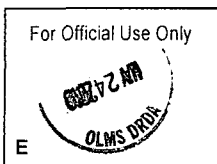


FORM LM-20

AGREEMENT AND ACTIVITIES REPORT



This report is mandatory under P.L. 86-257, as amended. Failure to comply may result in criminal prosecution, fines, or civil penalties as provided by 29 U.S.C. 439 or 440. Required of persons, including Labor Relations Consultants and Other Individuals and Organizations, Under Section 203(b) of the Labor-Management Reporting and Disclosure Act of 1959, as amended. (LMRDA)

READ THE INSTRUCTIONS CAREFULLY BEFORE PREPARING THIS REPORT.

1. File Number: C- 00591

429764

Person Filing	
2. Name and mailing address (include ZIP Code): Name Paul Murray Title President Organization Healthcare Strategies, LLC P.O. Box, Bldg., Room No., if any Street 7113 West 135th Street, #111 City Overland Park State Kansas ZIP Code + 4 66213	3. Any other address where records necessary to verify this report are kept: Name Title Organization P.O. Box, Bldg., Room No., if any Street City State ZIP Code + 4
4. Date fiscal year ends: Dec / 31	5. Type of person: a. <input type="checkbox"/> Individual b. <input type="checkbox"/> Partnership c. <input checked="" type="checkbox"/> Corporation d. <input type="checkbox"/> Other (Specify):

Nature of Agreement or Arrangement	
6. Full name and address of employer with whom made (include ZIP Code): Name Kathryn Conallen Organization Mercy Philadelphia Hospital Trade Name, if any P.O. Box, Bldg., Room No., if any Street 501 South 54th Street City Philadelphia State Pennsylvania ZIP Code + 4 19143	7. Date entered into: 4 / 24 / 10 8. Name of person(s) through whom made: Name Name Name Name Name

Signatures

Each of the undersigned declares, under penalty of perjury and other applicable penalties of law, that all of the information submitted in this report (including the information contained in any accompanying documents) has been examined by the signatory and is, to the best of the undersigned's knowledge and belief, true, correct, and complete. (See Section VII on penalties in the instructions.)

13. Signed <u>Paul E. Murray</u> President (If other title, see instructions) Title President	14. Signed _____ Treasurer (If other title, see instructions) Title Other (Specify) _____
On <u>5/15/2010</u> (913) 269-7042 Date Telephone Number	On _____ Date Telephone Number

9. Check the appropriate box to indicate whether an object of the activities undertaken, is directly or indirectly:

- a. ☒ To persuade employees to exercise or not to exercise, or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing.
- b. ☐ To supply an employer with information concerning the activities of employees or a labor organization in connection with a labor dispute involving such employer, except information for use solely in conjunction with an administrative or arbitral proceeding or a criminal or civil judicial proceeding.

10. Terms and conditions (Explain in detail; see instructions. Written agreements must be attached.):

communicate and educate employees on what is a union card, the NLRB, the NRLA of 1935 and the legal process for union organizing in an acute care hospital.

Specific Activities to be Performed

11. For each activity, separately list in detail the information required (See instructions):

a. Nature of activity:

Communicate & educate as above and answer employee questions

11.b. Period during which performed:

TBA

11.c. Extent performed:

11.d. Name and address through whom performed:

Name

Organization Healthcare Strategies

P.O. Box, Bldg., Room No., if any

Street 7113 West 135th Street, #111

City Overland Park

State Kansas

ZIP Code + 4 66213

Additional Name and address through whom performed, if any:

Name

Organization

P.O. Box, Bldg., Room No., if any

Street

City

State

ZIP Code + 4

12.a. Identify subject groups of employees:

hospital employees

12.b. Identify subject labor organizations: