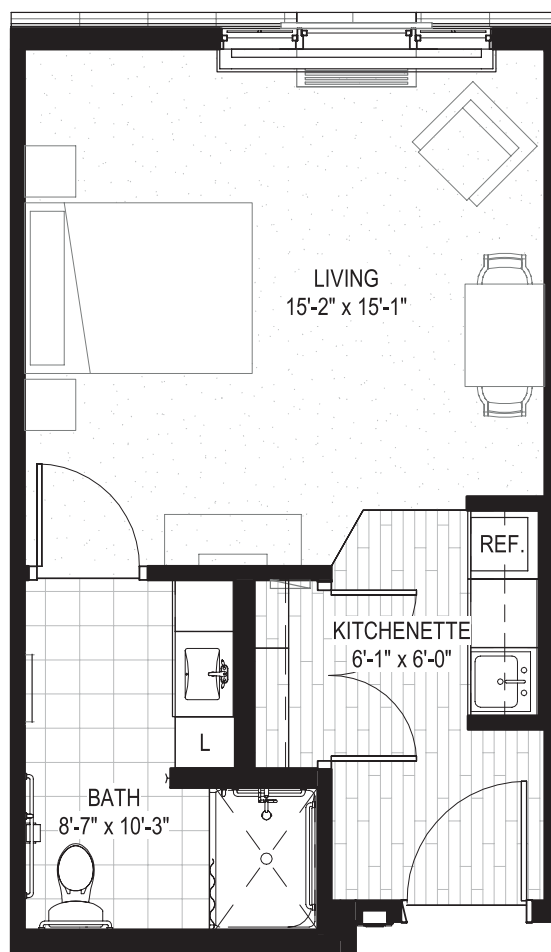


# American Beech

STUDIO • 434 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