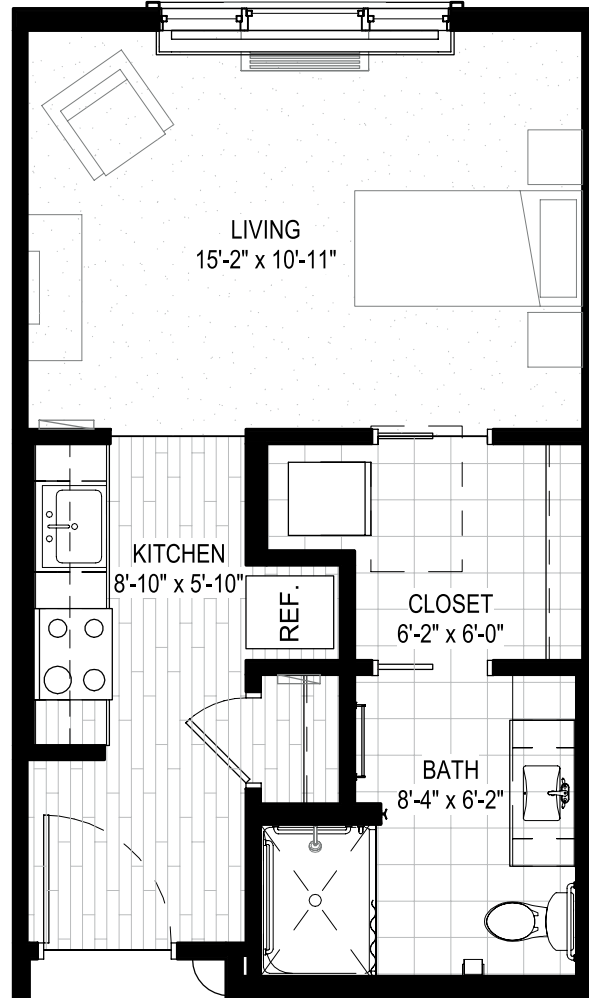


# Arrowhead

STUDIO · 434 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