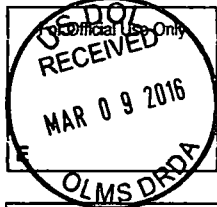


# FORM LM-21

## RECEIPTS AND DISBURSEMENTS REPORT

Form approved  
Office of Management  
and Budget  
No. 1245-0003  
Expires: 08-31-2016

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 Relations and Disclosure Act of 1959, as amended. (LMRDA)



READ THE INSTRUCTIONS CAREFULLY BEFORE PREPARING THIS REPORT

608261

1. File Number C: <input type="text"/>	2. Period Covered By This Report From: <input type="text"/>	Month/Day/Year (mm/dd/yyyy)	Through: <input type="text"/>	Month/Day/Year (mm/dd/yyyy)
00711	12/1/2015		12/31/2015	

<b>A. Person Filing</b>	
3. Name and mailing address (include ZIP Code):	
Name <input type="text"/>	E <input type="text"/>
Title <input type="text"/>	
Organization <input type="text"/>	
P.O. Box, Building and Room Number, if any <input type="text"/>	
Street <input type="text"/>	
City <input type="text"/>	
State <input type="text"/> ZIP Code + 4 <input type="text"/>	
4. Any other address where records necessary to verify this report are kept:	
Name <input type="text"/>	
Title <input type="text"/>	
Organization <input type="text"/>	
P.O. Box, Building and Room Number, if any <input type="text"/>	
Street <input type="text"/>	
City <input type="text"/>	
State <input type="text"/> ZIP Code + 4 <input type="text"/>	

### 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 the Section on penalties in the instructions).

17. Signed <input type="text"/>	President (if other title, see instructions)
Title <input type="text"/>	
On <input type="text"/>	734-478-5155
Date	Telephone Number
18. Signed <input type="text"/>	Treasurer (if other title, see instructions)
Title <input type="text"/>	
On <input type="text"/>	<input type="text"/>
Date	Telephone Number

Name of Person Filing: Nancy Jowske	File Number C- 00711
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**B. Statement of Receipts** Report all receipts from employers in connection with labor relations advice or services regardless of the purposes of the advice or services.

5.a. Name and Address of Employer (including trade name, if any).		Mailing Address:	
Employer	Via Christi Health	P.O. Box, Bldg., Room No., if any	
Trade Name		Street	848 North St. Francis
Attention To:	Gary Knight	City	Wichita
Title		State	Kansas
		ZIP Code + 4	67214
5.b. Termination Date		5.c. Amount	
12/10/2015		25,500	

5.a. Name and Address of Employer (including trade name, if any).		Mailing Address:	
Employer		P.O. Box, Bldg., Room No., if any	
Trade Name		Street	
Attention To:		City	
Title		State	
		ZIP Code + 4	
5.b. Termination Date		5.c. Amount	

5.a. Name and Address of Employer (including trade name, if any).		Mailing Address:	
Employer		P.O. Box, Bldg., Room No., if any	
Trade Name		Street	
Attention To:		City	
Title		State	
		ZIP Code + 4	
5.b. Termination Date		5.c. Amount	

5.a. Name and Address of Employer (including trade name, if any).		Mailing Address:	
Employer		P.O. Box, Bldg., Room No., if any	
Trade Name		Street	
Attention To:		City	
Title		State	
		ZIP Code + 4	
5.b. Termination Date		5.c. Amount	

5.a. Name and Address of Employer (including trade name, if any).		Mailing Address:	
Employer		P.O. Box, Bldg., Room No., if any	
Trade Name		Street	
Attention To:		City	
Title		State	
		ZIP Code + 4	
5.b. Termination Date		5.c. Amount	

5.a. Name and Address of Employer (including trade name, if any).		Mailing Address:	
Employer		P.O. Box, Bldg., Room No., if any	
Trade Name		Street	
Attention To:		City	
Title		State	
		ZIP Code + 4	
5.b. Termination Date		5.c. Amount	

Name of Person Filing: Nancy Jowske

File Number C- 00711

**B. Statement of Receipts** Report all receipts from employers in connection with labor relations advice or services regardless of the purposes of the advice or services.

5.a. Name and Address of Employer (including trade name, if any).

Mailing Address:

Employer Mid Michigan Health

P.O. Box, Building and Room Number, if any

Trade Name

Street 400 Wellness Drive

Attention To

Greg

Ghilardi

City

Midland

Title

Human Resources Director

State

Michigan

ZIP Code + 4 48670

5.b. Termination Date 3/12/2015

5.c. Amount 25,500

6. TOTAL RECEIPTS FROM ALL EMPLOYERS 51,000

**C. Statement of Disbursements** Report all disbursements made by the reporting organization in connection with labor relations advice or services rendered to the employers listed in Part B.

7. Disbursements to Officers and Employees:

(a) Name

(b) Salary

(c) Expenses (d) Totals

					9. Office and Administrative Expenses	
					10. Publicity	
					11. Fees for Professional Services	
					12. Loans Made	
					13. Other Disbursements	
8. Total disbursements to officers and employees:					14. Total Disbursements (Sum of Items 8-13)	

**D. Schedule of Disbursements for Reportable Activity**

Use this Schedule to report only disbursements made for the purposes described in Part D of the instructions.

15.a. Employer Name:

15.b. Trade Name, If any:

15.c. To Whom Paid

Name

Title

Organization

P.O. Box, Building and Room Number, if any

Street

City

State Washington

ZIP Code + 4

15.d. Amount

15.e. Purpose

16. TOTAL DISBURSEMENTS FOR ALL REPORTABLE ACTIVITY