

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD  
Eighteenth Region

ST. MARY'S DULUTH CLINIC HEALTH SYSTEM<sup>1</sup>

Employer

and

UNITED STEELWORKERS OF AMERICA,  
AFL-CIO, CLC

Petitioner

Case 18-RC-16399

**DECISION AND DIRECTION OF ELECTION**

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to me.

Upon the entire record in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.<sup>2</sup>

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<sup>1</sup> The name of the Employer appears as amended at the hearing.

<sup>2</sup> The Employer, St. Mary's Duluth Clinic Health System, a Minnesota corporation, is engaged in the provision of medical and health services at a number of facilities in Minnesota and Wisconsin, among which is an acute-care hospital known as St. Mary's Medical Center, located at 407 East Third Street, Duluth, Minnesota. In the past 12 months, the Employer has derived gross revenues in excess of

3. The labor organizations involved claim to represent certain employees of the Employer.<sup>3</sup>

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. The Petitioner and Intervenor seek to represent a residual technical unit consisting of all unrepresented technical employees (including unrepresented licensed practical nurses [LPNs]) employed by the Employer at St. Mary's Medical Center, the Employer's acute-care hospital in Duluth, Minnesota (hereafter referred to as "the hospital"). The petition involves only the Employer's Duluth hospital, a facility covering one square block, licensed for 300 beds and employing about 2100 employees.<sup>4</sup> The

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\$500,000 from its operations at St. Mary's Medical Center and has purchased and received at St. Mary's Medical Center goods and services valued in excess of \$50,000 directly from suppliers located outside the State of Minnesota.

<sup>3</sup> The motion to intervene of United Food and Commercial Workers Union, Local 1116, AFL-CIO, was granted at hearing.

There is some ambiguity in the record as to whether the Minnesota Licensed Practical Nurses Association (MLPNA) was an intervenor at the hearing in this matter. Following the hearing, by letter dated February 2, 1999, MLPNA notified me that "[i]n the event that an election is held in this case, the Minnesota Licensed Practical Nurses Association desires *to be* an intervenor" [emphasis added]. By letter dated February 4, 1999, I stated that any motions to intervene should be filed immediately in accordance with Section 102.65(a) and (b) of the Board's Rules and Regulations, and that such motions must state the grounds for the motion, be served on the other parties, and be supported by a showing of interest. On February 12, 1999, MLPNA filed a Motion to Intervene, along with a showing of interest. However, the showing of interest provided is dated after the close of the hearing on January 15, 1999. Pursuant to well-established Board precedent, I must and hereby do deny MLPNA's Motion to Intervene because the showing of interest is untimely. See, e.g., Union College, 247 NLRB 531 n.1 (1980); Gary Steel Products Corp., 127 NLRB 1170 n.3 (1960).

<sup>4</sup> A petition to represent a residual unit of unrepresented "service" (nonprofessional) employees at the hospital was also filed by the Steelworkers on November 17, 1998, in Case 18-RC-16398. That petition was consolidated with the residual technical petition herein for hearing. Prior to hearing, the cases were severed and the petition for the residual service unit was withdrawn.

job classifications which would be encompassed within the petitioned-for residual technical unit, should such a unit be found appropriate, have been identified and agreed upon by the parties. Although the exact number of employees in these unrepresented technical job classifications has not been agreed upon, there would be a total of about 230 employees in such a unit.

The Employer, contrary to the Petitioner, contends that the petitioned-for residual technical unit is inappropriate, is contrary to the Board's health care rule and precedent, and would result in undue proliferation of bargaining units. The Employer asserts that the only appropriate unit is a unit of *all* technical employees employed by the Employer at its hospital, including 175 LPNs currently represented by the Minnesota Licensed Practical Nurses Association (MLPNA). Moreover, the Employer argues that any non-incumbent union desiring to represent employees in the appropriate unit of all technicals (including LPNs) is currently barred from doing so by the contract in effect between the Employer and the MLPNA for the existing LPN unit.

There are currently four incumbent unions representing a total of about 1150 hospital employees in five existing bargaining units:

- (1) A unit of about 175 LPNs represented by the MLPNA since about 1955, currently covered by a collective-bargaining agreement in effect until September 30, 1999;
- (2) A unit of about 330 non-professional employees represented since about 1953 by a series of collective-bargaining representatives, the current one being the International Union of Operating Engineers, Local 70 (IUOE);<sup>5</sup>
- (3) A unit of about 25 skilled maintenance employees represented since about 1946 by the IUOE;

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<sup>5</sup> Per the Employer's post-hearing motion, the record is corrected to reflect that the IUOE's nonprofessional unit consists of 330 employees, rather than 130 as erroneously transcribed.

- (4) A unit of about 17 pharmacists represented since about 1972 by the United Food and Commercial Workers Union, Local 1116 (UFCW);
- (5) A unit of about 600 registered nurses (RNs) represented since about 1954 by the Minnesota Nurses Association (MNA).

These five units—all of which were in existence long before the promulgation of the 1989 “Collective-Bargaining Units in the Health Care Industry; Final Rule” (hereafter called “health care rule”)—are “non-conforming” units under the Board’s rules for acute-care facilities, in that there are unrepresented technicals (approximately 232, including 9 LPNs working in the “walk-in center” of the hospital) omitted from the existing MLPNA unit; unrepresented nonprofessionals (approximately 350) omitted from the existing IUOE nonprofessional unit; unrepresented skilled maintenance employees (approximately 5) omitted from the existing IUOE skilled maintenance unit; unrepresented professional employees (approximately 300) omitted from the existing UFCW pharmacists unit; and unrepresented RNs (approximately 50) omitted from the existing MNA unit. See “Collective Bargaining Units in the Health Care Industry; Final Rule,” 54 Fed. Reg. 16336, 16348, 29 C.F.R. Sec. 103.30, 248 NLRB 1580, 1597 (effective May 22, 1989).

Since the mid-1950’s, the Employer and the MLPNA have enjoyed a long period of collective bargaining in the unit of LPNs, having negotiated successive contracts right up to the present. Prior to the filing of this petition, no labor organization has expressed interest in representing the unrepresented technical employees as a residual unit. Although a petition was filed by the MLPNA in 18-RC-16304 for the unrepresented LPNs in the hospital’s walk-in center, I dismissed that petition on July 23, 1998,

because the unit was inappropriate in that it sought only a portion of the remaining unrepresented technical employees, rather than all unrepresented employees residual to the existing unit.

The Employer emphasizes that the represented LPNs and the unrepresented technical employees all work with patients, either directly or indirectly, and that their jobs are functionally integrated.<sup>6</sup> However, a community of interest analysis requires a more careful scrutiny of the education, skills, working conditions, job duties and interaction of the represented LPNs and the unrepresented technicals being sought as a residual unit.

LPN licensure requires about 1-1/2 years of course work, which is primarily completed at a community or technical school. Some of the other technical classifications also require technical/vocational course work. For example, incoming clinical laboratory technicians and respiratory care practitioners must have a two-year associate degree. In some cases, the courses required for LPN licensure and preparation for another technical position can overlap, with LPN and other technical candidates taking the same courses.

The day-to-day interaction among the represented LPNs and the unrepresented technical employees varies somewhat, but is intermittent and functionally insignificant

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<sup>6</sup> The Board abandoned its former distinctions between “direct” and “indirect” patient care in determining community of interest in Mount Airy Foundation d/b/a. Mount Airy Psychiatric Center, 217 NLRB 802 (1975).

across the board. While the Employer claims that the classifications work “side-by-side” and that they have “regular contact,” those claims are not supported by the record evidence. While some unrepresented technicals—such as the respiratory care practitioners—may work on the patient care floors and in the ambulatory care area (to which most of the represented LPNs are assigned), there is little substantive interaction among the employees. As one respiratory care practitioner testified, if he needs to consult with someone on the floor about a patient’s care, he would speak with the doctor or an RN, not with an LPN (except an occasional contact characterized as “courtesy” communications).

The interaction between the represented LPNs and the unrepresented technical employees appears to be random and limited to physical encounters when unrepresented technical employees such as pharmacy techs are on a patient floor to restock pharmaceuticals or when an X-ray tech brings portable equipment to a floor, to infrequent interaction resulting from the transporting of information or patients from one hospital location to another, such as when lab employees have “very intermittent” telephonic contact with LPNs or when surgical techs “hand off” patients to and from LPNs before or after surgery.

While there are some represented LPNs working in the same departments as the unrepresented technical classifications, the numbers are small. In radiology, there are “maybe” two represented LPNs working with about 65 unrepresented technical employees. There are no LPNs working in the surgery department, pharmacy or nutrition services, where more than 50 of the unrepresented technicals work. The number of LPNs working in the lab areas alongside the unrepresented technicals in

those departments would also be “insignificant,” according to the Employer’s own evidence.

There is no substitution among the represented LPNs and the unrepresented LPNs or other technical employees. The nine unrepresented LPNs working in the walk-in center, which has a separate street-level entrance, but is adjacent to the emergency room on the second floor of the hospital, do not work on the hospital’s patient care floors as part of their walk-in center duties; similarly, the represented “hospital” LPNs on the patient care floors do not work in the walk-in center area as part of their duties.<sup>7</sup> At most, the LPNs may have some interaction in those rare cases in which a patient initially seen in the walk-in center is admitted to the hospital. The represented LPNs—most of whom are assigned a “home floor” among the 11 patient floors in the east and west “towers” of the hospital—can be “floated” to various floors in the hospital. They are not, however, floated to the walk-in center. To the very limited extent that a walk-in center LPN may work as a “floor” LPN on a hospital floor—and vice versa—it occurs only as a result of a distinct employment relationship between the LPN and the Employer, the terms and conditions of which are governed by the MLPNA contract.

The working conditions for the represented LPNs and the unrepresented technicals are somewhat similar, but involve different supervision, work hours (for at least some classifications), pay scales, pension benefits and vacation/sick day policies. While the unrepresented LPNs in the walk-in center, for example, work a two-shift schedule, the represented LPNs work a 24-hour, three-shift schedule. There is no shared supervision among the represented LPNs and the unrepresented technical

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<sup>7</sup> None of the other unrepresented technical employees is assigned to work in the walk-in center either, although on occasion one may enter the walk-in center for some reason.

employees. Even the unrepresented LPNs are supervised by a different RN than are the represented LPNs on the hospital floors.<sup>8</sup>

While the benefits differ somewhat between the unrepresented and represented groups, both have dental, health, disability and pension plans.<sup>9</sup> There are some differences in the calculation and implementation of paid time off (vacation and sick leave), stemming from the historical distinctions between the clinic and hospital employees. Both groups share the same locker rooms, cafeterias, internal communication systems and recognition programs. While the Employer represents that the MLPNA LPNs' wages are comparable to the wages of the other, unrepresented technical employees, the wage ranges are not specified on the record so the breadth of the range is not known.

On the basis of the foregoing and the record as a whole, I conclude that the community of interest between the represented technicals and the unrepresented technicals is sufficiently distinct to warrant a separate unit and that, accordingly, the residual technical unit sought in this petition is not inappropriate on that basis. However, the inquiry into the petition's appropriateness cannot stop with just a community of interest analysis. The fact that the Employer is an acute-care hospital

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<sup>8</sup> Historically, the walk-in center where the nine unrepresented LPNs work was part of the Duluth Clinic, rather than the acute-care hospital, even though it is located within the physical boundaries of the hospital. Now, all the LPNs and other technical employees are paid by the St. Mary's Duluth Clinic Health System, the new corporation resulting from the January 1997 merger of the Duluth Clinic and the St. Mary's Medical Center.

<sup>9</sup> For example, some of the unrepresented technical employees are covered by a defined contribution plan, while others are covered by the same defined benefit plan in which the represented LPNs participate.

under the Board's health care rule requires additional deliberation, because Board rules set forth eight appropriate units for collective bargaining in acute-care hospitals.

However, the question concerning representation raised by this petition cannot be resolved through a simple application of the eight unit descriptions set forth in the rule, because the existing LPN unit is an "existing non-conforming" unit within the meaning of the Board's health care rule. More specifically, the rule states:

(a) . . . Except in extraordinary circumstances *and in circumstances in which there are existing non-conforming units*, the following shall be appropriate units, and the only appropriate units, for petitions. . .

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. . . .

(c) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed. . .the Board shall find appropriate only units which comport, *insofar as practicable*, with the appropriate unit set forth in paragraph (a) of this section.

54 Fed. Reg. at 16347, 29 C.F.R. at Sec. 103.30(a) (emphases added).<sup>10</sup>

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<sup>10</sup> The Union asserts that the existence of non-conforming units constitutes an "extraordinary circumstance" within the meaning of Sec. 103.30(a). While I reject the claim that non-conforming units constitute "extraordinary circumstances," the existence of non-conforming units is still explicitly acknowledged within the language of the health care rule as a possible exception to the application of the eight appropriate units. 29 C.F.R. 103.30(a). See also American Hospital Association v. NLRB, 499 U.S. 606, 608 (1991).

What is “practicable” is, of course the question whose answer determines whether the residual unit of all unrepresented technical employees sought herein by a non-incumbent union is appropriate or whether the only appropriate unit is an all-technical unit, including the already-represented LPNs.<sup>11</sup>

The Employer argues that the petitioned-for unit is inappropriate and that the only appropriate unit is an all-technical unit, including the represented LPNs. The Employer, in advancing its position, relies heavily on both the 1989 health care rule and Levine Hospital of Hayward, 219 NLRB 327 (1975). In Levine, a case predating the 1989 health care rule by more than 12 years, an employer operating an acute-care hospital had collective-bargaining relationships with two different unions representing almost all of its 150 employees. The petitioner was a third, non-incumbent union seeking to represent a separate unit of seven medical record clerks and transcribers. The petitioner argued that the sought-after unit was an appropriate residual unit of unrepresented nonprofessional employees. The Board, which expressed concern about undue proliferation of units at the health care facility and specifically noted the small size of the unit being sought, held that the unit was inappropriate because the medical records clerks and transcribers properly belonged in one of the existing units with whom they shared a very strong community of interest.

In Levine, the group being sought consisted of seven employees working in two classifications and the existing nonprofessional unit was a broad one. In contrast to

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<sup>11</sup> An all-technical unit could be sought—subject to contract bar limitations—either by the incumbent representative of the represented LPNs (the MLPNA) or by a non-incumbent union seeking not only to represent the unrepresented technicals, but also to raid the represented LPNs.

Levine—which the Board later acknowledged involved “a very unusual set of circumstances”<sup>12</sup>—the residual technicals being sought herein consist of about 232 employees working in about 40 different classifications, and the existing unit consists of a smaller number of employees (about 175) working in only one classification (LPN).

The Employer asserts that Levine and the Board’s health care rule clearly compel a dismissal of this petition. But, as the Board itself acknowledged during its deliberations over the health care rule, it’s not clear at all. In fact, the Board expressly acknowledged that in a Levine-type fact pattern—where non-conforming units exist and a non-incumbent union seeks a residual unit—the requirement of an all-inclusive unit may *not* be “practicable” and the outcome should be adjudicated on a case-by-case basis:

(2) Where existing units are not in conformity with the new proposed final rule, we can anticipate a number of questions arising with respect to the applicability of the new rules. Where units smaller than those permitted by the rules already exist, may the incumbent petition for a residual unit [?] May another labor organization [?] What will be the continued viability of the principles enunciated in *Levine* [?] (citation omitted). . . .These issues have not been extensively addressed during the rulemaking proceeding, and it is the Board’s judgment that their resolution should, for the time being, be deferred pending the adjudication of particular cases that present these issues. The Board will, in the adjudication of cases, attempt to apply the new rules to these situations insofar as practicable.

“Notice of Proposed Rulemaking II, XV. Partially Organized Facilities,” 53 Fed. Reg. 33930.

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<sup>12</sup> St. Francis Hospital, 265 NLRB 1025 n. 67 (1982), vacated on other grounds 271 NLRB 948 (1984).

The “continued viability of the principles enunciated in *Levine*” has *not* been addressed by the Board since the implementation of the 1989 health care rule in any case with facts such as the ones faced here, where a non-incumbent union seeks a residual unit. However, in St. John’s Hospital, 307 NLRB 767 (1992), an incumbent representative of some skilled maintenance employees petitioned for a separate unit of some (but not all) of the unrepresented skilled maintenance classifications. The Board held that not only must the union seek *all* unrepresented skilled maintenance employees, but it must also add the unrepresented skilled maintenance employees to its existing skilled maintenance unit, rather than forming another (in this case, the sixth) non-conforming skilled maintenance unit:

Even in representation cases which do not involve health care facilities, the Board has long held that it will not entertain an *incumbent’s* petition for a separate residual unit.

307 NLRB at 768 (emphasis added).

The distinction between an incumbent and a non-incumbent union is a critical one. If the petitioning union is an incumbent union, it is arguably more “practicable” to require the incumbent union to add unrepresented classifications to a unit it already represents at the same facility. But requiring a non-incumbent union to petition for all technicals, rather than all residual technicals, is to require that non-incumbent union to raid an existing unit in which it has expressed no prior interest in representing and to disrupt a long-standing bargaining relationship. Moreover, when—as here—the community of interest of the residual technicals is sufficiently distinct to warrant a separate unit, it does not seem “practicable,” or consistent with the purposes and policies of the Act, to restrict employees’ statutory rights by forcing them to choose

between representation by an incumbent union which has no expressed interest in representing them or no representation at all. While the avoidance of proliferation of units in the health care industry is an important concern in health care cases, it is not the only component to be considered in resolving health care unit issues.<sup>13</sup> See, e.g., Bay Medical Center, Inc., 588 F.2d 1174 (6th Cir. 1978), enforcing 218 NLRB 620 (1975) (policy against undue proliferation must be reconciled with policy against disruption of existing bargaining relationships).<sup>14</sup>

In American Hospital Association v. NLRB, 899 F.2d 651 (7th Cir. 1990), enf'd 499 U.S. 606 (1991), the American Hospital Association (AHA) brought an action to enjoin the Board from enforcing the then-newly promulgated health care rule. The Circuit Court of Appeals, with the approval of the United States Supreme Court, expressly acknowledged the importance of balancing competing interests in making unit determinations:

In making unit determinations the Board is thus required to strike a balance among the competing interests of unions, employees (whose interests are not always identical with those of unions), employers, and the broader public. The statute, though otherwise nondirective, can be read to suggest that the tilt should be in favor of unions, and hence toward relatively many rather than relatively few units. . . . It is true that among the rights that the Act explicitly confers on workers is the right

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<sup>13</sup> The Employer has voiced its concerns in its post-hearing brief about what might happen in the future if additional non-incumbent unions petition for separate residual units. While those concerns have been carefully considered, speculation about potential future organizing among the non-technical employees is not a factor in my decision on this specific question concerning representation.

<sup>14</sup> The Employer emphatically points out in its brief that the Board in Bay Medical Center “expressly refused to include unrepresented LPNs” in the petitioned-for unit. However, in Bay Medical Center (a pre-health care rule case issued shortly before Levine) the Board excluded *all* LPNs from the petitioned-for technical unit because of its concerns about disrupting the bargaining relationship already in place for some of the LPNs. While the Employer argues that Bay Medical Center is “flatly inconsistent” with Levine, Levine—issued only a month after Bay Medical Center by the same Board members—contains no references whatsoever to Bay Medical Center, much less any indications that Bay Medical Center was being overruled or modified.

not to organize. But even with the Taft-Hartley amendments this is not the principal right of workers under the National Labor Relations Act. The principal purpose of the Act was and is to protect workers who want to organize for collective bargaining. In any event, the precise balance among the competing interests is certainly not spelled out in the statute; it is for the Board to decide.

899 F.2d at 654 [citations omitted].

On the basis of both the community-of-interest factors developed in the record and Board policy and precedent concerning bargaining units in acute-care hospitals, as discussed earlier herein, I conclude that a residual unit of all unrepresented technical employees is appropriate. In reaching my conclusion on community-of-interest factors, I rely particularly on the facts that there is no routine or substantive functional interaction among the unrepresented technical employees and the represented LPNs; that they are separately supervised; that their job duties are different; and that they work primarily in different areas of the Employer's facility.

In reaching my conclusion regarding the proper disposition of this case in light of the Board's health care policies and precedent, I rely particularly on the facts that the petitioning Union seeks to represent a residual unit of not just some, but *all* unrepresented technical employees; that the existing unit of LPNs is represented by a union (MLPNA) other than the Petitioner; that the MLPNA, the incumbent union which represents the LPNs, has expressed no interest—other than through an unsuccessful attempt to intervene in this proceeding after the close of the hearing—in representing a residual unit of *all* unrepresented technical employees; that the MLPNA and the Employer have had a long and harmonious bargaining relationship for the existing LPN unit since the mid-1950's; and that it would be unduly disruptive to that bargaining

relationship to compel a non-incumbent union to seek to expand the existing unit by more than 130 percent through the addition of about 40 new job classifications.

6. The following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

All full-time and regular part-time technical employees employed by the Employer at its acute care hospital located in Duluth, Minnesota, working in the following classifications: autopsy & med photo tech; cardio monitor tech -- surgery; cardiology technician; cardiovascular technician; case cart technician; certified occupational therapy assistant; certified pharmacy tech -- outpatient; clinical lab assistant; certified pharmacy technician; certified surgical technologist; communication specialist; CT technologist; diagnostic sonographer; dietetic technician; ECG technician; echocardiography technician; endoscopy technician 1; histologist; invasive technologist; LPNs (walk-in center); medical lab technician/certified lab technician; MRI technologist; non-certified surgical technologist; nuclear medical technologist; perfusionist; pharmacy tech/inventory; pharmacy technician; pharmacy technician -- outpatient; physical therapy assistant; prosthetics/orthotics technician; pulmonary function technician; registered medical sonographer; registered radiologic technologist; respiratory care practitioner; special imaging technician; surgical tech/assistant; team LDR/diagnostic sonographer; team leader/CT technologist; team leader/MRI technologist; and X-ray technician (NR).

#### **DIRECTION OF ELECTION**<sup>15</sup>

An election by secret ballot will be conducted by the undersigned among the employees in the unit found appropriate at the time and place set forth in the Notice of Election to be issued subsequently, subject to the Board's Rules and Regulations.

Eligible to vote are those in the unit who were employed during the payroll period ending immediately preceding the date below, including employees who did not work during

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<sup>15</sup> Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 - 14th Street, N.W., Washington, D.C. 20570. This request must be received by the Board in Washington by **March 5, 1999**.

that period because they were ill, on vacation or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period, and their replacements. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are persons who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced.<sup>16</sup>

Those eligible shall vote whether or not they desire to be represented for collective-bargaining purposes by the United Steelworkers of America, AFL-CIO, CLC; by United Food and Commercial Workers Union, Local 1116, AFL-CIO; or by Neither.

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<sup>16</sup> To ensure that all eligible voters have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses that may be used to communicate with them. Excelsior Underwear Inc., 156 NLRB 1236 (1966); NLRB v. Wyman-Gordon Co., 394 U.S. 759 (1969). Accordingly, it is directed that three copies of an election eligibility list containing the *full* names and addresses of all the eligible voters must be filed by the Employer with the Regional Director within seven (7) days of the date of this Decision and Direction of Election. North Macon Health Care Facility, 315 NLRB 359 (1994). The Regional Director shall make the list available to all parties to the election. In order to be timely filed, these lists must be received in the Minneapolis Regional Office, 234 Federal Courts Building, 110 South Fourth Street, Minneapolis, MN 55401, on or before **February 26, 1999**. No extension of time to file this list may be granted by the Regional Director except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the filing of such list. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed.

Signed at Minneapolis, Minnesota, this 19th day of February, 1999.

/s/ Ronald M. Sharp

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Ronald M. Sharp, Regional Director  
Eighteenth Region  
National Labor Relations Board

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