

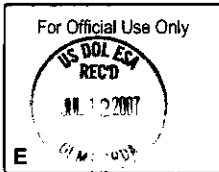
FORM LM-21

RECEIPTS AND DISBURSEMENTS REPORT

Form approved
Office of Management
and Budget
No. 1215-0188
Expires 11-30-2009

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

331392

1. File Number C- <u>626</u>	2. Period Covered By This Report	Month/Day/Year (mm/dd/yyyy)	Through:	Month/Day/Year (mm/dd/yyyy)
	From:	<u>6/13/07</u>		<u>6/26/07</u>

A. Person Filing	
3. Name and mailing address (include ZIP Code):	4. Any other address where records necessary to verify this report are kept:
Name <u>MARIA C. SILVA-ODES</u>	Name
Title	Title
Organization	Organization
P.O. Box, Building and Room Number, if any	P.O. Box, Building and Room Number, if any
Street <u>10309 S. KARLOV AVE.</u>	Street
City <u>OAK LAWN</u>	City
State <u>ILLINOIS</u> ZIP Code + 4 <u>60453</u>	State ZIP Code + 4

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 <u>[Signature]</u> President (if other title, see instructions)	18. Signed <u>[Signature]</u> Treasurer (if other title, see instructions)
Title President	Title Treasurer
On <u>06/11/2007</u> Date Telephone Number <u>(708) 422-7163</u>	On <u>1/1</u> Date Telephone Number

Name of Person Filing: MARIA C. SILVA-ODES	File Number C-
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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): Employer Mt. Sinai Health System Trade Name Attention To Allen H. Channing Title President	Mailing Address: P.O. Box, Building and Room Number, if any Street 15th + California City Chicago State ILLINOIS ZIP Code + 4 60608
5.b. Termination Date 6-27-2007	5.c. Amount 1590.44 1670.44
6. TOTAL RECEIPTS FROM ALL EMPLOYERS 159 1670.44	

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: SELF	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 0	
	15.e. Purpose	
16. TOTAL DISBURSEMENTS FOR ALL REPORTABLE ACTIVITY 0		