

Exhibit 3

**REQUEST FOR WAIVER OF ELECTRONIC FILING
OF MEDICARE COST REPORT**

After this form is completed, please FAX it to:

For cost reports to be filed in Syracuse, NY:	For cost reports to be filed in Milwaukee, WI:	For cost reports to be filed in Ohio:
Christine Chamberlain Medicare Audit and Reimbursement National Government Services, Inc. PO Box 4846 Syracuse, NY 13221-4846 Fax: 315-442-4980	Beverly Rader-Eggert Medicare Audit and Reimbursement National Government Services, Inc. PO Box 7149 Indianapolis, IN 46207-7149 Fax: 414-459-5496	Kathy Guran National Government Services, Inc. MP: OH0603-A846 PO Box 7141 Indianapolis, IN 46207-7141 Fax: 513-419-3622

For cost reports to be filed in Virginia:	For cost reports to be filed in West Virginia:
Mary G. Hairston Medicare Audit and Reimbursement National Government Services, Inc. 8002 Discovery Drive, Suite 110 Richmond, VA 23229 Fax: 804-521-2360	Danene Hartley Medicare Audit and Reimbursement National Government Services, Inc. 300 Summers Street, Suite 1380 Charleston, WV 25301 Fax: 304-340-5252

PROVIDER NAME: _____

COST REPORT PERIOD FROM: _____ THRU: _____

Write in Medicare Provider number(s) and total (Part A and Part B) projected Medicare payments and cost. (Claims plus lump sum adjustments).

PROJECTED PAYMENTS:

Provider No.: _____ Projected Total Medicare Payments: \$ _____

Provider No.: _____ Projected Total Reimbursable Cost: \$ _____

PROJECTED DAYS/VISITS:

N/A for FQHC providers.

Any other Provider Types: Provider No.: _____ Projected Medicare Days/Visits: \$ _____

Projected Total Days/Visits: \$ _____

This is the written request required by CMS for waiver of the electronic cost report-filing requirement for the above-indicated provider and cost reporting period. The provider understands that the Medicare contractor's determination will be initially based on the projected Medicare payments and days/visits above, which will be re-evaluated by the Medicare contractor against actual Medicare payments and days/visits on the PS&R report.

AUTHORIZED PERSON REQUESTING WAIVER:

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

TITLE: _____ PHONE: _____

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PROVIDER NUMBER: _____

COST REPORT PERIOD FROM: _____ THRU: _____

FOR MEDICARE CONTRACTOR USE ONLY: Basis for Recommendation to CMS-CO
(FQHC Threshold = \$10,000 / All Other Provider Types Threshold = \$200,000 or 10% Medicare utilization)

Table with 2 columns: FQHC, ALL OTHER. Rows include: Provider's Estimate Payments, PS&R Payments*, Provider's Estimate Medicare Days/Visits, PS&R Medicare Days/Visits*, Calculated Medicare Utilization.

* Normally runs 3 months after Fiscal Year End

- () Meets threshold requirement/eligible for waiver
() Does not meet threshold requirement/not eligible for waiver

Prepared By: _____ Date: _____

Reviewed By: _____ Date: _____

MEDICARE COST REPORT FILING REQUIREMENTS

Home Office Cost Statements

1. Include a completed and legible cost statement on the proper forms (CMS-287-05).
2. Provide general information and certification page which includes the original signature of an officer (administrator, chief financial officer, or chief executive officer).

Home office cost statements are to be submitted within 150 days of the chain home office's fiscal year end. If the chain home office fails to submit a cost statement within that time frame, they will be notified of their failure to submit a cost statement, and the servicing intermediary will issue a demand notice requiring repayment of home office costs. The intermediaries are required to reduce interim payments to the providers to reflect the disallowance of any home office costs.

Low and No Medicare Utilization Cost Reports


The criteria to qualify to file a low utilization cost report for all provider types (except FQHCs) are:

- Less than 10% Medicare utilization, or
- Less than \$200,000 Medicare Part A + B net reimbursement


The criteria to file a low utilization cost report for FQHCs are:

- Net Reimbursement less than \$10,000

Items required to be submitted for a low utilization cost report:

- Certification Page (Worksheet S), signed in ink by an officer or administrator
- Applicable S-series worksheets
- Waiver of Electronic Filing Form 
- Balance sheet and income statement (these can be worksheets from the cost report (i.e. F-series worksheets for the 1728-94 cost report)

Items required to be submitted for a no Medicare utilization cost report:

- Certification Page (Worksheet S), signed in ink by an officer or administrator
- Waiver of Electronic Filing Form 
- Certification for No Medicare Utilization Form 