

		FOR BHF USE			

LL2

Supportive Living Facility
2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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> <hr/> <p>Address: <u>2720 West Foster Ave</u> <u>Chicago</u> <u>60625</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 506-6900</u> Fax # <u>(773) 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%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 <u>501c3</u></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 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>Dan Lowe</u> Telephone Number: <u>(773) 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>02/01/17</u> to <u>01/31/18</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 align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Bill Lowe</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> _____</td> <td>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) <u>()</u> _____	Fax # () _____
<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 _____																																													
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) <u>()</u> _____	Fax # () _____																																												

Facility Name Covenant Home of Chicago

Report Period Beginning: 02/01/17 Ending: 01/31/18

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 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	3,847	9,960		13,807	5
6	Double Unit		1,275		1,275	6
7	Other					7
8	TOTALS	3,847	11,235		15,082	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 73.79%

D. Indicate the number of paid bed-hold days the SLF had during this year

754 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 125 (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: 01/31/18 Fiscal Year: 01/31/18

* 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:

02/01/17

Ending:

01/31/18

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	211,236	181,764	14,282	407,282	(2,411)	404,871	1
2	Housekeeping, Laundry and Maintenance	39,258	65,806	25,269	130,333		130,333	2
3	Heat and Other Utilities			169,996	169,996	(26,006)	143,990	3
4	Other (specify): Rubbish Disposal and Landscaping			17,080	17,080		17,080	4
5	TOTAL General Services	250,494	247,570	226,627	724,691	(28,417)	696,274	5
B. Health Care and Programs								
6	Health Care/ Personal Care	164,320	3,384	7,870	175,574		175,574	6
7	Activities and Social Services	389,563	2,633	19,182	411,378		411,378	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	553,883	6,017	27,052	586,952		586,952	9
C. General Administration								
10	Administrative and Clerical	269,945	9,983	358,550	638,478	(76,940)	561,538	10
11	Marketing Materials, Promotions and Advertising	50,862	3,829	59,556	114,247		114,247	11
12	Employee Benefits and Payroll Taxes			245,245	245,245		245,245	12
13	Insurance-Property, Liability and Malpractice			85,235	85,235		85,235	13
14	Other (specify): Bad Debts			48,394	48,394	(48,394)		14
15	TOTAL General Administration	320,807	13,812	796,980	1,131,599	(125,334)	1,006,265	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,125,184	267,399	1,050,659	2,443,242	(153,751)	2,289,491	16
Capital Expenses								
D. Ownership								
17	Depreciation			289,673	289,673		289,673	17
18	Interest			146,164	146,164	(144,173)	1,991	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			343	343		343	21
22	Other (specify):							22
23	TOTAL Ownership			436,180	436,180	(144,173)	292,007	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,125,184	267,399	1,486,839	2,879,422	(297,924)	2,581,498	24

Facility Name: Covenant Home of Chicago

Report Period Beginning: 02/01/17

Ending: 01/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 25.50	1
2	Licensed Practical Nurses	1	24.41	2
3	Certified Nurse Assistants	12	12.06	3
4	Activity Director & Assistants	1	24.71	4
5	Social Service Workers			5
6	Head Cook	2	13.82	6
7	Cook Helpers/Assistants	1	13.77	7
8	Dishwashers	3	11.67	8
9	Maintenance Workers	1	17.90	9
10	Housekeepers	2	12.63	10
11	Laundry			11
12	Managers	2	29.16	12
13	Other Administrative	2	18.61	13
14	Clerical	2	11.50	14
15	Marketing	1	35.92	15
16	Other	1	26.61	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

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Cynthia Chow & Associates - Dietary Management	\$ 1,306	1
2	Chicago Methodist Senior Services	112,032	2
Total		\$ 113,338	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	City
Covenant Retirement Communities	Skokie, IL
Covenant Ministries of Benevolence	Chicago, IL

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business

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:

02/01/17

Ending:

01/31/18

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		3,746,733	6
7	2011 - see attached			2011	12,576	1,258	10	1,258		8,177	7
8	2012 - see attached			2012	14,670	1,467	10	1,467		8,069	8
9	2013 - see attached			2013	99,743	9,974	10	9,974		44,883	9
10	2014 - see attached			2014	288,403	28,840	10	28,840		100,940	10
11	2015 - see attached			2015	193,564	19,356	10	19,356		48,390	11
12	2016 - see attached			2016	46,475	4,646	10	4,646		6,969	12
13	Nurse Call System			2017	94,555	4,729	10	4,729		4,729	13
14	Construction/Painting/Flooring - Floors 3,4			2017	28,830	1,442	10	1,442		1,442	14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,972,396	\$ 258,494		\$ 258,494	\$	\$ 3,970,332	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	\$ 754,781	\$ 31,179	\$ 31,179		10	\$ 570,916	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 754,781	\$ 31,179	\$ 31,179	\$		\$ 570,916	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: 02/01/17

Ending: 01/31/18

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 \$ 343

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				Advance From Parent Corp	/ /	\$	\$	/ /	0.0500	\$ 146,164	1
2				Interest Income Offset	/ /			/ /		-144,173	2
3					/ /			/ /			3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$			\$ 1,991	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$ 1,991	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: 02/01/17

Ending:

01/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 122,031	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	95,261		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,948		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)	\$ 240,240	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,039,186		12
13	Land	552,188		13
14	Buildings, at Historical Cost	7,972,396		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	754,781		16
17	Accumulated Depreciation (book methods)	(4,541,248)		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	143,535		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,920,838	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,161,078	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,225	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	159,102		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,399		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	4,943,051		35
36	Accrued Expenses	7,040		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 5,194,817	\$	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)	\$ 5,196,529	\$	45
46	TOTAL EQUITY	\$ 3,964,549	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,161,078	\$	47

*(See instructions.)

Facility Name: Covenant Home of Chicago

Report Period Beginning: 02/01/17

Ending:

01/31/18

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,392,538	1
2	Discounts and Allowances	(286,623)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,105,915	3
B. Other Operating Revenue			
4	Special Services	29,635	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	593	7
8	Barber and Beauty Care	2,967	8
9	Non-Resident Meals	2,411	9
10	Laundry	10,449	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 46,055	11
C. Non-Operating Revenue			
12	Contributions	312,521	12
13	Interest and Other Investment Income	144,173	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 456,694	14
D. Other Revenue (specify):			
15	Entrance Fees/Miscellaneous	15,684	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 15,684	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,624,348	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	724,691	19
20	Health Care/ Personal Care	586,952	20
21	General Administration	1,131,599	21
B. Capital Expense			
22	Ownership	436,180	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)	\$ 2,879,422	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (255,074)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (255,074)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 331,324	32
33	Private Pay - Net Inpatient Revenue	1,774,591	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,105,915	37

2017 Cost Report, Page 3, Report IV, Column 5

<u>Line</u>	<u>Column</u>	<u>Amount</u>	<u>Description</u>
1	5	2,411	Employee Meal Income
3	5	26,006	Cable Television - Resident's Rooms
10	5	67,237	Fund Raising Activities
10	5	2,280	Transportation Fees
10	5	6,739	Telephone Revenue
10	5	684	Miscellaneous Income
14	5	48,394	Bad Debts
18	5	<u>144,173</u>	Investment Income
		<u>297,924</u>	Total

2017 Cost Report, Page 8, Report XII

<u>Line</u>	<u>Column</u>	<u>Amount</u>	<u>Description</u>
12	1	312,521	Contributions
13	1	144,173	Interest and Other Investment Income
15	1	15,684	Entrance Fees/Miscellaneous

2017 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		1,872
Interior-Sprinkler Heads/Wall Guards/Security Camera	2011	6,093	610	10	610		3,965
Pump Motor	2011	3,593	360	10	360		2,340
Total		12,576	1,258		1,258		8,177
Awning	2012	3,125	314	10	314		1,727
Resident Room Restoration	2012	4,265	426	10	426		2,343
Sprinkler Heads	2012	7,280	727	10	727		3,999
Total		14,670	1,467		1,467		8,069
Resident Room Restoration	2013	9,920	992	10	992		4,464
HVAC Chiller	2013	14,385	1,438	10	1,438		6,472
Remodeling Project Consulting/Design	2013	44,130	4,413	10	4,413		19,859
Retaining Wall Repair	2013	12,450	1,245	10	1,245		5,604
Air Compressor Controller	2013	5,367	537	10	537		2,413
Roof Repair	2013	4,378	438	10	438		1,971
Wireless Monitoring	2013	9,113	911	10	911		4,100
Total		99,743	9,974		9,974		44,883
Remodeling Project Consulting/Design	2014	244,084	24,412	10	24,412		85,442
Flooring - Resident Rooms - 2nd, 3rd, 4th Floor	2014	15,287	1,524	10	1,524		5,334
Access Control System - HVAC	2014	29,032	2,904	10	2,904		10,164
Total		288,403	28,840		28,840		100,940
Construction/Painting/Flooring - Floors 1,2,3,4,5	2015	177,411	17,740	10	17,740		43,548
Walk-In Cooler - Kitchen	2015	8,629	864	10	864		2,588
Security System - Building	2015	7,524	752	10	752		2,254
Total		193,564	19,356		19,356		48,390
Construction/Painting/Flooring - Floors 2,3,4,5	2016	46,475	4,646	10	4,646		6,969
Total		46,475	4,646		4,646		6,969