

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2007  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2007)**

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><b>I.</b></p> <p>Facility Name: <u>Heritage Woods of Batavia</u></p> <p>Address: <u>1079 E. Wilson St.</u> <u>Batavia</u> <u>60510</u>  <small>Number City Zip Code</small></p> <p>County: <u>Kane</u></p> <p>Telephone Number: ( <u>630</u> ) <u>406-9440</u> Fax # <u>630-406-9451</u></p> <p>Federal Employer ID Number: <u>36-4469417</u></p> <p>Date Current Owners were Certified: <u>08/22/03</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 checked="" 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 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>Selena Edgington</u> Telephone Number: <u>815-935-1992</u> <u>232</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" 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 type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> <td></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____</td> <td></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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" 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 type="checkbox"/> Limited Liability Co.	_____																																								
	<input type="checkbox"/> Trust																																									
	<input type="checkbox"/> Other _____																																									
<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>David J. Mitchell</u>																																									
	(Title) <u>CFO</u>																																									
<b>Paid Preparer</b>	(Signed) _____	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) _____																																									
	(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____																																									

Facility Name Heritage Woods of Batavia

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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	93	Single Unit Apartment	93	33,945	1
2		Double Unit Apartment			2
3		Other			3
4	93	TOTALS	93	33,945	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	19,754	13,595		33,349	5
6	Double Unit					6
7	Other					7
8	TOTALS	19,754	13,595		33,349	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)     98.24%    

**D. Indicate the number of paid bed-hold days the SLF had during this year**     409     Also, indicate the number of unpaid bed-hold days the SLF had during this year.     113     (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:     12/31/07     Fiscal Year:     12/31/07    

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

**J. Does the facility have any Illinois Housing Development Authority Loans outstanding?**     Yes     If yes, did the facility make all of the required payments of interest and principle?     Yes    

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: Heritage Woods of Batavia

Report Period Beginning:

01/01/2007

Ending: 12/31/2007

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	239,643	172,213	1,028	412,884		412,884	1
2	Housekeeping, Laundry and Maintenance	76,000	23,658	65,179	164,837		164,837	2
3	Heat and Other Utilities			118,326	118,326	(15,678)	102,648	3
4	Other (specify):			11,923	11,923		11,923	4
5	<b>TOTAL General Services</b>	<b>315,643</b>	<b>195,871</b>	<b>196,456</b>	<b>707,970</b>	<b>(15,678)</b>	<b>692,292</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	454,233	1,736		455,969		455,969	6
7	Activities and Social Services	30,111	5,611		35,722		35,722	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>484,344</b>	<b>7,347</b>		<b>491,691</b>		<b>491,691</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	151,543	15,950	195,778	363,271	(16,626)	346,645	10
11	Marketing Materials, Promotions and Advertising	51,524	2,887	27,877	82,288		82,288	11
12	Employee Benefits and Payroll Taxes			211,184	211,184		211,184	12
13	Insurance-Property, Liability and Malpractice			50,396	50,396		50,396	13
14	Other (specify):			37,897	37,897		37,897	14
15	<b>TOTAL General Administration</b>	<b>203,067</b>	<b>18,837</b>	<b>523,132</b>	<b>745,036</b>	<b>(16,626)</b>	<b>728,410</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,003,054</b>	<b>222,055</b>	<b>719,588</b>	<b>1,944,697</b>	<b>(32,304)</b>	<b>1,912,393</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			399,646	399,646		399,646	17
18	Interest			492,073	492,073		492,073	18
19	Real Estate Taxes			62,017	62,017		62,017	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			348,144	348,144		348,144	22
23	<b>TOTAL Ownership</b>			<b>1,301,880</b>	<b>1,301,880</b>		<b>1,301,880</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,003,054</b>	<b>222,055</b>	<b>2,021,468</b>	<b>3,246,577</b>	<b>(32,304)</b>	<b>3,214,273</b>	<b>24</b>

Facility Name: Heritage Woods of Batavia

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 28.32	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	15	11.11	3
4	Activity Director & Assistants	1	14.60	4
5	Social Service Workers			5
6	Head Cook	1	22.68	6
7	Cook Helpers/Assistants	10	8.91	7
8	Dishwashers			8
9	Maintenance Workers	1	11.42	9
10	Housekeepers	3	8.12	10
11	Laundry			11
12	Managers	1	37.67	12
13	Other Administrative	2	14.52	13
14	Clerical			14
15	Marketing	1	22.71	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>37</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	BMA Management, LTD	\$ 119,602	1
2			2
<b>Total</b>		<b>\$ 119,602</b>	<b>3</b>

**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

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: Heritage Woods of Batavia

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**VIII. OWNERSHIP COSTS**

A. Purchase price of land 928,771 Year land was acquired 2001

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	93			2003	\$ 8,569,550	\$ 311,589	28	\$ 311,859	\$ 270	\$ 1,335,146	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Land Improvements			292,138	19,476	15		(19,476)	87,662	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 8,861,688	\$ 331,065		\$ 311,859	\$ (19,206)	\$ 1,422,808	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	\$ 584,105	\$ 67,289	\$ 67,289	\$	5	\$ 550,461	18
19	Vehicles	11,216	1,292	1,292		5	9,277	19
20	TOTAL (lines 18 and 19)		\$ 595,321	\$ 68,581	\$ 68,581		\$ 559,738	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: Heritage Woods of Batavia

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

**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	<b>TOTAL</b>				\$			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		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	<b>A. Directly Facility Related Long-Term</b>									
1	IHDA		X	First Mortgage Loan	5/1/02	\$ 7,335,000	\$ 7,004,003	2/1/44	0.0688	\$ 485,383
2	IHDA		X	Second Mortgage Loan	5/1/03	750,000	656,921	6/1/32	0.0100	6,690
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 8,085,000	\$ 7,660,924			\$ 492,073
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 8,085,000	\$ 7,660,924			\$ 492,073

\* 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: Heritage Woods of Batavia

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

12/31/2007

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 317,980	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	439,479		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,430		6
7	Other Prepaid Expenses	7,856		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 840,745	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	878,771		13
14	Buildings, at Historical Cost	8,569,551		14
15	Leasehold Improvements, at Historical Cost	292,138		15
16	Equipment, at Historical Cost	595,321		16
17	Accumulated Depreciation (book methods)	(1,982,546)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	498,975		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(249,048)		20
21	Restricted Funds	1,034,845		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 9,638,007	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 10,478,752	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 312,664	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,688		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Accrued Liabilities & Unearned Rev	29,480		35
36	Accrued Property Taxes	62,017		36
37	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 36)	\$ 438,849	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,660,924		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities</b> (sum of lines 38 thru 43)	\$ 7,660,924	\$	44
45	<b>TOTAL LIABILITIES</b> (sum of lines 37 and 44)	\$ 8,099,773	\$	45
46	<b>TOTAL EQUITY</b>	\$ 2,378,979	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 45 and 46)	\$ 10,478,752	\$	47

\*(See instructions.)

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,932,832	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 2,932,832	3
<b>B. Other Operating Revenue</b>			
4	Special Services	50,340	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	22,825	8
9	Non-Resident Meals	1,495	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 74,660	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	43,719	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 43,719	14
<b>D. Other Revenue (specify):</b>			
15	Rental Income	3,000	15
16	2006 Property Taxes & Ins refund	19,055	16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 22,055	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 3,073,266	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	707,970	19
20	Health Care/ Personal Care	491,691	20
21	General Administration	745,036	21
<b>B. Capital Expense</b>			
22	Ownership	1,301,880	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 3,246,577	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (173,311)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (173,311)	31

Cost Center Expenses

A. General Services - Other

Exterminating	1,365
Rubbish Removal	5,573
Vehicle Expense	3,775
Misc Operating Expenses	1,210
Total	<b>11,923</b>

C. General Administration - Other

Consulting	1
Legal	19,595
Accounting	30
Audit	9,500
Bad Debt	8,771
Total	<b>37,897</b>

D. Ownership

Mortgage Service Fee	17,691
Mortgage Insurance Premium	35,253
Partnership Management Fee	50,000
Asset Management Fee	23,250
Incentive Manangement Fee	209,862
Tax Credit Fee & Incentive Fee	1,775
Amortization Expense	10,313
Total	<b>348,144</b>

Reclassifications and Adjustments

Heat & Other Utilities (15,678) Cable

Administrative and Clerical (16,626) Telephone Revenue