Exhibit 179

(Rev. 85, Issued: 07- 19-13, Effective: 07-19-13, Implementation: 07-19-13)

INFORMATION ON MEDICARE PARTICIPATION FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

CMS recognizes the essential role FQHCs play in promoting access to preventive and primary care among medically underserved populations by utilizing a streamlined Medicare enrollment process. This streamlined process allows an FQHC applicant to use a self-attestation (see below) to confirm that it meets Medicare health and safety standards instead of having an on-site initial and subsequent recertification, survey to assess the FQHC's compliance. The FQHC attests to its eligibility to participate in Medicare and agrees to remain in compliance with all of the FQHC requirements specified in Medicare regulations at 42 CFR Part 405 Subpart X, and at 42 CFR Part 491, with the exception of §491.3.

Medicare Definition of an FQHC:

For purposes of enrolling in Medicare, an FQHC is defined as an entity that has entered into an agreement with CMS and:

- Is receiving a grant under §330 of the Public Health Service (PHS) Act; or
- Is receiving funding under a contract with the recipient of a §330 grant, and meets the requirements to receive a grant under §330 of the PHS Act; or
- Is an FQHC "Look-Alike," i.e., Health Resources and Services Administration (HRSA), has *notified it that it* meet*s* the requirements for receiving a §330 grant, even though it is not actually receiving such a grant; or
- Was treated by CMS as a comprehensive federally funded health center as of January 1, 1990; or
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

Medicare Agreement:

CMS will enter into an agreement with an entity to participate as an FQHC when:

- CMS receives a complete application Form CMS 855A, Medicare Enrollment Application, Institutional Providers;
- CMS receives a copy of the applicant's Notice of Grant Award *or* FQHC Look-Alike Designation *notice issued* by HRSA, or the applicant is confirmed as a qualifying tribal or Urban Indian organization outpatient healthcare facility;

- The applicant assures CMS that it satisfies the regulatory requirements at 42 CFR 405 Subpart X, and 42 CFR Part 491, except for §491.3; and

- The applicant terminates other Medicare provider agreements it has, unless it assures CMS that it is not using the same space, staff and resources simultaneously as an FQHC and as a physician's office or other type of provider or supplier. For example, a rural health clinic (RHC) cannot concurrently be approved for Medicare as both an RHC and FQHC.

In accordance with 42 CFR 491.5(a)(3)(iii), each permanent site at which an FQHC offers services requires a separate agreement with Medicare.

- This means that an FQHC that operates several health centers at different sites but under one management must have each site separately enrolled in Medicare as an FQHC. While this requirement for a separate agreement with CMS for each permanent site does not prevent an FQHC which has several permanent sites from consolidating Medicare claims and cost report data, it would be a violation of Medicare regulations for the FQHC to submit claims for services provided at a site for which there is no specific Medicare agreement.

- Mobile units of an FQHC are not required to be separately enrolled in Medicare, but are treated as part of the FQHC. Mobile units must also comply with the Medicare health and safety standards.

Medicare Enrollment Application:

To participate in the Medicare program as an FQHC, applicants must submit to CMS:

- A signed and completed application Form CMS-855A, Medicare Enrollment Application, Institutional Providers. Form CMS-855A may be downloaded from CMS' Web site at: http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf. *Applications must be submitted as follows:*

- *In the case of applicants that are operated by a tribe or tribal organization, to the jurisdiction H A/B MAC; and*

- *In the case of all other applicants, to the A/B MAC that covers the State where the applicant facility is located. (Previously all FQHC applications and claims were processed by one national fiscal intermediary. This system is being phased out as CMS implements the MAC contracts, and all new FQHC applications are to be assigned to the applicable MAC, as described above. In the case of a new applicant that is a permanent unit owned and operated by an existing FQHC in a different location in the same state, this could mean that each permanent unit would have a different MAC until the transition to MACs has been completed nationwide. However, accommodations have been made for a set of FQHCs that straddle MAC jurisdiction boundaries to continue filing a consolidated cost report.)*

An on-line application option is also available.

Information on enrollment procedures and a list of A/B MACs may be found at:

- *http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html?redirect=/center/fqhc.asp*

- *http://www.cms.gov/medicare-coverage-database/indexes/contacts-part-a-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&*

- Two copies of the standard attestation statement, each with an original signature and date. When countersigned by CMS, this statement serves as the Medicare FQHC agreement. One signed copy will be returned to the FQHC by CMS. A template attestation statement *with instructions* may be downloaded from CMS' Web site at: http://www.cms.hhs.gov/manuals/downloads/som107_exhibit_177.pdf

- In the case of applicants eligible to be an FQHC on the basis of: 1) receiving a HRSA §330 grant; or 2) receiving funding under a contract with an FQHC receiving a HRSA §330 grant; or 3) FQHC Look-Alike designation, *the* HRSA Notice of Grant Award to an FQHC or *the notice of* FQHC Look-Alike designation. *The notice must indicate the approved or designated practice location, which must be the same as that reported on the Form CMS 855A*;

- *Form CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement;*

- *Copy of* Clinical Laboratory Improvement Act (CLIA) Certificate *(if applicable). Facilities that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings is considered a laboratory and must meet CLIA requirements. These facilities must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed. Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. One example would be facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostics test. Chapter 6, Section 6002 of the State Operations Manual provides additional details regarding laboratories and laboratory tests NOT subject to CLIA requirements. It is the responsibility of the FQHC applicant to review the CLIA requirements and obtain a CLIA certificate if needed. Neither the MAC/FI nor the Regional Office makes a determination as to whether the FQHC applicant must obtain and submit a CLIA certificate; and*

- *Copy of* State License (*i*f *a*pplicable).

Medicare Regulatory Requirements:

- The FQHC must remain in substantial compliance with all of the FQHC regulatory requirements specified in 42 CFR Part 405 Subpart X, and at 42 CFR Part 491, with the exception of §491.3. The FQHC's are encouraged to access the on-line Code of Federal Regulations to download a copy of the regulatory requirements at the following Web site: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl

- **42 CFR Section 405.2436 provides that CMS may terminate an agreement with an FQHC if it finds that the FQHC is not in substantial compliance with the Medicare regulatory requirements**

- Medicare regulations governing FQHCs include health and safety requirements found in 42 CFR Part 491, setting standards for such things as:

  – Compliance with applicable Federal, State and local laws and regulations;

  – Policies and lines of authority and responsibilities are clearly set forth in writing;
  – Provision of medical direction to the FQHC by a physician;
  – Clinical staff and staff responsibilities;
  – Provision of services and patient care policies;
  – Patient health records;
  – Program quality assessment/improvement;
  – The construction and maintenance of the FQHC ‘s physical plant; and
  – Handling of non-medical emergencies in the FQHC.

- There are also other Medicare regulations found at 42 CFR Part 405, Subpart X governing:

  – Definition of an FQHC
  – Entering into an FQHC agreement with CMS
  – Content of the Medicare agreement, including but not limited to:

    - Agreement to accept Medicare beneficiaries for care and treatment in the same way that it provides care for non-Medicare beneficiaries;
    - Maintaining compliance with Part 491, except for §491.3;
    - Promptly reporting to CMS any changes that result in noncompliance;
    - Effective date of the agreement; and
    - Charges to Medicare beneficiaries, including agreement not to charge beneficiaries for services that they are entitled to have Medicare pay for.

  – Scope of services covered by Medicare and payment provisions, including supplemental payments to FQHCs;
  – Beneficiary appeals;
  – Report and maintenance of records;
  – Termination of the agreement with CMS, including notice to the public and conditions for reinstatement after termination; and
  – Change of ownership.

- **Before signing the FQHC attestation statement, applicants should carefully review the regulations cited above to ensure the accuracy of their attestation of compliance.**