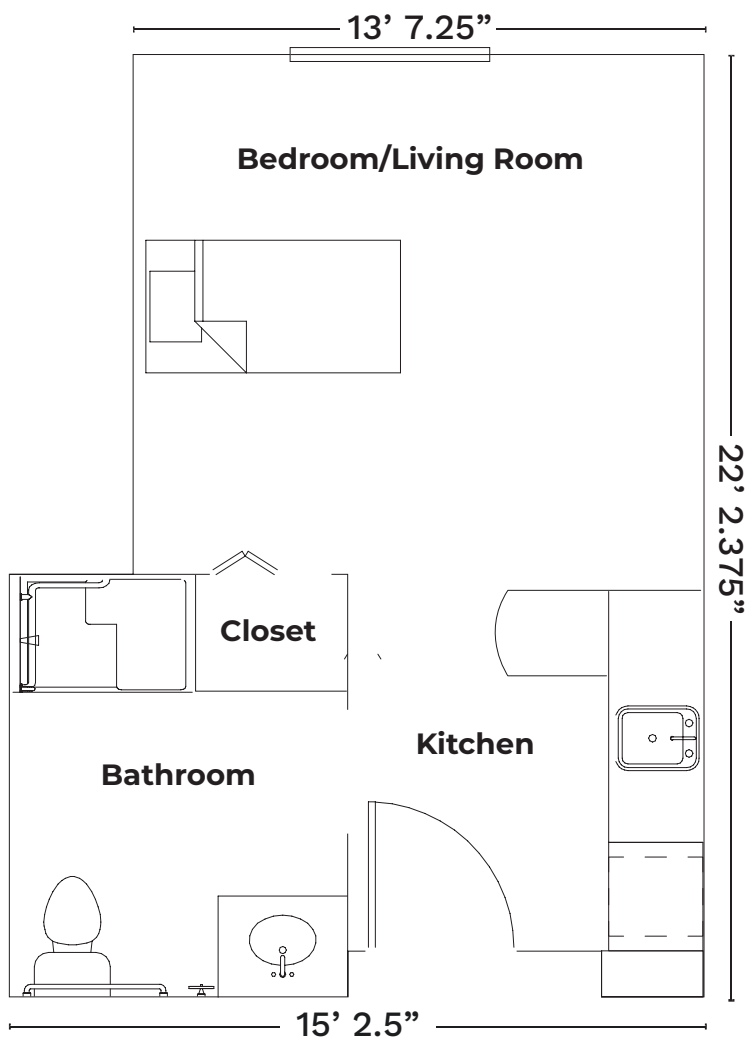


Studio

345-348 SQ. FT.



DATE _____ RESIDENCE NUMBER _____ PREPARED BY _____

ONE-TIME COMMUNITY FEE MONTHLY FEE SECOND-PERSON FEE ESTIMATED LEVEL OF CARE*

\$ _____ \$ _____ \$ _____ \$ _____

OTHER TOTAL MONTHLY FEE

\$ _____ \$ _____

*To be determined based upon clinical assessment