

**SCHEDULE J  
REQUEST FOR REIMBURSEMENT  
RELATED TO RESPIRATORY THERAPY  
JULY 1 THROUGH SEPTEMBER 30, 2003**

**FACILITY NAME:** \_\_\_\_\_

**PROVIDER NUMBER:** \_\_\_\_\_

RECIPIENT NAME	MAID NUMBER	CHARGES FOR SERVICES	CHARGE TO COST RATIO	COST FOR SERVICES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**TOTAL COST PER FACILITY** \$ \_\_\_\_\_