

		FOR BHF USE			

LL2

Supportive Living Facility
2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)

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:</p> <p>Name: <u>Dan Lowe</u> Telephone Number: <u>(773) 596-2217</u></p> <p>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>10/01/19</u> to <u>09/30/20</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 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																																												
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Facility Name Covenant Home of Chicago

Report Period Beginning: 10/01/19 Ending: 09/30/20

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	14,640	1
2	16	Double Unit Apartment	16	5,856	2
3		Other			3
4	56	TOTALS	56	20,496	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	4,414	10,215		14,629	5
6	Double Unit	274	2,966		3,240	6
7	Other					7
8	TOTALS	4,688	13,181		17,869	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.18%

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

293 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: 09/30/20 Fiscal Year: 09/30/20

* 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 principal?
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 principal?
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 principal?
If no, explain.

Facility Name: Covenant Home of Chicago

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	249,935	217,299	15,830	483,064	(183)	482,881	1
2	Housekeeping, Laundry and Maintenance	49,611	87,600	46,916	184,127		184,127	2
3	Heat and Other Utilities			171,002	171,002	(30,255)	140,747	3
4	Other (specify): Rubbish Disposal and Landscaping			21,144	21,144		21,144	4
5	TOTAL General Services	299,546	304,899	254,892	859,337	(30,438)	828,899	5
B. Health Care and Programs								
6	Health Care/ Personal Care	186,531	7,394	3,409	197,334		197,334	6
7	Activities and Social Services	486,650	18,517	24,005	529,172		529,172	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	673,181	25,911	27,414	726,506		726,506	9
C. General Administration								
10	Administrative and Clerical	317,952	7,236	255,997	581,185	(7,888)	573,297	10
11	Marketing Materials, Promotions and Advertising	39,933	1,399	30,799	72,131		72,131	11
12	Employee Benefits and Payroll Taxes			246,858	246,858		246,858	12
13	Insurance-Property, Liability and Malpractice			117,421	117,421		117,421	13
14	Other (specify): Bad Debts			180,919	180,919	(180,919)		14
15	TOTAL General Administration	357,885	8,635	831,994	1,198,514	(188,807)	1,009,707	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,330,612	339,445	1,114,300	2,784,357	(219,245)	2,565,112	16
Capital Expenses								
D. Ownership								
17	Depreciation			317,974	317,974		317,974	17
18	Interest			157,115	157,115	(132,988)	24,127	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			295	295		295	21
22	Other (specify):							22
23	TOTAL Ownership			475,384	475,384	(132,988)	342,396	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,330,612	339,445	1,589,684	3,259,741	(352,233)	2,907,508	24

Facility Name: Covenant Home of Chicago

Report Period Beginning: 10/01/19

Ending: 09/30/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3	\$ 33.77	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12	15.01	3
4	Activity Director & Assistants	1	20.74	4
5	Social Service Workers			5
6	Head Cook	2	16.07	6
7	Cook Helpers/Assistants	1	15.93	7
8	Dishwashers	3	14.51	8
9	Maintenance Workers	1	21.43	9
10	Housekeepers	1	13.75	10
11	Laundry			11
12	Managers	2	35.48	12
13	Other Administrative	2	27.18	13
14	Clerical	2	15.57	14
15	Marketing	0	41.51	15
16	Other	1	25.35	16
17	Total (lines 1 thru 16)	32	\$	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/Galter Life Center	\$ 1,078	1
2	Chicago Methodist Senior Services	116,011	2
		Total	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
1	2
Covenant Living Communities	Skokie, IL
Covenant Ministries of Benevolence	Chicago, IL

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
3	4	5

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:

10/01/19

Ending:

09/30/20

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	179,370		179,370		4,231,875	6
7	2011 - see attached			2011	12,576	1,258	10	1,258		11,532	7
8	2012 - see attached			2012	14,670	1,467	10	1,467		11,981	8
9	2013 - see attached			2013	99,743	9,974	10	9,974		71,480	9
10	2014 - see attached			2014	288,403	28,840	10	28,840		177,847	10
11	2015 - see attached			2015	193,564	19,356	10	19,356		100,006	11
12	2016 - see attached			2016	46,475	4,648	10	4,648		19,364	12
13	2017 - see attached			2017	123,385	12,339	10	12,339		39,075	13
14	2018 - see attached			2018	145,796	14,580	10	14,580		31,590	14
15	2019 - see attached			2019	49,101	4,910	10	4,910		7,365	15
16	Flooring/Elevator/Fire Alarm - Floors 1,2,3,4,5			2020	37,209	1,860	10	1,860		1,860	16
17	TOTAL (lines 1 thru 16)				\$ 8,204,502	\$ 278,602		\$ 278,602	\$	\$ 4,703,975	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	\$ 857,227	\$ 39,372	\$ 39,372	\$	10	\$ 670,983	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 857,227	\$ 39,372	\$ 39,372	\$		\$ 670,983	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: 10/01/19

Ending: 09/30/20

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 \$ 295

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	\$ 157,115	1
2				Interest Income Offset	/ /			/ /		-132,988	2
3					/ /			/ /			3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$			\$ 24,127	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$ 24,127	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: 10/01/19

Ending:

09/30/20

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/20

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 150,634	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	144,468		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,742		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)	\$ 305,844	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,346,419		12
13	Land	552,188		13
14	Buildings, at Historical Cost	8,204,502		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	857,227		16
17	Accumulated Depreciation (book methods)	(5,374,958)		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	128,670		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,714,048	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,019,892	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,655	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	188,044		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,957		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/Other Current Liabilities	5,237,682		35
36	Accrued Expenses	9,900		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 5,596,238	\$	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)	\$ 5,597,950	\$	45
46	TOTAL EQUITY	\$ 3,421,942	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,019,892	\$	47

*(See instructions.)

Facility Name: Covenant Home of Chicago

Report Period Beginning: 10/01/19

Ending:

09/30/20

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	\$ 3,107,056	1
2	Discounts and Allowances	(402,504)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,704,552	3
B. Other Operating Revenue			
4	Special Services	15,917	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	974	7
8	Barber and Beauty Care	1,836	8
9	Non-Resident Meals	183	9
10	Laundry	9,288	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 28,198	11
C. Non-Operating Revenue			
12	Contributions	1,125	12
13	Interest and Other Investment Income	132,988	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 134,113	14
D. Other Revenue (specify):			
15	Entrance Fees/Miscellaneous	13,512	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 13,512	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,880,375	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	859,337	19
20	Health Care/ Personal Care	726,506	20
21	General Administration	1,198,514	21
B. Capital Expense			
22	Ownership	475,384	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)	\$ 3,259,741	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (379,366)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (379,366)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 400,549	32
33	Private Pay - Net Inpatient Revenue	2,304,003	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,704,552	37

2020 Cost Report, Page 3, Report IV, Column 5

<u>Line</u>	<u>Column</u>	<u>Amount</u>	<u>Description</u>
1	5	183	Employee Meal Income
3	5	30,255	Cable Television - Resident's Rooms
10	5	1,616	Transportation Fees
10	5	5,760	Telephone Revenue
10	5	512	Miscellaneous Income
14	5	180,919	Bad Debts
18	5	<u>132,988</u>	Investment Income
		<u><u>352,233</u></u>	Total

2020 Cost Report, Page 8, Report XII

<u>Line</u>	<u>Column</u>	<u>Amount</u>	<u>Description</u>
12	1	1,125	Contributions
13	1	132,988	Interest and Other Investment Income
15	1	13,512	Entrance Fees/Miscellaneous

<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		2,640
Interior-Sprinkler Heads/Wall Guards/Security Cam	2011	6,093	610	10	610		5,592
Pump Motor	2011	3,593	360	10	360		3,300
Total		12,576	1,258		1,258		11,532
Awning	2012	3,125	314	10	314		2,564
Resident Room Restoration	2012	4,265	426	10	426		3,479
Sprinkler Heads	2012	7,280	727	10	727		5,938
Total		14,670	1,467		1,467		11,981
Resident Room Restoration	2013	9,920	992	10	992		7,109
HVAC Chiller	2013	14,385	1,438	10	1,438		10,307
Remodeling Project Consulting/Design	2013	44,130	4,413	10	4,413		31,627
Retaining Wall Repair	2013	12,450	1,245	10	1,245		8,924
Air Compressor Controller	2013	5,367	537	10	537		3,845
Roof Repair	2013	4,378	438	10	438		3,139
Wireless Monitoring	2013	9,113	911	10	911		6,529
Total		99,743	9,974		9,974		71,480
Remodeling Project Consulting/Design	2014	244,084	24,412	10	24,412		150,541
Flooring - Resident Rooms - 2nd, 3rd, 4th Floor	2014	15,287	1,524	10	1,524		9,398
Access Control System - HVAC	2014	29,032	2,904	10	2,904		17,908
Total		288,403	28,840		28,840		177,847
Construction/Painting/Flooring - Floors 1,2,3,4,5	2015	177,411	17,740	10	17,740		90,855
Walk-In Cooler - Kitchen	2015	8,629	864	10	864		4,892
Security System - Building	2015	7,524	752	10	752		4,259
Total		193,564	19,356		19,356		100,006
Construction/Painting/Flooring - Floors 2,3,4,5	2016	46,475	4,648	10	4,648		19,364
Total		46,475	4,648		4,648		19,364
Nurse Call System	2017	94,555	9,456	10	9,456		29,945
Construction/Painting/Flooring - Floors 3,4	2017	28,830	2,883	10	2,883		9,130
Total		123,385	12,339		12,339		39,075
HVAC	2018	36,861	3,686	10	3,686		7,986
Construction/Painting/Flooring - Floors 1,2,3,4,5	2018	108,935	10,894	10	10,894		23,604
Total		145,796	14,580		14,580		31,590
Flooring/HVAC - Floors 1,2,3,4,5	2019	49,101	4,910	10	4,910		7,365
Total		49,101	4,910		4,910		7,365