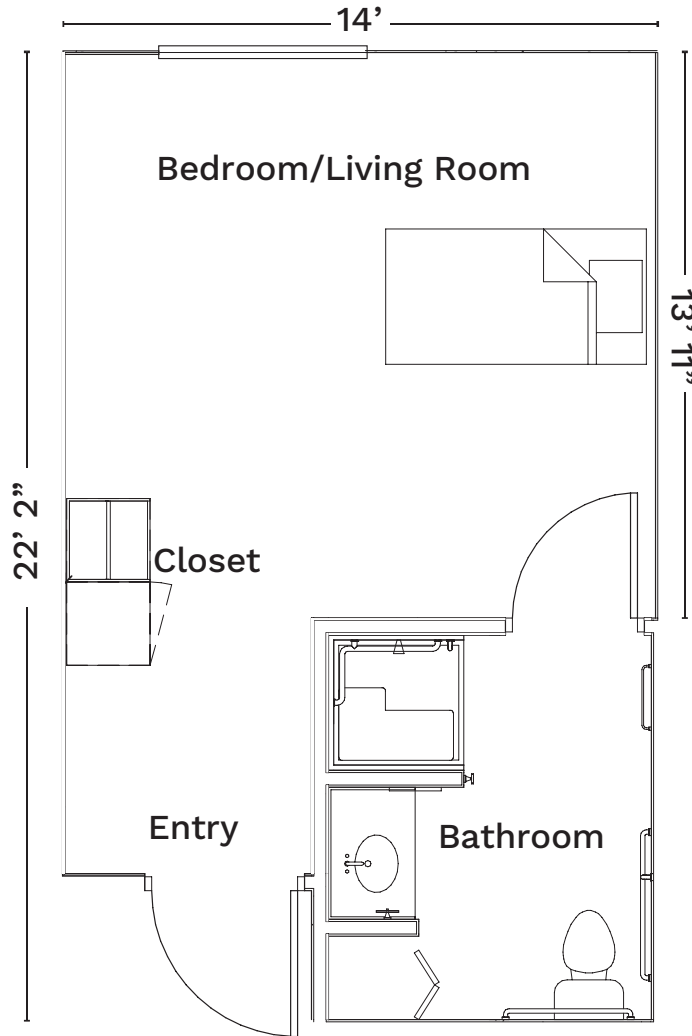




# Studio

307-315 SQ. FT.



DATE _____	RESIDENCE NUMBER _____	PREPARED BY _____	
ONE-TIME COMMUNITY FEE	MONTHLY FEE	ESTIMATED LEVEL OF CARE*	OTHER
\$ _____	\$ _____	\$ _____	\$ _____
TOTAL MONTHLY FEE			
\$ _____			

\*To be determined based upon clinical assessment