

FOR BHF USE					

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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. Facility ID Number: <u>1000126</u></p> <p>Facility Name: <u>Covenant Home of Chicago</u></p> <p>Address: <u>2720 West Foster Ave</u> <u>Chicago</u> <u>60625</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>506-6900</u> Fax # (<u>773</u>) <u>878-4530</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>09/30/2010</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501c3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dan Lowe</u> Telephone Number: (<u>773</u>) <u>596-2217</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input 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>02/01/15</u> to <u>01/31/16</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Bill Lowe</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>President</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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>Bill Lowe</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) () _____ Fax # () _____																																						

Facility Name Covenant Home of Chicago

Report Period Beginning: 02/01/15 Ending: 01/31/16

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	40	Single Unit Apartment	40	14,600	1
2	16	Double Unit Apartment	16	5,840	2
3		Other			3
4	56	TOTALS	56	20,440	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	5,083	9,505		14,588	5
6	Double Unit		2,601		2,601	6
7	Other					7
8	TOTALS	5,083	12,106		17,189	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.09%

D. Indicate the number of paid bed-hold days the SLF had during this year
596 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 358 (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: 01/31/16 Fiscal Year: 01/31/16

* 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. _____

Facility Name: Covenant Home of Chicago

Report Period Beginning:

02/01/15

Ending:

01/31/16

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	191,555	171,540	11,917	375,012	(2,542)	372,470	1
2	Housekeeping, Laundry and Maintenance	41,003	68,068	33,060	142,131		142,131	2
3	Heat and Other Utilities			166,352	166,352	(23,421)	142,931	3
4	Other (specify): Rubbish Disposal and Landscaping			17,158	17,158		17,158	4
5	TOTAL General Services	232,558	239,608	228,487	700,653	(25,963)	674,690	5
B. Health Care and Programs								
6	Health Care/ Personal Care	113,680	3,542	826	118,048		118,048	6
7	Activities and Social Services	334,941	5,066	18,079	358,086		358,086	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	448,621	8,608	18,905	476,134		476,134	9
C. General Administration								
10	Administrative and Clerical	281,494	6,131	224,382	512,007	(23,131)	488,876	10
11	Marketing Materials, Promotions and Advertising	35,557	2,423	71,370	109,350		109,350	11
12	Employee Benefits and Payroll Taxes			196,943	196,943		196,943	12
13	Insurance-Property, Liability and Malpractice			110,901	110,901		110,901	13
14	Other (specify): Bad Debts			44,211	44,211	(44,211)		14
15	TOTAL General Administration	317,051	8,554	647,807	973,412	(67,342)	906,070	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	998,230	256,770	895,199	2,150,199	(93,305)	2,056,894	16
Capital Expenses								
D. Ownership								
17	Depreciation			264,943	264,943		264,943	17
18	Interest			140,074	140,074	(140,074)		18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			60	60		60	21
22	Other (specify):							22
23	TOTAL Ownership			405,077	405,077	(140,074)	265,003	23
24	GRAND TOTAL (Sum of lines 16 and 23)	998,230	256,770	1,300,276	2,555,276	(233,379)	2,321,897	24

Facility Name: Covenant Home of Chicago

Report Period Beginning 02/01/15

Ending: 01/31/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.60	1
2	Licensed Practical Nurses	1	23.59	2
3	Certified Nurse Assistants	11	11.01	3
4	Activity Director & Assistants	1	21.53	4
5	Social Service Workers			5
6	Head Cook	2	12.97	6
7	Cook Helpers/Assistants	1	12.81	7
8	Dishwashers	3	9.70	8
9	Maintenance Workers	1	18.28	9
10	Housekeepers	2	11.51	10
11	Laundry			11
12	Managers	2	27.32	12
13	Other Administrative	3	17.19	13
14	Clerical	2	10.48	14
15	Marketing	1	27.55	15
16	Other	1	25.56	16
17	Total (lines 1 thru 16)	31	\$	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					2
3					3
4					4
5					5
Total				\$	6

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
Covenant Retirement Communities		Skokie, IL	
Covenant Ministries of Benevolence		Chicago, IL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Cynthia Chow & Associates - Dietary Management/Galter Life Center	\$	1,116	1	
2	Chicagoland Methodist Senior Services		105,600	2	
Total			\$	106,716	3

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: Covenant Home of Chicago

Report Period Beginning:

02/01/15

Ending:

01/31/16

VIII. OWNERSHIP COSTS

A. Purchase price of land 552,188 Year land was acquired 1992

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	56		1992		\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Balance Forward				7,193,580	186,782		186,782		3,373,169	6
7	2011 - see attached			2011	12,576	1,258	10	1,258		5,661	7
8	2012 - see attached			2012	14,670	1,467	10	1,467		5,135	8
9	2013 - see attached			2013	99,743	9,974	10	9,974		24,935	9
10	2014 - see attached			2014	288,403	28,840	10	28,840		43,260	10
11	Construction/Painting/Flooring - Floors 1,2,3,4,5			2015	177,411	8,068	10	8,068		8,068	11
12	Walk-In Cooler - Kitchen			2015	8,629	860	10	860		860	12
13	Security System - Building			2015	7,524	750	10	750		750	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,802,536	\$ 237,999		\$ 237,999	\$	\$ 3,461,838	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	\$ 704,540	\$ 26,944	\$ 26,944	\$	10	\$ 511,022	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 704,540	\$ 26,944	\$ 26,944	\$		\$ 511,022	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: Covenant Home of Chicago

Report Period Beginning: 02/01/15

Ending: 01/31/16

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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 \$ 60

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1					Advance From Parent Corp	/ /	\$		/ /	0.0500	\$ 140,074	1
2					Interest Income Offest	/ /			/ /		-140,074	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$	\$			\$	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$	\$			\$	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.

Facility Name: Covenant Home of Chicago

Report Period Beginning: 02/01/15

Ending:

01/31/16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/16

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 76,798	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	204,181		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,962		6
7	Other Prepaid Expenses	3,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 303,941	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,648,758		12
13	Land	552,188		13
14	Buildings, at Historical Cost	7,802,536		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	704,540		16
17	Accumulated Depreciation (book methods)	(3,972,860)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Charitable Trust Remainder Interest	267,637		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,002,799	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,306,740	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,923	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	146,910		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,432		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Due to Affiliates	4,620,485		35
36	Accrued Expenses	1,540		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 4,835,290	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Unexpended Restricted Gifts	1,712		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 1,712	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,837,002	\$	45
46	TOTAL EQUITY	\$ 4,469,738	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,306,740	\$	47

*(See instructions.)

Facility Name: Covenant Home of Chicago

Report Period Beginning: 02/01/15

Ending:

01/31/16

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	\$ 2,597,791	1
2	Discounts and Allowances	(288,171)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,309,620	3
B. Other Operating Revenue			
4	Special Services	30,225	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	77	7
8	Barber and Beauty Care	3,080	8
9	Non-Resident Meals	2,542	9
10	Laundry	10,089	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 46,013	11
C. Non-Operating Revenue			
12	Contributions	115,501	12
13	Interest and Other Investment Income	143,658	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 259,159	14
D. Other Revenue (specify):			
15	Entrance Fees/Miscellaneous	39,700	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 39,700	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,654,492	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	700,653	19
20	Health Care/ Personal Care	476,134	20
21	General Administration	973,412	21
B. Capital Expense			
22	Ownership	405,077	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,555,276	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 99,216	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 99,216	31

<u>Line</u>	<u>Column</u>	<u>Amount</u>	<u>Description</u>
1	5	2,542	Employee Meal Income
3	5	23,421	Cable Television - Resident's Rooms
10	5	13,207	Fund Raising Activities
10	5	1,550	Transportation Fees
10	5	8,179	Telephone Revenue
10	5	195	Guest Fees
14	5	44,211	Bad Debts
18	5	<u>140,074</u>	Investment Income
		<u><u>233,379</u></u>	Total

<u>Line</u>	<u>Column</u>	<u>Amount</u>	<u>Description</u>
12	1	115,501	Contributions
13	1	143,658	Interest and Other Investment Income
15	1	39,700	Entrance Fee/Miscellaneous

2015 Cost Report, Page 5, Report VIII

<u>Improvement Type</u>	<u>Year Constructed</u>	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Life in Years</u>	<u>Straight Line Depreciation</u>	<u>Adjustments</u>	<u>Accumulated Depreciation</u>
Exterior-Awning	2011	2,890	288	10	288		1,296
Interior-Sprinkler Heads/Wall Guards/Security Cam Pump Motor	2011	6,093	610	10	610		2,745
	2011	3,593	360	10	360		1,620
Total		12,576	1,258		1,258		5,661
Awning	2012	3,125	314	10	314		1,099
Resident Room Restoration	2012	4,265	426	10	426		1,491
Sprinkler Heads	2012	7,280	727	10	727		2,545
Total		14,670	1,467		1,467		5,135
Resident Room Restoration	2013	9,920	992	10	992		2,480
HVAC Chiller	2013	14,385	1,438	10	1,438		3,596
Remodeling Project Consulting/Design	2013	44,130	4,413	10	4,413		11,033
Retaining Wall Repair	2013	12,450	1,245	10	1,245		3,114
Air Compressor Controller	2013	5,367	537	10	537		1,339
Roof Repair	2013	4,378	438	10	438		1,095
Wireless Monitoring	2013	9,113	911	10	911		2,278
Total		99,743	9,974		9,974		24,935
Remodeling Project Consulting/Design	2014	244,084	24,412	10	24,412		36,618
Flooring - Resident Rooms - 2nd, 3rd, 4th Floor	2014	15,287	1,524	10	1,524		2,286
Access Control System - HVAC	2014	29,032	2,904	10	2,904		4,356
Total		288,403	28,840		28,840		43,260

