 (36.9)	.07
Female	7535 (64.2)	4199 (35.8)	
Age range, y			
67-69	1086 (59.4)	742 (40.6)	< .001
70-74	3366 (62.4)	2026 (37.6)	
75-79	4806 (62.4)	2891 (37.6)	
80-84	4444 (64.8)	2413 (35.2)	
≥85	3427 (66.5)	1730 (33.5)	
Race			
White	15 888 (63.5)	9708 (36.5)	.005
Black	(76.9)[b]	(23.1)[b]	
Other	(71.3)[b]	(28.7)	
Skin location			
Lip	242 (39.9)	365 (60.1)	< .001[c]
Eyelid	299 (42.8)	400 (57.2)	
Ear and external auditory canal	999 (52.5)	903 (47.5)	
Other unspecified area of face	7086 (54.3)	5956 (45.7)	
Scalp and skin of neck	1814 (75.4)	592 (24.6)	
Trunk except scrotum	2080 (90.8)	209 (9.1)	
Upper limb including shoulder	2628 (88.3)	348 (11.7)	
Lower limb including hip	1112 (86.7)	170 (13.3)	
Other specified sites of skin	147 (16.3)	753 (83.7)	
Skin site unspecified	719 (87.2)	106 (12.8)	

Abbreviations: MMS, Mohs micrographic surgery; NMSC, nonmelanoma skin cancer.

[a] *P* values were calculated using χ^2 test statistics for comparing the association between variables and type of surgical intervention.

[b] Any cell size that is smaller than 11 must be suppressed per Surveillance, Epidemiology, and End Results–Medicare policy.

[c] This *P* value reflects the association between lesions located on the face vs other body areas

nant neoplasms located below the face were treated with surgical excision. A total of 753 (83.7%) lesions on other specified sites of skin were treated with MMS.

TEMPORAL TRENDS AND REGIONAL CHARACTERISTICS

From 2001 through 2006, the total use of surgical treatment increased, primarily due to the increase in MMS over time (**Figure 1**). In 2001, every 0.7 of 100 Medicare beneficiaries received MMS treatment for NMSC. This number doubled by 2006 (1.5 per 100 beneficiaries). Surgical excision increased slightly during this period (1.8 per 100 beneficiaries in 2001 to 2.1 in 2006).

Atlanta, Georgia, had the highest proportion of patients with NMSC treated with MMS (45.1%) (**Table 2**). Regions, including New Jersey (42.7%), Los Angeles, California (41.6%), Iowa (41.0%), and Detroit, Michigan (41.2%), also had comparable MMS use rates in the 6-year period. Areas with fewer MMS performed included Louisiana (11.0%), Hawaii (19.4%), and New Mexico (27.1%).

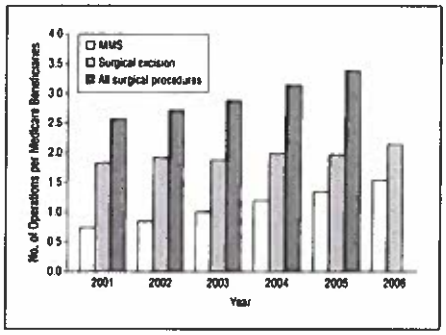

Figure 1. Annual treatment intensity for each surgical type. MMS indicates Mohs micrographic surgery.

Table 2. Surgical Treatment Type by SEER Region, 2001-2006

SEER Region	No. (%) of Surgically Treated Patients Who Underwent Surgical Excision	No. (%) of Surgically Treated Patients Who Underwent MMS
Los Angeles, California	1385 (58.4)	988 (41.6)
San Francisco–Oakland, California	708 (72.1)	274 (27.9)
San Jose–Monterey, California	365 (63.9)	206 (36.1)
Greater California	4305 (61.7)	2672 (38.3)
Connecticut	1195 (67.4)	578 (32.6)
Detroit, Michigan	686 (58.8)	480 (41.2)
Atlanta, Georgia	497 (54.9)	409 (45.1)
Rural Georgia	51 (60.7)	33 (39.3)
Hawaii	179 (80.6)	43 (19.4)
Iowa	937 (59.0)	652 (41.0)
Kentucky	1385 (66.7)	692 (33.3)
Louisiana	1224 (89.0)	152 (11.0)
New Jersey	2109 (57.3)	1574 (42.7)
New Mexico	404 (72.9)	150 (27.1)
Seattle–Puget Sound, Washington	584 (65.0)	368 (35.0)
Utah	549 (66.3)	279 (33.7)

Abbreviations: MMS, Mohs micrographic surgery; SEER, Surveillance, Epidemiology, and End Results.

When examining the United States, the West and Northeast regions had the greatest proportion of surgically treated patients undergoing MMS, whereas patients were less likely to undergo this procedure type in the Midwest and Pacific areas (**Figure 2**).

COMMENT

Our study demonstrated that surgical treatment of NMSC increased substantially from 2001 through 2006, primarily due to a doubling in the rate of MMS procedures. Although there was no sex discrimination with respect to surgery type, the age of the patient was significant; a higher proportion of MMS was performed in younger patients.

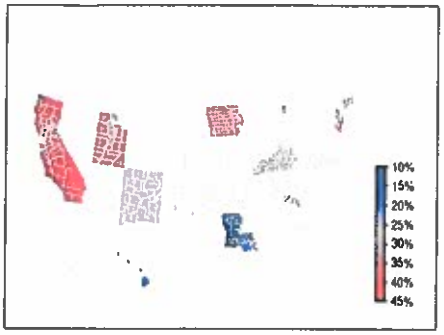

Figure 2. Proportion of surgically treated patients undergoing Mohs micrographic surgery or surgical excision compared with all surgical procedures by Surveillance, Epidemiology, and End Results region. Treatment intensity was calculated by dividing the total number of each procedure by the total number of Medicare beneficiaries each year multiplied by 100.

In addition, as age increased, the number of surgical excisions for NMSC increased. We hypothesize that younger patients and their physicians may be more concerned with cosmetic outcome, tissue preservation, and minimizing recurrence compared with older individuals, who may have comorbidities or other medical needs in which MMS would not be an appropriate treatment option.

It is difficult to assess the role of race because most patients surgically treated with NMSC were white in this study (approximately 99%). However, the proportion of surgical excisions vs MMS in blacks and other minorities with NMSC was far greater when compared with whites. This finding may imply that minorities may not have access or are not referred as often to surgeons who perform MMS. Although our research does not examine nonsurgical NMSC treatments or NMSC incidence by race, further research is needed to assess the potential underdiagnosis and surgical treatment in these patient populations. Consistent with the core principles of tissue preservation and aesthetic outcome, we found that most MMS procedures were performed on the face. Our findings reveal that 46.9% of all facial lesions were surgically treated with MMS; we were not able to identify, however, whether these lesions were primary or recurrent. The overall validity of Medicare claims data for tracking billable procedures has been studied and represents an accurate data source for the study of population-based patterns of surgical treatment.[21,22]

Factors that influence the regional variation not accounted for by this study could be cumulative sun exposure, regional incidence of NMSC, and the percentage of the population older than 65 years (Medicare beneficiaries). The West and Northeast may also represent regions of the country with several academic settings, a greater likelihood of surgeons trained to perform MMS, and therefore a greater proportion of MMS procedures being performed. There may also be geographic variation due to dermatologists and/or other physicians practicing MMS without formal training or a small group representing a monopoly on the MMS procedures performed in that specific region. Variations in care may also result from lack of consensus (eg, whether to perform MMS on primary lesions) or are influenced by the medical environment in which the patient has sought treatment. Future studies are needed to further evaluate the cause of this regional variation and to identify regional disparity.

In the past decade, the total proportion of MMS procedures has doubled. Recent studies[1,23,24] demonstrated that the number of NMSCs diagnosed and the number of procedures (an increase of 16% from 2002-2006) in Medicare beneficiaries has increased significantly since the early 1990s. Our study revealed that although the rate of surgical excision slightly increased during this period (1.8 vs 2.1 of 100 Medicare beneficiaries), the rate of MMS doubled (0.75 vs 1.5 of 100 Medicare beneficiaries). However, the increase in NMSC incidence does not explain the increase in MMS use. This trend mirrors the increase in the number of members trained by the American College of Mohs Surgery (ACMS), which has quadrupled in the past 15 years. The ACMS has approximately 1000 members and reports approval of 79 procedural dermatology fellowships in 2009 throughout the country for, on average, 1 physician per year through the San Francisco match. The American Society of Mohs Surgery has 1235 members, of whom 900 are dermatologists and the remaining members are MMS technicians.

Although our study has the strength of analyzing the national trends of MMS use using a large database, it is limited in its scope because we only use Medicare beneficiaries and cannot assess the patterns of use of other patients. This limitation could underestimate the use of MMS for NMSC because MMS is a costly procedure and may be favored by patients younger than 65 years who are willing to pay out of pocket or have other insurance. However, because the incidence of NMSC increases with age, most patients older than 65 years have some degree of Medicare coverage, and therefore our study is a good starting point for analyzing MMS for NMSC throughout the United States. Additional variables play a role in the decision to use MMS for NMSC, including histopathologic findings and tumor size, which we have not accounted for in this study. We have only examined surgical excision and MMS treatment options and have not included other surgical therapy types in this study (eg, electrodessication and curettage) for the treatment of NMSC. Although the SEER registry is an accepted and widely used representation of cancer prevalence in the United States, it does not include states such as Florida and New York. In addition, because most current SEER data are restricted to the year 2006, we were unable to make any conclusions regarding MMS intensity for 2009 through 2010.

The use of MMS has been steadily increasing during the past decade, with MMS representing approximately one-third of all surgical procedures for NMSC. To our knowledge, this is the only study to examine the national patterns of use of MMS for NMSC over time. Patient age and lesion location were significantly associated with type of surgery (MMS vs surgical excision), yet there were wide variations in regional MMS use and geographical disparity that warrant further investigation. Additional large, prospective studies are needed to further identify surgical treatment outcomes for NMSC.

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Correspondence: Cary P. Gross, MD, Department of Medicine, Yale University School of Medicine, 333 Cedar St, LMP-1072, PO Box 208056, New Haven, CT 06520 (cary.gross@yale.edu).
Author Contributions: All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design*: Viola, Jhaveri, Soulos, Turner, Tolpinrud, Doshi, and Gross. *Acquisition of data*: Viola, Jhaveri, Soulos, and Gross. *Analysis and interpretation of data*: Viola, Jhaveri, Soulos, and Gross. *Drafting of the manuscript*: Viola, Jhaveri, Soulos, Turner, Tolpinrud, Doshi, and Gross. *Critical revision of the manuscript for important intellectual content*: Viola, Soulos, Turner, and Gross. *Statistical analysis* Viola, Gross, and Soulos. *Administrative, technical, or material support*: Soulos. *Study supervision*: Gross and Turner.
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PRACTICE GAPS

Use of Mohs Micrographic Surgery for the Treatment of Nonmelanoma Skin Cancer

The lack of evidence-based management algorithms for the treatment of nonmelanoma skin cancer (NMSC) is a practice gap. Practicing physicians have no algorithm of care for the most common cancer, NMSC. In the absence of algorithms, there is regional variation in the use of Mohs surgery. Consensus regarding tumor pathologic type, diameter, and anatomical location led to definitions of low risk for recurrence and high risk for recurrence of NMSC. Chren et al[1] demonstrated adherence to a protocol in a single institution for low-risk vs high-risk NMSC. Mohs surgery is predominantly used to treat facial lesions, especially of the lip and eyelid, where the tissue-sparing benefit is most needed. The crux of the concern is that the doubling rate of Mohs

Authors: Kishwer Nehal, MD, Erica Lee, MD
Section Editor: Stanley J Miller, MD
Deputy Editor: Rosamaria Corona, MD, DSc

INTRODUCTION

Mohs micrographic surgery (MMS) is a specialized surgical technique for removing locally invasive, high-risk skin cancers. MMS provides high cure rates with maximal preservation of unaffected tissue [1-4]. In contrast to standard excision, in which only a small portion of the margins are evaluated, in MMS, specimens are cut in horizontal sections that allow the evaluation of the entire peripheral and deep margins of the tumor.

The most common malignancies treated with MMS are basal cell carcinoma (BCC) and squamous cell carcinoma (SCC). MMS is also used to remove other skin malignancies such as dermatofibrosarcoma protuberans (DFSP), microcystic adnexal carcinoma, extramammary Paget disease (EMPD), and lentigo maligna.

The MMS technique and its indications will be discussed in this topic review. Alternative treatments for skin tumors are discussed separately.

- (See "Treatment of basal cell carcinomas at high risk for recurrence".)
- (See "Recognition and management of high-risk (aggressive) cutaneous squamous cell carcinoma".)

Literature review current through: Oct 2018. | **This topic last updated:** Oct 30, 2018.

METRO EAST
DERMATOLOGY & SKIN CANCER CENTER

March 27, 2019

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield IL 62761

Re: CON Permit Application
Skin Cancer Surgery Center, LLC
ASTC Establishment

Dear Ms. Avery,

On behalf of my solo private medical practice, Metro East Dermatology and Skin Cancer Center, Shiloh, Illinois, 62269, please accept this CON permit application to establish a single specialty, single room, non-hospital based Ambulatory Surgical Treatment Center (ASTC).

I am developing a new medical office building (MOB) to house my relocated private dermatology practice. The new practice site will be located at 331 Regency Park Drive, O'Fallon, Illinois, 62269. The MOB will have unfinished space intended to house the proposed new ASTC identified as "Skin Cancer Surgery Center, LLC", which will be dedicated to Mohs Surgery repair and reconstruction procedures, as described in the enclosed CON permit application. These procedures are integral to my office-based medical practice and a proximal ASTC surgical environment will provide an optimal physical relationship to ensure the highest quality medical care. Requisite documentation is provided within the permit application.

A check in the amount of $2,500.00 is enclosed for the initial application processing fee. The check number is 1267. Please let me know if any additional fees are applicable.

If you have any questions, please contact me at jmcginness@dermskincancercenter.com or at 618-622-7546.

Sincerely,

Jamie L. McGinness, M.D.
On behalf of: Skin Cancer Surgery Center, LLC

CC: Mike Constantino, Supervisor, Project Review Section
Ed Parkhurst, Jr. PRISM Healthcare Consulting