

		FOR BHF USE			

LL2

Supportive Living Facility
2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I.</p> <p>Facility Name: <u>THE FORT ARMSTRONG</u></p> <p>Address: <u>1900 THIRD AVENUE</u> <u>ROCK ISLAND</u> <u>61201</u> Number City Zip Code</p> <p>County: <u>ROCK ISLAND</u></p> <p>Telephone Number: (<u>309</u>) <u>786-0400</u> Fax # (<u>309</u>) <u>788-9729</u></p> <p>Federal Employer ID Number: <u>36-4455063</u></p> <p>Date Current Owners were Certified: <u>02/05</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: <u>kvanstockum@kbkbcpa.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td>(Type or Print Name) <u>VICTOR HOROWITZ</u></td> </tr> <tr> <td></td> <td>(Title) <u>MANAGER</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td>(Print Name and Title) <u>BOB VICE-PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)	(Type or Print Name) <u>VICTOR HOROWITZ</u>		(Title) <u>MANAGER</u>	Paid Preparer	(Signed) _____ (Date)	(Print Name and Title) <u>BOB VICE-PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712</u>	(Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u>
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Facility Name THE FORT ARMSTRONG

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	130	Single Unit Apartment	130	47,580	1
2	14	Double Unit Apartment	14	5,124	2
3		Other			3
4	144	TOTALS	144	52,704	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	22,771	20,033		42,804	5
6	Double Unit					6
7	Other					7
8	TOTALS	22,771	20,033		42,804	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.22%

D. Indicate the number of paid bed-hold days the SLF had during this year NONE Also, indicate the number of unpaid bed-hold days the SLF had during this year. (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/08 Fiscal Year: 12/31/08

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

STATE OF ILLINOIS

Page 3

Facility Name: THE FORT ARMSTRONG

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	295,983	286,287	951	583,221		583,221	1
2	Housekeeping, Laundry and Maintenance	168,672	57,759	1,833	228,264		228,264	2
3	Heat and Other Utilities			172,087	172,087	(15,867)	156,220	3
4	Other (specify):			9,406	9,406		9,406	4
5	TOTAL General Services	464,655	344,046	184,277	992,978	(15,867)	977,111	5
B. Health Care and Programs								
6	Health Care/ Personal Care	714,398	29,302		743,700		743,700	6
7	Activities and Social Services	44,554	2,184	400	47,138		47,138	7
8	Other (specify):BUS & AUTO			11,328	11,328		11,328	8
9	TOTAL Health Care and Programs	758,952	31,486	11,728	802,166		802,166	9
C. General Administration								
10	Administrative and Clerical	287,170	8,182	220,788	516,140	(12,294)	503,846	10
11	Marketing Materials, Promotions and Advertising	66,678		25,179	91,857		91,857	11
12	Employee Benefits and Payroll Taxes			212,236	212,236		212,236	12
13	Insurance-Property, Liability and Malpractice			52,378	52,378		52,378	13
14	Other (specify):							14
15	TOTAL General Administration	353,848	8,182	510,581	872,611	(12,294)	860,317	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,577,455	383,714	706,586	2,667,755	(28,161)	2,639,594	16
Capital Expenses								
D. Ownership								
17	Depreciation			10,305	10,305	171,171	181,476	17
18	Interest			35,796	35,796	385,417	421,213	18
19	Real Estate Taxes					65,887	65,887	19
20	Rent -- Facility and Grounds			362,400	362,400	(362,400)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			408,501	408,501	260,075	668,576	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,577,455	383,714	1,115,087	3,076,256	231,914	3,308,170	24

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.19	\$ 24.80	1
2	Licensed Practical Nurses	6.80	16.95	2
3	Certified Nurse Assistants	19.59	9.87	3
4	Activity Director & Assistants	2.14	9.98	4
5	Social Service Workers			5
6	Head Cook	1.98	11.51	6
7	Cook Helpers/Assistants	14.49	8.16	7
8	Dishwashers			8
9	Maintenance Workers	2.25	13.04	9
10	Housekeepers	6.19	8.33	10
11	Laundry			11
12	Managers	1.00	48.14	12
13	Other Administrative			13
14	Clerical	7.33	14.36	14
15	Marketing	1.00	42.47	15
16	Other			16
17	Total (lines 1 thru 16)	63.96	\$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2	V. HOROWITZ	66.5	25	52,228	2
3					3
4					4
5					5
Total				\$ 52,228	6

VI. (B) Management fees paid to unrelated parties

	NAME and FUNCTION	Amount of Fee	
1	HAVEN MANAGEMENT - MARCI HALPERT	\$ 52,228	1
2			2
Total		\$ 52,228	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
HAVEN MANAGEMENT		CHICAGO		MANAGEMENT	

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: _____ If yes, what is the value of those services? \$ _____
 (Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

VIII. OWNERSHIP COSTS

A. Purchase price of land 375,000 Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

*Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1			2003		\$ 1,000,000	\$ 36,364	27.5	\$ 36,364	\$	\$ 192,426	1
2											2
3											3
4											4
5											5
Improvement Type											
6		RENOVATIONS			1,295,873	47,123	27.5	47,123		139,406	6
7		RENOVATIONS		2004	32,239	1,172	27.5	1,172		4,639	7
8		WOODWORK		2007	8,558	311	27.5	311		480	8
9		BOILER		2007	12,955	471	27.5	471		726	9
10		FIRE ALARM		2007	6,625	241	27.5	241		371	10
11		ROOF		2007	16,000	582	27.5	582		897	11
12		CARPET		2007	46,040	6,577	7	6,577		11,181	12
13		WALLPAPER		2007	2,096	299	7	299		509	13
14		A/C & GENERATOR		2008	13,150	259	27.5	259		259	14
15		CARPET		2008	8,051	577	7	577		577	15
16											16
17		TOTAL (lines 1 thru 16)			\$ 2,441,587	\$ 93,976		\$ 93,976	\$	\$ 351,471	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 875,000	\$ 87,500	\$ 87,500	\$	10	\$ 481,250	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 875,000	\$ 87,500	\$ 87,500	\$		\$ 481,250	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

	1	2	3	4	5	6	
	Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building		/ /	\$			3
4	Additions		/ /				4
5			/ /				5
6			/ /				6
7	TOTAL			\$			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
A. Directly Facility Related											
Long-Term											
1	LaSalle Bank		x	mortgage / remodel - PROPERTIES	9/12/02	\$ 3,175,000	\$ 2,888,694	/ /		\$ 281,034	1
2					//			/ /			2
3					/ /			/ /			3
Working Capital											
4				working capital - PROPERTIES	/ /			/ /		104,383	4
5					/ /			/ /			5
6				working capital - OPERATIONS	/ /			/ /		35,796	6
7	TOTAL Facility Related					\$ 3,175,000	\$ 2,888,694			\$ 421,213	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 3,175,000	\$ 2,888,694			\$ 421,213	10

* If there is an option to buy the building, please provide complete details on an attached schedule.

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

STATE OF ILLINOIS

Page 7

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 1,764	\$ 1,764	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	419,575	419,575	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	68,703	68,703	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	885,641	885,641	8
9 Other(specify):EMP LOANS / WAGE ASSIGN	12,369	12,369	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,388,052	\$ 1,388,052	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		375,000	13
14 Buildings, at Historical Cost		1,000,000	14
15 Leasehold Improvements, at Historical Cost	32,239	1,388,103	15
16 Equipment, at Historical Cost		928,484	16
17 Accumulated Depreciation (book methods)	(5,811)	(1,119,485)	17
18 Deferred Charges LOAN COST		18,171	18
19 Organization & Pre-Operating Costs	73,612	73,612	19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds RENT DEP	8,250	8,250	21
22 Other Long-Term Assets (specify):	38,469	165,855	22
23 Other(specify): GOODWILL NET AMORT		161,565	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 146,759	\$ 2,999,555	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,534,811	\$ 4,387,607	25

*(See instructions.)

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 807,659	\$ 807,659	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	240,000	3,128,694	29
30 Accrued Salaries Payable	58,876	58,876	30
31 Accrued Taxes Payable		128,325	31
32 Accrued Interest Payable		228,302	32
33 Deferred Compensation			33
34 Federal and State Income Taxes			34
Other Current Liabilities(specify):			
35 DUE TO LANDLORD	393,106		35
36			36
37 TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,499,641	\$ 4,351,856	37
D. Long-Term Liabilities			
38 Long-Term Notes Payable		1,639,407	38
39 Mortgage Payable			39
40 Bonds Payable			40
41 Deferred Compensation			41
Other Long-Term Liabilities(specify):			
42			42
43			43
44 TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$ 1,639,407	44
45 TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,499,641	\$ 5,991,263	45
46 TOTAL EQUITY	\$ 35,170	\$ (1,603,656)	46
47 TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,534,811	\$ 4,387,607	47

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,520,070	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 3,520,070	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	53	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 53	14
D. Other Revenue (specify):			
15	ANTENNA RENTAL INCOME	12,474	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 12,474	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,532,597	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	992,978	19
20	Health Care/ Personal Care	802,166	20
21	General Administration	872,611	21
B. Capital Expense			
22	Ownership	408,501	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 3,076,256	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 456,341	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 456,341	31

ROCK ISLAND SUPPORTIVE LIVING CENTER, LLC.
ATTACHMENT #1 ADJUSTMENT RECAP
ADJUSTMENT RECAP

DESCRIPTION	AMOUNT	LINE #
BANK OVERDRAFT CHARGES	(11,654.00)	10
PENALTIES	(340.00)	10
CONTRIBUTIONS	(300.00)	10
CABLE T.V RESIDENT ROOMS	(15,867.00)	3
NON STRAIGHT LINE DEPRECIATION	(9,133.00)	17
RELATED PARTY ADJUSTMENT (see attachment)	269,208.00	SEE ATTACHED
ADJUSTMENT TOTAL	----- 231,914.00 =====	

ROCK ISLAND SUPPORTIVE LIVING CENTER, LLC.

ATTACHMENT #2

RELATED PARTY ADJUSTMENT

DESCRIPTION	AMOUNT	LINE #
RENT	(362,400.00)	20
DEPRECIATION (S/L)	180,304.00	17
INTEREST (net of income)	385,417.00	18
REAL ESTATE TAX	65,887.00	19

TOAL ADJUSTMENT

269,208.00
=====