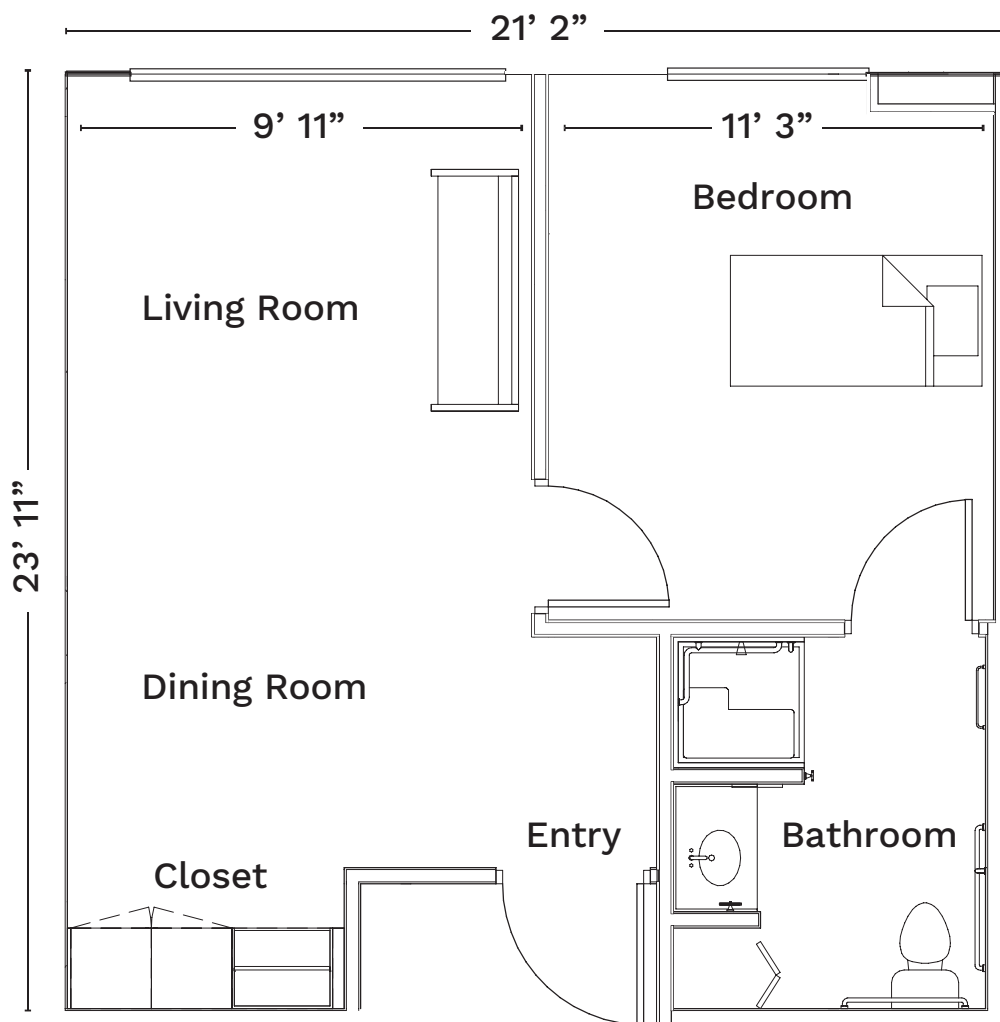


One Bedroom

475-514 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