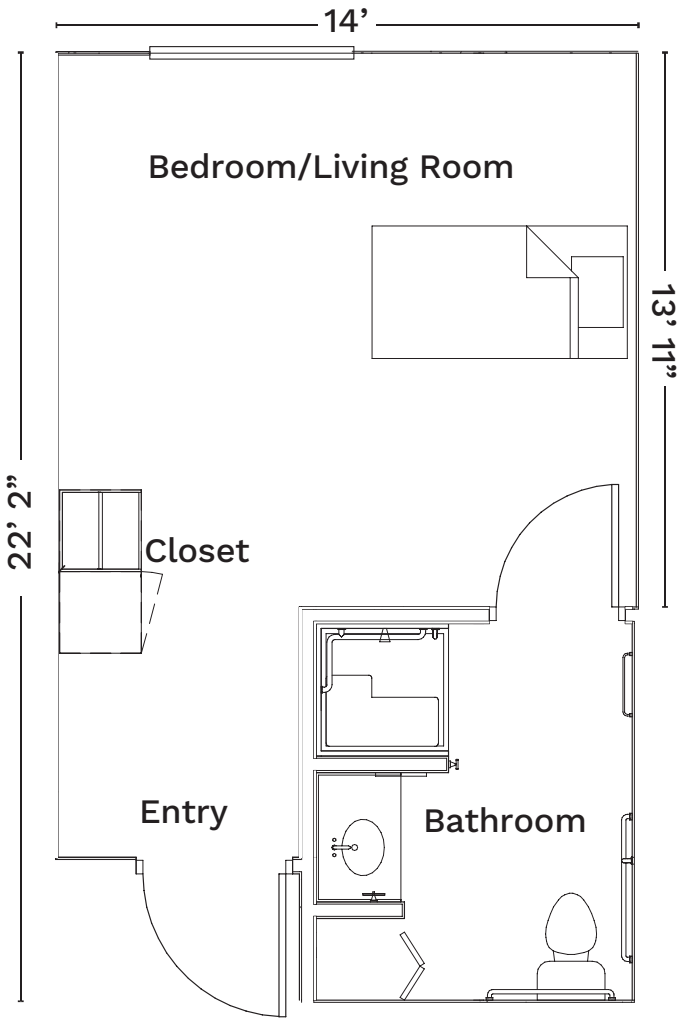
Studio

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

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