

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)

For Official Use Only

READ THE INSTRUCTIONS CAREFULLY BEFORE PREPARING THIS REPORT

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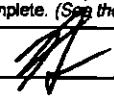
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1. File Number C- 770	2. Period Covered By This Report From:	Month/Day/Year (mm/dd/yyyy) 11 / 02 / 2013	Through:	Month/Day/Year (mm/dd/yyyy) 12 / 02 / 2013
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A. Person Filing	
3. Name and mailing address (include ZIP Code): Name KEITH PERAINO Title PRESIDENT Organization PERAINO & ASSC DBA NATIONAL LABOR CONSULT P.O. Box, Building and Room Number, if any 422812 Street City KISSIMEE State Florida ZIP Code + 4 34742	4. Any other address where records necessary to verify this report are kept: Name Title Organization P.O. Box, Building and Room Number, if any Street City 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  Title President (if other title, see instructions)	18. Signed _____ Title Treasurer (if other title, see instructions)
On 3 / 31 / 2014 407 603 5135 Date Telephone Number	On / / _____ Date Telephone Number

Name of Person Filing:	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 WESTPORT HEALTH CARE CENTER Trade Name Attention To Title		Mailing Address: P.O. Box, Building and Room Number, if any 1 Street BURR RD. City WESTPORT State Connecticut ZIP Code + 4 06888	
5.b. Termination Date 11/25/2014		5.c. Amount 44769.00	
6. TOTAL RECEIPTS FROM ALL EMPLOYERS		44769.00	

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		
ANTHONY CONDRA	11500.00	6635.	18,135	9. Office and Administrative Expenses	
WILLIAM SULLIVAN	6000.		6000	10. Publicity	
MARTIN DREISS	14000.	6635.	20635	11. Fees for Professional Services	
			28135	12. Loans Made	
				13. Other Disbursements	
8. Total disbursements to officers and employees:			44,769.00	14. Total Disbursements (Sum of Items 8-13) 44,769.00	

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		