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

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

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READ THE INSTRUCTIONS CAREFULLY BEFORE PREPARING THIS REPORT

655798

1. File Number C-776	2. Period Covered By This Report	Month/Day/Year (mm/dd/yyyy)		Month/Day/Year (mm/dd/yyyy)
	From:	10 / 01 / 2013	Through:	10 / 30 / 2013

A. Person Filing

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

Name KEITH PERAINO

Title PRESIDENT

Organization PERAINO & ASSC DBA, NATIONAL LABOR CONSUL

P.O. Box, Building and Room Number, if any
422812

Street

City KISSIMMEE

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 _____ President (if other title, see instructions)

Title President

On 3 / 31 / 2014 (Date) 407 603 5135 (Telephone Number)

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

Title

On / / (Date) _____ (Telephone Number)

Name of Person Filing:	File Number C-

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 RIVER GLENN HEALTH CARE CENTER

Trade Name

Attention To

Title

Mailing Address: P.O. Box, Building and Room Number, if any

Street 162 SOUTH BRITAIN RD

City SOUTHBURY

State Connecticut ZIP Code + 4 06488

5.b. Termination Date 10/30/2013

5.c. Amount 9293.00

6. TOTAL RECEIPTS FROM ALL EMPLOYERS 9293.00

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
KEITH	PERAINO	3000	778.	
MARTIN	DREISS	3000		
BILL	SULLIVAN	1500		

8. Total disbursements to officers and employees: 8278.00

9. Office and Administrative Expenses	
10. Publicity	
11. Fees for Professional Services	1015.
12. Loans Made	
13. Other Disbursements	
14. Total Disbursements (Sum of Items 8-13)	9293.00

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 ZIP Code + 4

15.d. Amount

15.e. Purpose

16. TOTAL DISBURSEMENTS FOR ALL REPORTABLE ACTIVITY

U.S. Department of Labor
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Washington, DC 20210

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1. File Number C-	2. Period Covered By This Report From: (Month/Day/Year (mm/dd/yyyy))	Through: (Month/Day/Year (mm/dd/yyyy))
	10 / 01 / 2013	10 / 30 / 2013

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 KISSIMME

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 _____ President (if other title, see instructions)

Title President

On 3 / 31 / 2014 (Date) 407 603 5135 (Telephone Number)

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

Title

On / / (Date) _____ (Telephone Number)

Name of Person Filing:	File Number C-

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 GOLDEN HILL HEALTH CARE CENTER

Trade Name

Attention To

Title

Mailing Address: P.O. Box, Building and Room Number, if any

Street 2028 BRIDGEPORT AVE

City MILFORD

State Connecticut ZIP Code + 4 06460

5.b. Termination Date 10/30/13

5.c. Amount 9804.00

6. TOTAL RECEIPTS FROM ALL EMPLOYERS 9804.00

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
MARTIN	DREISS	3000	1485	
KEITH	PERAINO	3000		
CAROL	ACEVEDO	1500		

8. Total disbursements to officers and employees: 8985.00

9. Office and Administrative Expenses	
10. Publicity	
11. Fees for Professional Services	819.
12. Loans Made	
13. Other Disbursements	
14. Total Disbursements (Sum of Items 8-13)	9804.00

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 ZIP Code + 4

15.d. Amount

15.e. Purpose

16. TOTAL DISBURSEMENTS FOR ALL REPORTABLE ACTIVITY