U.S. Department of Labor
Office of Labor-Management Standards
Washington, DC 20210

# FORM LM-20
# AGREEMENT AND ACTIVITIES REPORT

Form approved
Office of Management and Budget
No. 1215-0188
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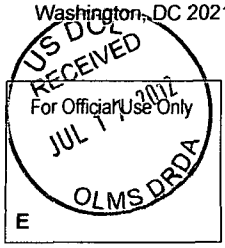


For Official Use Only

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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.**

500987

1. File Number: C- 765

**Person Filing**

2. Name and mailing address (include ZIP Code):

Name ROBERT LONG

Title CEO

Organization HEALTHCARE LABOR SOLUTIONS

P.O. Box, Bldg., Room No., if any SUITE 190

Street 24 CORPORATE PLAZA

City NEWPORT BEACH

State California ZIP Code + 4 92660

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. ☐ Individual b. ☐ Partnership c. ☒ Corporation d. ☐ Other (Specify):

**Nature of Agreement or Arrangement**

6. Full name and address of employer with whom made (include ZIP Code):

Name SUSAN DONKER

Organization SUTTER CENTRAL VALLEY HOSPITALS

Trade Name, if any SUTTER TRACY COMMUNITY HOSPITAL

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

Street 1420 N. TRACY BLVD.

City TRACY

State California ZIP Code + 4 95376

7. Date entered into: 1 / 26 / 2012

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 _____ President (If other title, see instructions)

Title President

On 3/2/2012 (Date) 877-484-9799 (Telephone Number)

14. Signed _____ Treasurer (If other title, see instructions)

Title Treasurer

On 3/2/2012 (Date) 877-484-9799 (Telephone Number)

| Filer: ROBERT LONG HEALTHCARE LABOR SOLUTIONS | File Number C- |
|---|---|

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

a. [X] 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.):

All services described in Section 11a. below shall be performed on an hourly fee basis. Expenses in connection with the performeance of such services as travel, accomodations, copies, telephone long distance, etc., will be reimbursed to Healthcare Labor Solutions at actual cost.

**Specific Activities to be Performed**

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

a. Nature of activity:

Healthcare Labor Solutions has been retained to assist the employer named above in communication with its employees with regard to the manner in which they exercise their rights to organize and bargain collectively. We will assist in communications and conducting meetings with employees.

| 11.b. Period during which performed: | 11.c. Extent performed: |
|---|---|
| 1/25/2012- | ONGOING |

| 11.d. Name and address through whom performed: | Additional Name and address through whom performed, if any: |
|---|---|
| Name | Name |
| Organization HEALTHCARE LABOR SOLUTIONS | Organization |
| P.O. Box, Bldg., Room No., if any Suite 190 | P.O. Box, Bldg., Room No., if any |
| Street 24 Corporate Plaza | Street |
| City Newport Beach | City |
| State California ZIP Code + 4 92660 | State ZIP Code + 4 |

| 12.a. Identify subject groups of employees: | 12.b. Identify subject labor organizations: |
|---|---|
| ALL PART-TIME AND FULL-TIME EMPLOYEES AS AGREED TO BETWEEN THE PARTIES. | CALIFORNIA NURSES ASSOCIATION (CNA)<br>NATIONAL NURSES UNION (NNU) |