Sun Health COMMUNITIES

Capital Expenditure Form

Date _____

Community _____ Department _____

Proj Name in Capital Budget _____ Name of Item _____ ☐ New ☐ Replacement

Project Budget Cost $ _____ Est. Useful Life _____

1) Facility Management will assist TL/TM to complete Estimated Cost:

A. Facility Modifications ☐ Yes ☐ No $ _____

B. Utility/Mechanical Modifications ☐ Yes ☐ No $ _____

C. Installation Cost $ _____

D. Estimated Furniture/Equipment Cost $ _____

E. Estimated Total Project Cost $ _____

2) Scope of Work, Justification and Alternative Considerations:

2a) Purchase Date _____ ☐ Q1 (Jul-Sept) ☐ Q2 (Oct-Dec) ☐ Q3 (Jan-Mar) ☐ Q4 (Apr-June)

3) Will Project involve decorating? ☐ Yes ☐ No

4) Competitive Bids Received:

Vendor	Bid
A. _____	$ _____
B. _____	$ _____
C. _____	$ _____

Date _____ Requested by: _____ _____
Printed Name Signature

Date _____ Approved by: _____ _____
Executive Director Printed Name Signature

Date _____ Approved by: _____ _____
Financial Approval Signature