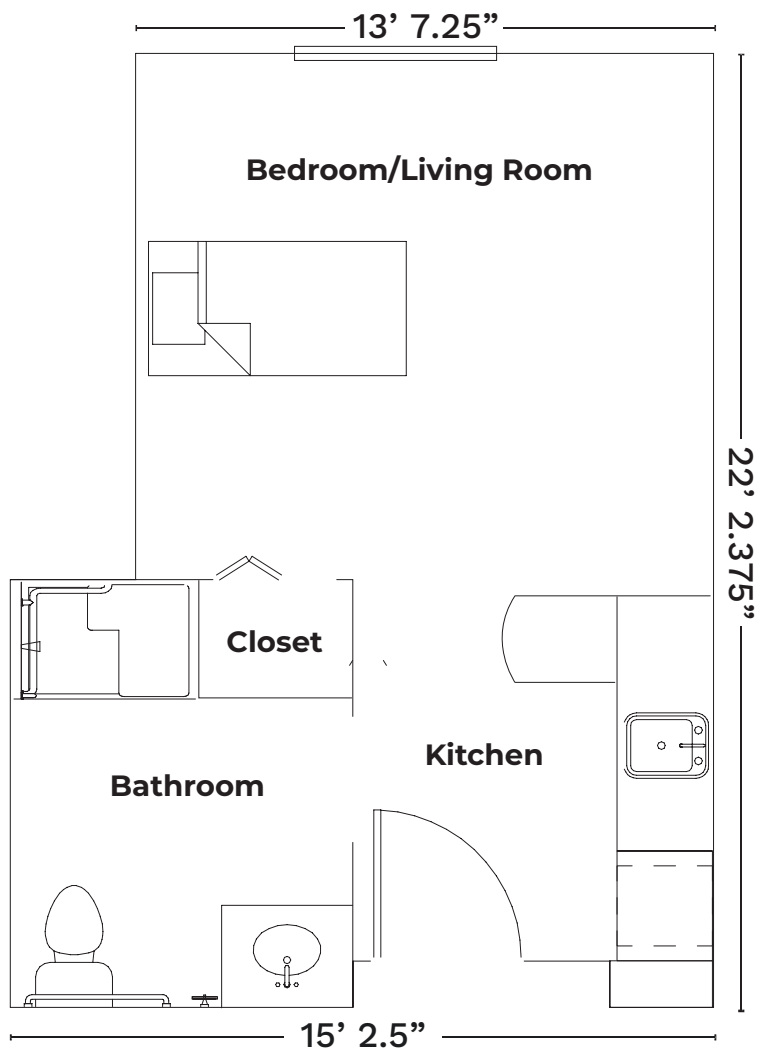


Studio

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