UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 18 - SUBREGION 30

ROGERS MEMORIAL HOSPITAL, INC. Employer and NATIONAL UNION OF HEALTHCARE WORKERS (NUHW) Petitioner	Cases 18-RC-380431 and 18-RC-380683

DECISION, ORDER SEVERING CASES, AND DIRECTIONS OF ELECTIONS

Rogers Memorial Hospital, Inc.[1] (Employer) operates behavioral health clinics throughout the United States. The National Union of Healthcare Workers (Petitioner) filed two petitions seeking to represent employees in single-facility units at two of the Employer's outpatient clinics in Wisconsin. The Employer argues that single-facility units are inappropriate and that both units must be merged into a Wisconsin-wide unit encompassing all 13 of the Employer's Wisconsin-based facilities. For the reasons discussed below, I reject the Employer's argument and find that the single-facility units are appropriate.

The remainder of the Employer's arguments relate only to nurse practitioners and physician psychiatrists employed at its West Allis, Wisconsin outpatient clinic (also referred to as the "Lincoln Center Clinic") in Case 18-RC-380431.[2] The Employer argues nurse practitioners and physician psychiatrists must be excluded because they: (a) are managers of the Employer; (b) are statutory supervisors; and (c) do not share a community of interest with other employees in the petitioned-for Lincoln Center Clinic unit. Having reviewed the record carefully with respect to each of these arguments, I find that the Employer failed to prove that the Lincoln Center Clinic nurse practitioners and physician psychiatrists are managers or supervisors. I also find that the nurse practitioners and physician psychiatrists share a community of interest with other petitioned-for classifications within the proposed Lincoln Center Clinic unit.

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[1] I grant the parties' motion to amend the record to reflect the Employer's correct legal name as stated here.

[2] In Case 18-RC-380683, relating to the Employer's Madison outpatient clinic, Petitioner did not seek to include nurse practitioners or physician psychiatrists as part of its proposed unit.

Accordingly, I am directing separate elections at the Lincoln Center Clinic and the Madison Clinic in their respective petitioned-for units.

I. PROCEDURAL HISTORY AND PARTIES' STIPULATIONS

A. Case 18-RC-380431 - Lincoln Center Clinic

The Petitioner filed Case 18-RC-380431 on February 4, 2026, seeking a *Sonotone*[3] election in a unit of professional and nonprofessional employees employed at the Employer's Lincoln Center Clinic located in West Allis, Wisconsin. The parties stipulated that all full-time, regular-part time and per diem professional and nonprofessional employees in the following job classifications at the Lincoln Center Clinic should be included in any unit of employees employed at the Lincoln Center Clinic that is found appropriate by the Regional Director:

Group A (Professional): Therapist I (including without limitation Therapist I Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2 Hourly and Therapist 2 Hourly SUD); Experiential Therapists (including without limitation Experiential Therapist II and Experiential Therapist Music Movement); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Case Specialists (including without limitation Case Specialist and Case Specialist SUD); Case Manager MHAR (Mental Health Addiction Recovery).

Group B (Nonprofessional): Clinical Support Coordinator I; Clinical Support Coordinator II; Behavioral Health Technician I; Behavioral Health Technician II.

Vote by Challenge: The parties agreed that employees employed as Lead Therapists and Dieticians may vote by challenge in any election and that their eligibility or inclusion will be resolved, if necessary, following the election.[4]

The Petitioner seeks inclusion of Nurse Practitioners and Physician Psychiatrists (referred to collectively as "providers") in the Lincoln Center Clinic unit, while the Employer argues that providers should be excluded from the above unit. The Employer also maintains that this petitioned-for single-facility unit is inappropriate and should be merged along with the unit in 18-RC-380683 into a Wisconsin-wide unit comprising all the Employer's 13 facilities in Wisconsin.

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[3] See *Sonotone Corp.*, 90 NLRB 1236 (1950).

[4] However, there is no evidence that there are any dieticians currently employed at the Lincoln Center Clinic.

B. Case 18-RC-380683 – Madison Behavioral Health Treatment Center (Madison Clinic)

Petitioner filed the second Petition in Case 18-RC-380683 on February 9, 2026, seeking a *Sonotone* election in a unit of professional and nonprofessional employees employed at the Employer's outpatient Madison Behavioral Health Treatment Center (Madison Clinic) located in Madison, Wisconsin. The parties stipulated that all full-time, regular-part time and per diem professional and nonprofessional employees in the following job classifications at the Madison Clinic should be included in any unit of employees employed at the Madison Clinic that is found appropriate by the Regional Director:

> **Group A (Professional):** Therapists I (including without limitation Therapist 1 Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2; Hourly and Therapist 2 Hourly SUD); Experiential Therapists (including without limitation Experiential Therapist II); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Behavioral Specialist II; Case Manager MHAR (Mental Health Addiction Recovery).
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> **Group B (Nonprofessional):** Behavioral Health Technician III, Clinic Assistant.
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> **Vote by Challenge:** The parties agreed that employees employed as Lead Therapists and Dieticians may vote by challenge in any election and that their eligibility or inclusion will be resolved, if necessary, following the election.

Because the Petitioner does not seek to represent the providers at the Madison Clinic, the sole issue to be resolved at this time with regard to this clinic is whether a single-facility unit is appropriate.

On February 11, 2026, in agreement with the parties, I consolidated these cases for hearing. A hearing officer of the Board held a consolidated hearing on both petitions on February 23, 24, 25, and 27, 2026. The parties presented oral arguments on their respective positions and submitted memoranda of law which were received by the Hearing Officer, which I have considered, along with relevant Board law.

II. EMPLOYER OPERATIONS

The Employer provides mental health and addiction treatment. It operates approximately 27 facilities nationwide, including 13 locations in Wisconsin. Among its 13 Wisconsin locations, the Employer operates three hospitals located in West Allis, Oconomowoc, and Brown Deer. The remainder of the Employer's facilities are outpatient facilities. Outpatient facilities provide counseling and medication management, intensive outpatient programs, and partial hospitalization programs. The Employer's three hospitals provide residential treatment and inpatient treatment. Patients often move between different levels of care within the Employer's system. To do so, patients must be discharged from one level of care and admitted to another level of care. This may be done

within a single facility. For example, a patient requiring a higher level of care at the Lincoln Center Clinic may need to be discharged from its intensive outpatient program and admitted to its partial hospitalization program while continuing to receive treatment at the Lincoln Center Clinic. Similarly, if a hospitalized patient requires less acute care, the patient must be discharged from the Employer's hospital and admitted to one of the outpatient programs at an outpatient facility.

The Employer's Wisconsin operations are centralized out of its corporate offices located in Oconomowoc, Wisconsin and headed by its Chief Operating Officer. Four vice presidents of operations report up to the Chief Operating Officer and are responsible for designated portions of the Employer's Wisconsin operations. Three of the four vice presidents oversee a "campus" consisting of a hospital and nearby outpatient clinics: Vice President of Operations - West Allis Campus (which includes the Lincoln Center Clinic); Vice President of Operations - Oconomowoc Campus; and Vice President of Operations - Brown Deer. The remaining Vice President of Operations oversees the remaining outpatient clinics in Wisconsin, including the Madison Clinic. Each outpatient facility, including Lincoln Center Clinic and the Madison Clinic, has its own Operations Director who report up through their respective vice presidents.

Common to all facilities is that employees across different job classifications work together as part of a treatment team when caring for patients. Treatment teams, like the ones utilized at the Employer, are the industry standard for all behavioral health treatment. The core of a treatment team consists of a psychiatrist or advanced practice nurse practitioner (provider),[5] a registered nurse, and therapist. Depending on the situation, there may also be a mental health or behavioral health technician, behavioral specialist, experiential therapist, or dietician assigned to the treatment team.

The Employer has standardized trainings, operational policies, personnel policies, and protocols. The Employer's corporate-level human resources department is responsible for advising and overseeing any discipline or termination system-wide among all job classifications. Its job classifications are also standardized. Except for providers, the Employer utilizes standard wage scales set by its corporate human resources compensation team. Provider compensation is handled centrally by a separate corporate-level talent and compensation committee. The Employer also has a centralized leave department that handles requests for unpaid time off or longer periods of non-routine leave.

The Employer's proposed state-wide unit would include approximately 1,383 employees working across its 13 facilities, including its three hospitals.

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[5] Throughout the hearing in this matter, the term "provider" is used to describe nurse practitioners and physician psychiatrists, implying that they are largely interchangeable with one another. With respect to outpatient care, the evidence reflects that nurse practitioners and physician psychiatrists' day-to-day job duties and roles as part of treatment teams are indistinguishable.

A. Lincoln Center Clinic

The Lincoln Center Clinic is located approximately three quarters of a mile from the Employer's West Allis Behavioral Treatment Center Hospital (West Allis Hospital). It averages approximately 135 patients per day and provides medication management, intensive outpatient programs, and partial hospitalization programs.

The first floor of the Lincoln Center Clinic is dedicated to the adolescent unit, while the third floor is dedicated to the adult unit. The second floor houses the employee breakroom, administrative space, and overflow spaces. Generally, patients are admitted to either the intensive outpatient program or the partial hospitalization program at the Lincoln Center Clinic. The Lincoln Center Clinic provides patients with cognitive behavioral and dialectical behavioral therapy, medication management, mental health addiction recovery, as well as services under its "personalized care model" which is tailored to a patient's particular mental health needs. It also offers adolescent treatment, including a teen recovery program for addictive substances. The Lincoln Center Clinic does not treat eating disorders.

There are approximately 68 employees at the Lincoln Center Clinic in the petitioned-for unit. The breakdown of the petitioned-for classifications is reflected in the table below:

CLASSIFICATION	NUMBER OF EMPLOYEES
Professional	
Nurse Practitioner	5
Physician Psychiatrist	1
Therapist 1	17
Therapist 2	10
Experiential Therapist [6]	2
Registered Nurse	9
Behavioral Specialist	11
Case Specialist	7
Case Manager - Mental Health and Addiction Recovery	2
Lead Therapist[7]	2
Nonprofessional	
Clinic Support Coordinator I	1
Clinic Support Coordinator II	1
Behavioral Health Technician I	1
Behavioral Health Technician II	1

[6] The Lincoln Center experiential therapists do not appear on the Employer's Attachment B to its Statement of Position in Case 18-RC-380431, but the record reflects there are two experiential therapists that spend at least 75 percent of their time at the Lincoln Center Clinic and rotate weekend shifts at the West Allis Hospital every four weeks.

[7] As noted above, the parties agreed that Lead Therapists will vote by challenge.

Elizabeth Erickson is the vice president of operations for the West Allis campus and oversees the operations of both the Employer's West Allis Hospital and Lincoln Center Clinic, jointly referred to as the "West Allis Campus." West Allis Lincoln Center Clinic Senior Director of Operations Jessica Pitre has an office at the Lincoln Center Clinic and reports to VP Erickson. Senior Director of Operations Pitre is responsible for the day-to-day operations of the clinic and oversees two Lincoln Center Clinic Operations Managers.

While the exact nature of the reporting structure for each classification of employees at Lincoln Center Clinic is unclear on the record, it appears nearly all professional positions have some level of dual reporting, where employees report both to a local operations manager and a supervisor specific to their job classification. The supervisor that is specific to their job classification may or may not be based onsite at the Lincoln Center Clinic. For example, therapists report both to an onsite clinical supervisor and an onsite operations manager. The Lincoln Center Clinic case managers report both to an onsite operations manager and the mental health addiction recovery service line leader who is based offsite at the Employer's Oconomowoc, Wisconsin location. There is also testimony that the registered nurses are supervised, at least in part, by the Director of Nursing for Outpatient services who works remotely from Nashville. Finally, the Lincoln Center Clinic nurse practitioners and physician psychiatrists are supervised by Lincoln Center Clinic Associate Medical Director Dr. Mateen Khazi, whose office is located within Lincoln Center Clinic.

B. Madison Behavioral Health Treatment Center (Madison Clinic)

Like the Lincoln Center Clinic, the Employer's Madison Behavioral Health Treatment Center (Madison Clinic) provides intensive outpatient and partial hospitalization treatment. Its specialized programs include an obsessive-compulsive disorder anxiety unit, a mental health addictions recovery unit, an eating disorder unit, and a primary behavioral health unit. The two-story facility has several rooms that can be used for group therapy rooms, a conference room, an employee break room, and employee offices. The clinic treats between 70 and 90 patients per day.

There are approximately 36 employees in the petitioned-for unit at the Madison Clinic. Unlike the Lincoln Center Clinic, the Petitioner did not seek to include nurse practitioners or physician psychiatrists in its proposed unit. The breakdown of the petitioned-for classifications is reflected in the table below:

CLASSIFICATION	NUMBER OF EMPLOYEES
Professional[8]	
Therapist 1	10
Therapist 2	10
Registered Nurse	3
Behavioral Specialist	7
Behavioral Specialist II	1
Case Manager - Mental Health and Addiction Recovery	1
Dietician[9]	1
Nonprofessional[10]	
Clinic Assistant	3

The Madison Clinic is led by onsite Director of Operations Scott Wysocki and Operations Manager Matt Froze. Director of Operations Wysocki reports up to the Vice President of Service Areas, which includes the Madison Clinic. The evidence suggests that professional employees at the Madison Clinic have the same dual reporting structure as those employees at the Lincoln Center Clinic, where petitioned-for professional employees report both to an onsite operations manager and a supervisor specific to their job classification that may be located offsite. As a specific example, a behavioral specialist testified that she reported both to the onsite operations manager, Matt Froze, and to an onsite clinical supervisor, Stephanie Payne.

III. THE APPROPRIATENESS OF SINGLE-FACILITY UNITS

The Employer contends that the single-facility units sought by the Petitioner are inappropriate. It argues that any unit must encompass employees at all 13 Wisconsin facilities. For the reasons described below, I reject the Employer's argument and find that the single-facility units are appropriate.

A. The Single-Facility Presumption

A single facility unit in the healthcare industry is presumptively appropriate. *Manor Healthcare Corp*., 285 NLRB 224 (1987); *St. Luke's Health System, Inc*., 340 NLRB 1171, 1172 (2003). A party seeking to rebut that presumption bears a "heavy burden" to demonstrate "integration so substantial as to negate the separate identity of the single facility." *Mercy Sacramento Hospital,* 344 NLRB 790, 790 (2005), citing *Heritage Park Health Care Center*, 324 NLRB 447, 451 (1997), enfd. 159 F.3d 1346 (2d Cir. 1998).

[8] The parties agreed to include "Experiential Therapists (including without limitation Experiential Therapist II)" in the Madison Clinic unit, but there is no evidence that any Experiential Therapist regularly worked at the Madison Clinic as of the time of the hearing.
[9] As noted above, the parties agreed that the Dietician will vote by challenge.
[10] The parties also agreed to include "Behavioral Health Technician III" in the Madison Clinic unit but there is no record evidence reflecting any employee worked in this classification at the Madison Clinic at the time of hearing.

To determine whether the single-facility presumption has been rebutted in the healthcare industry, the Board examines several factors: (1) centralized control over daily operations and labor relations, including the extent of local autonomy; (2) the degree of employee interchange, transfer, and contact; (3) functional integration; (4) similarity of skills, functions and working conditions; (5) geographic proximity; (6) bargaining history; and (7) whether a single-facility unit creates an increased risk of work disruption or other adverse impact upon patient care should a labor dispute arise. *Heritage Park Health Care Center,* above at 451; *Manor Healthcare,* above at 226. The Board considers the degree of separate supervision and interchange to be of particular importance in determining whether the single-facility presumption has been rebutted. *Mercy Sacramento Hospital,* above at 790, citing *Passavant Retirement & Health Care*, 313 NLRB 1216, 1218 (1994); *Heritage Park Health Care Center,* above at 451.

In examining the above factors, I find that the Employer has not met is evidentiary burden to overcome the single-facility presumption.

1. Centralized Control Over Daily Operations and Labor Relations

The Board has held that even where there is substantial centralized control over some labor relations policies and procedures, there may remain sufficient local autonomy to support that the single facility presumption has not been rebutted. *California Pacific Medical Center*, 357 NLRB 197, 198 (2001), citing *Mercy Sacramento Hospital,* above. In analyzing this factor, the Board looks to "whether the employees perform their day-to-day work under the supervision of someone who is involved in rating their performance and in affecting their job status and who is personally involved with the daily matters which make up their grievances and routine problems." *Hilander Foods*, 348 NLRB 1200, 1203 (2006).

While the Employer maintains standardized personnel policies and utilizes a centralized human resources department, that is not sufficient to establish that there is no local autonomy at either the Lincoln Center Clinic or the Madison Clinic. Rather, the evidence reflects that day-to-day supervision of employees is performed by local supervisors and managers. For example, performance appraisals of therapists are conducted by their clinical supervisors and operations managers, both of whom are located within the same physical facility as the therapists. A Madison behavioral specialist testified she received her annual performance review from the Madison Clinic operations manager, who also participated in her interview. Likewise, a Lincoln Center Clinic provider testified that she was interviewed and given a performance appraisal directly by her supervisor, the onsite medical director. The evidence also reflects that routine scheduling issues or standard leave requests are handled by onsite supervision at both clinics.

While Human Resources must review and approve any disciplinary action, the evidence suggests that these matters are escalated by local supervisors, including local operation managers. Local supervisors also work with Human Resources to draft any discipline which must be approved by Human Resources before presenting it to the employee. In instances where there is a dual reporting structure for those professional

classifications that also report to supervisors offsite, there remains collaboration between the onsite operational manager and the appropriate corporate-level supervisor on issues related to performance, hiring, firing and scheduling.[11] Professional improvement plans are handled locally and independently from the human resources department as they are not considered disciplinary in nature.

The evidence suggests that despite centralization of certain human resources functions, the day-to-day supervision of employees is generally performed locally. For this reason, I do not find that this factor weighs against the single facility presumption.

2. Degree of Employee Interchange, Transfer, and Contact

a. Interchange and Transfer

Employee contact is considered interchange where a portion of the workforce of one facility is involved in the work of the facilities through temporary transfer or assignment of work. A "significant portion" of the workforce must be involved, and the work force must be supervised at the worksite to which they are not normally assigned to meet the burden of proof on the party opposing the single-facility unit. *New Britain Transportation Co.*, 330 NLRB 397, 398 (1999). Where the amount of interchange is unclear both as to scope and frequency because it is unclear how the total amount of interchange compares to the total amount of work performed, the burden of proof is not met, including where a party fails to support a claim of interchange with either documentation or specific testimony providing context. *Cargill Inc.,* 336 NLRB 1114 (2001); *Courier Dispatch Group*, 311 NLRB 728, 731 (1993). Also important in considering interchange is whether the temporary employee transfers are voluntary or required, the number of permanent employee transfers, and whether the permanent employee transfers are voluntary. *New Britain Transportation Co*., above at 398. Voluntary interchange is given less weight in determining if employees from different locations share a common identity. Id. at 398.

Here, the evidence of interchange is not sufficient to rebut the single-facility presumption. With some limited exceptions described below, employee interchange between facilities is performed exclusively on a voluntary basis. Employee testimony was consistent that voluntary interchange is not a common occurrence. While the two experiential therapists at the Lincoln Center Clinic rotate weekend shifts at the West Allis Hospital, two employees out of a unit of approximately 68 employees does not constitute a "significant portion" of the workforce. Additionally, while the providers also take calls for the

[11] While the COO summarily testified that the Nashville-based Director of Nursing for Outpatient Services directs the day-to-day activities of all outpatient nurses, this testimony was devoid of any detail as to how that assignment functions given that there are approximately 37 registered nurses working at ten different facilities across the state. The Employer also did not call the Director of Nursing for Outpatient Services as a witness. In any event, there is evidence that there is collaboration between the corporate level supervisors like the Director of Nursing for Outpatient Services and onsite operational managers. No registered nurse testified.

West Allis Hospital once a week, this task is performed remotely. Furthermore, there is no evidence that taking intermittent calls for the hospital represents a significant amount of work compared to the total amount of work they perform.

The Employer submitted spreadsheets reflecting instances where patients received care from an employee that was assigned to a facility other than the one where the patient was located. However, this evidence lacks the necessary details and context to meet the Employer's rebuttal burden. First, it is unknown whether employees performed the work virtually from their assigned locations or onsite. Second, many of the entries reflect work performed by experiential therapists at the Lincoln Center Clinic. Experiential therapists are administratively assigned to the hospital, even while predominantly assigned to be working in-person with patients at the Lincoln Center Clinic. This further undermines the value of these spreadsheets as evidence of interchange.[12]

Finally, while there was testimony that the spreadsheets show the aggregate number of patients receiving treatment at the Employer, this appears incorrect. The spreadsheets only reflect instances in which a patient received care from an employee not normally assigned to the facility where the patient is located. There is also no indication of how much of an employee's total time is spent performing work away from their primary location. Employee testimony suggests it is not a common occurrence for most employees.

For these reasons, the evidence regarding interchange and transfer is insufficient to rebut the single-facility presumption.

b. Contact

There is little evidence of contact between the petitioned-for employees and employees at other facilities. There was no evidence of regular contact between the Madison Clinic staff and other employees within the Employer's system. With respect to the Lincoln Center Clinic, there are "nurse to nurse" contacts when sending a patient from the Lincoln Center Clinic to the West Allis Hospital, but that occurs only once a week and this communication does not continue. Transfers from the hospital to outpatient care at the Lincoln Center Clinic happen daily, but there was no evidence that this resulted in contact between employees. While Lincoln Center Clinic providers have some contact with employees from other facilities by virtue of their taking calls for the hospital and attending monthly medical staffing meetings, such contact is limited. Information related to patients is maintained in the Employer's electronic health records system, resulting in only a limited number of instances in which further information is obtained through direct contact between employees of different facilities.

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[12] Furthermore, for both the Lincoln Center and Madison Clinics, many of the entries included in these spreadsheets are for social workers or care advocates, which are not among the employees in the petitioned-for unit. There is no evidence that social workers or care advocates interchange with any other classification of employee at either clinic.

In conclusion, I find that the evidence under this factor does not rebut the single-facility presumption.

3. Functional Integration

Evidence of functional integration is also relevant to the issue of whether a single-facility unit is appropriate. Functional integration refers to when employees at two or more facilities are closely integrated with one another functionally notwithstanding their physical separation. *Budget Rent A Car Systems*, 337 NLRB 884 (2002). Functional integration involves employees at the various facilities participating equally and fully at various stages in the employer's operation, such that the employees constitute integral and indispensable parts of a single work process. Id. Employee contact is a key factor in determining whether different facilities are sufficiently functionally integrated to merit their inclusion in a single bargaining unit. Id. at 885.

Here, while there is evidence that patients move between different levels of care within the Employer's system, this requires that a patient be discharged from one facility and separately admitted to the receiving facility. Nor are clinic operations dependent upon one another for work-flow purposes. For example, a patient may only seek outpatient treatment and never require inpatient treatment by the local hospital. Or a patient may be seen at a single outpatient facility and never require assistance by any other clinic or hospital. Compare *Budget Rent a Car Systems,* above at 885 (finding significant functional integration substantial enough to rebut the single-facility where: there was no separate fleet inventory for any of the market stores, there was contact between store employees three to four times a day to coordinate operations; truck mechanics had to service trucks at all stores, requiring frequent travel to the stores; and there was evidence of temporary and permanent employee transfers among the five stores).

Even for those patients that do transfer between facilities, once a patient is admitted to a different facility, there is no evidence of any ongoing care provided by the originating facility's employees. Crucially, there is also no evidence that patient transfers of this nature result in frequent contact between employees at different facilities.

I do not find that the degree of functional integration rebuts the single-facility presumption.

4. Similarity of Skills, Functions and Working Conditions

The similarity or dissimilarity of work, qualifications, working conditions, wages and benefits between among employees at the facilities the Employer contends should be in the unit has some bearing on determining the appropriateness of the single-facility unit. However, this factor is less important than whether individual facility management has autonomy and whether there is substantial interchange. See, e.g., *Dattco, Inc*., 338 NLRB 49, 51 (2002).

In the outpatient setting, there is evidence that employees share many of the same functions, skills, and working conditions. The Employer's medical record program known as Oracle is used by employees throughout its operations. Employees attend some of the same trainings and are subject to standardized policies and protocols. Job classifications and pay scales are standardized.

There are some differences between outpatient clinics with respect to the specialized patient population they serve. For example, the Madison Clinic treats patients with eating disorders, while the Lincoln Center Clinic does not. Additionally, the record is less clear as it relates to how jobs compare between the outpatient and inpatient settings. Clearly, those employees working for an inpatient hospital must be scheduled to allow constant coverage, while outpatient employees appear to generally be scheduled during daytime hours. Inpatient employees also work with a higher level of acuity of the patients they serve and are subject to different protocols in an inpatient setting.

Overall, I find this factor to cut slightly against the single-facility presumption.

5. Geographic Proximity

Significant geographic distance between locations is normally a factor in favor of a single-facility unit. *Trane*, 339 NLRB 866, 867 (2003). Here, the distances between the Employer's 13 facilities varies substantially from facility to facility, largely based on whether the clinic is part of a "campus" which includes a hospital. For example, the Lincoln Center Clinic is .6 miles away from the West Allis Hospital. Outpatient clinics in Oconomowoc and Brown Deer are likewise located very close to their respective hospitals in those areas. However, the Madison Clinic is approximately 58 miles from the nearest Employer facility. The Employer's Wausau Behavioral Treatment Center is over 90 miles from the nearest Employer facility.

Overall, I find this factor to be neutral based on the varying degrees of geographic proximity between the Employer's facilities.

6. Bargaining History

There is no bargaining history in this matter. The absence of bargaining history is a neutral factor in the analysis of whether a single unit facility is appropriate. *Trane*, above at 868, fn. 4.

7. Increased Risk of Work Disruption or Other Adverse Impact Upon Patient Care should a Labor Dispute Arise

As described in *Manor Healthcare Corp*., 285 NLRB 224, 226 (1987), the single-facility presumption can be rebutted by weighing, in addition to the usual community-of-interest factors, evidence demonstrating that approval of the single-facility unit will threaten the kinds of disruptions to the continuity of patient care which Congress sought to prevent by its admonition against undue proliferation of health care bargaining units. As already

described above, the evidence reflects that Madison Clinic and the Lincoln Center Clinic provide patient care that is generally independent of the Employer's other facilities.[13] This factor does not weigh against the single-facility presumption.

8. Conclusion

I have carefully considered the record evidence and weighed the various factors that bear on the determination of whether the single-facility units are appropriate. Ultimately, the Employer has the burden of overcoming the single-facility presumption. I find that none of the factors, singularly or in combination with one another, suggest that the Lincoln Center Clinic or Madison Clinic have lost their separate identity such that a single-facility unit would be inappropriate. Rather, in finding that each of the single-facility units sought by Petitioner are appropriate, I note that there remains local supervision in each facility, evidence of interchange is insufficient, the facilities generally operate independently of other Employer facilities, and there is little evidence of regular contact between employees working at different facilities.

B. LINCOLN CENTER CLINIC NURSE PRACTITIONERS AND PHYSICIAN PSYCHIATRISTS

Having found a single-facility unit is appropriate for both the Madison Clinic and Lincoln Center Clinic, the remaining issues relate only to the petitioned-for classifications of nurse practitioner and physician psychiatrist at the Lincoln Center Clinic. The evidence reflects at the time of hearing, there were four nurse practitioners and one physician psychiatrist working at Lincoln Center Clinic. Collectively, these positions are referred to by the Employer as "providers."

The Employer asserts that Lincoln Center Clinic providers are not employees under the Act because they are managers or supervisors. Alternatively, the Employer argues that even if found to be employees, providers do not share a sufficient community of interest with the other petitioned-for employees at the Lincoln Center Clinic. I reject these arguments for the reasons set forth below.

1. Employee Status of Lincoln Center Clinic Providers

a. The Employer did not meet its burden of proving that any of the petitioned-for providers are managers.

Managerial employees are excluded from the protections of the Act. *NLRB v. Bell Aerospace Co., Division of Textron, Inc.*, 416 U.S. 267, 274-275 (1974). The party seeking to establish that an employee is a manager has the burden of proving managerial status.

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[13] Compare *W. Jersey Health System,* 293 NLRB 749 (1989), where the Board concluded that single-facility units would cause adverse consequences to patient care because certain critical functions, such as radiology, nuclear medicine, and hot food service, were based only in certain divisions, but provided services to the entire system.

See, e.g., *Constellis, LLC d/b/a Academic Training Center, LLC*, 372 NLRB No. 81 (2023). The determination of whether an individual is a managerial employee involves a fact-intensive inquiry into the specific responsibilities of employees. See, e.g., *Salinas Newspapers*, 279 NLRB 1007, 1010 (1986). This requires a case-by-case "close examination of the duties performed by the person in question while occupying a position alleged to be 'managerial.'" *Curtis Noll Corp*., 218 NLRB 1447, 1448 (1975). Further, the "question whether particular employees are 'managerial' must be answered in terms of the employees' actual job responsibilities, authority, and relationship to management." *Bell Aerospace*, above at 290, fn. 19. As to medical employees in particular, the Board has held that physicians may be managerial "if their activities on behalf of their employer fall outside the scope of decision-making routinely performed by similarly situated health care professionals and that is primarily incident to their treatment of patients." *FHP, Inc*., 274 NLRB 1141, 1142-1143 (1985) (citing *Montefiore Hospital & Medical Center*, 261 NLRB 569, 570 (1982)).

Much of the Employer's evidence with respect to managerial status of the petitioned-for providers was presented as generalized testimony applicable to all providers within its system. For example, there was substantial testimony about providers within the Employer's system and their eligibility to serve on different committees in leadership roles. However, there was no evidence that any of the petitioned-for Lincoln Center Clinic providers hold any such positions. It may be that some providers within the Employer's system, by nature of their holding positions on committees or policy-making bodies at the Employer, are managerial employees. However, that is immaterial to the question of whether the petitioned-for employees are managers.

There is no evidence that any of the petitioned-for employees "formulate and effectuate high-level employer policies" or "have discretion in the performance of their jobs independent of their employer's established policy." *Constellis, LLC d/b/a Academic Training Center, LLC*, 372 NLRB No. 81, slip op. at 6 (2023). Evidence that the petitioned-for providers are responsible for what is called "advocacy," as vaguely described in their employment agreement, is not sufficient to establish managerial status. Furthermore, the Employer's contention that providers are decision-makers with respect to the course of treatment for their patients is not indicative of their managerial status. See *FHP, Inc*., above at 1142-1143 (1985). I conclude that the Employer has not carried its evidentiary burden to show the Lincoln Center Clinic providers are managers.

b. The Employer did not meet its burden of proving that the petitioned-for providers are supervisors.

Section 2(11) of the Act defines a supervisor as any individual with the authority to engage in several supervisory functions, which include the authority "to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action . . . ." Purported supervisors must: (1) possess any one of the twelve enumerated supervisory functions; (2) exercise independent judgment in applying that authority in a manner that is not merely routine or clerical; and (3) and hold their authority "in the interest of the employer." *Oakwood Healthcare*, *Inc*., 348 NLRB 686, 687 (2006).

Here, the Employer bears the burden of proof because it is the party alleging supervisory status. Id. Accordingly, any lack of evidence is construed against the Employer. *Busco Tug and Barge, Inc.,* 359 NLRB 486, 490 (2012). To meet its burden, the Employer must present "detailed, specific evidence" that is not "in conflict or otherwise inconclusive." Id.

The Employer argues that Lincoln Center Clinic providers are: (1) responsible for directing other employees; (2) can assign work to employees on their treatment team; and (3) can effectively recommend disciplinary action, including termination.[14] For the reasons described below, the Employer failed to meet its burden of proof with respect to any of these supervisory indicia.

i. Responsible Direction

To establish supervisory status based on the exercise of responsible direction, the purported supervisor must not merely direct but must also be "held fully accountable and responsible for the performance and work product of the employees he directs." *Oakwood Healthcare, Inc.*, above, at 691-692 (internal quotations omitted). "[T]o establish accountability for purposes of responsible direction, it must be shown that the employer delegated to the putative supervisor the authority to direct the work and the authority to take corrective action, if necessary. It also must be shown that there is a prospect of adverse consequences for the putative supervisor if he/she does not take these steps." Id. While accountability under *Oakwood Healthcare* requires "only a prospect of consequences," there "must be a more-than-merely-paper showing that such a prospect exists." *Golden Crest Healthcare*, 348 NLRB 727, 731 (2006).

There is no evidence reflecting that the petitioned-for providers are responsible for directing the performance of other members of the treatment team. Providers work as an integral and important part of the treatment team assigned to treat the patient, but they do not have the necessary expertise or education permitting them to "responsibly direct" others on the treatment team. As pointed out in testimony by the Lincoln Center Clinic nurse practitioner, she does not have the requisite training to meaningfully direct the therapy portion of the patient's treatment, which is why she would defer to the therapist and the therapist's supervisor should an issue arise. Furthermore, there is no evidence suggesting that any of the petitioned-for providers are accountable for work performed by another employee in the manner contemplated by *Oakwood*, above.

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[14] Nothing suggests that Lincoln Center Clinic providers have any authority to hire, transfer, suspend, lay off, recall, promote, reward, or adjust employee grievances. While the Employer asserts that they could recommend removal of a member from their treatment team, there was no evidence of what, if any, independent judgment is used in such instances or whether such recommendations are effective. Furthermore, this authority was contradicted by the testimony of a Lincoln Center Clinic nurse practitioner who testified that she was unaware of having any such authority.

ii. Assign

The Board defines "assign" as referring "to the act of designating an employee to a place (such as a location, department, or wing), appointing an employee to a time (such as a shift or overtime period), or giving significant overall duties, i.e., tasks, to an employee." *Oakwood*, above at 689. There is no evidence suggesting that Lincoln Center Clinic providers exercise this type of authority over employees on their treatment team.

iii. Discipline, Including Termination

The Employer argues that the petitioned-for Lincoln Center Clinic providers make effective recommendations as to discipline, including termination of other employees. There was general testimony that a provider's recommendation would be given significant weight based on their role on the treatment team. Even assuming that is the case, that is not sufficient to confer supervisory status. To establish supervisory authority based on the authority to discipline, "'the exercise of disciplinary authority must lead to personnel action, without the independent investigation or review of other management personnel.'" *Lucky Cab Co.*, 360 NLRB 271, 272 (2014) (quoting *Franklin Home Health Agency*, 337 NLRB 826, 830 (2002)). Employer witnesses testified that providers do not issue discipline nor perform any investigative function in the disciplinary process. Rather, they are expected to escalate any concerns to a site leader or medical director, who would handle the matter in consultation with the Employer's Human Resources Department. Warnings that simply bring substandard performance to the employer's attention without recommendations for future discipline serve nothing more than a reporting function and are not evidence of supervisory authority. See *Williamette Industries, Inc.*, 336 NLRB 743, 744 (2001); *Loyalhanna Health Care Associates*, 332 NLRB 933, 934 (2000).

Accordingly, I do not find that the Employer has met its burden to show that the petitioned-for providers are supervisors under the Act.

3. Providers' Community of Interest with Other Employees in the Unit

The Employer argues that Lincon Center Clinic providers do not share a community of interest with the other employees in the petitioned-for unit and therefore their inclusion in the unit would render the unit inappropriate.[15] The parties stipulated that the following petitioned-for classifications should be included in any unit found appropriate by the Director at the Lincoln Center Clinic:

Voting Group A (Professional Unit): Therapists I (including without limitation Therapist I Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2 Hourly and Therapist 2 Hourly SUD); Experiential Therapists

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[15] Apart from the issue related to the inclusion of the providers within the unit, I have already determined that the petitioned-for unit of employees at the Lincoln Center Clinic constitutes an identifiable and sufficiently distinct segment of employees that is an appropriate voting group.

(including without limitation Experiential Therapist II and Experiential Therapist Music Movement); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Case Specialists (including without limitation Case Specialist and Case Specialist SUD); Case Manager MHAR (Mental Health Addiction Recovery).

Voting Group B (Nonprofessional Unit): Clinical Support Coordinator I; Clinical Support Coordinator II; Behavioral Health Technician I; Behavioral Health Technician II.

The parties further stipulated that Lead Therapists and Dieticians may vote by challenge in the election and to defer the resolution of their eligibility or inclusion until after the election.

The Board has repeatedly emphasized that a petitioned-for unit need only be *an* appropriate unit, not the *most* appropriate unit. *American Steel Construction, Inc*., 372 NLRB No. 23, slip op. at 4 (2022). In assessing the appropriateness of any proposed unit, the Board considers such community of interest factors such as: whether employees are organized into a separate administrative grouping or department; have distinct skills and training; have distinct job functions and perform distinct work, including inquiry into the amount and type of job overlap between classifications; are functionally integrated with the other employees; have frequent contact with other employees; interchange with other employees; have distinct terms and conditions of employment; and are separately supervised. Id. at 2, citing *United Operations, Inc*., 338 NLRB 123, 123 (2002). These factors can be given different weight depending on the totality of the circumstances. See, e.g., *Executive Resources Associates*, 301 NLRB 400, 401 (1991).

In weighing all relevant factors, I find there exists a community of interest between the Lincoln Center nurse practitioners and physicians with the other employees in the petitioned-for unit.

a. Administrative organization

An important consideration in any unit determination is whether the proposed unit conforms to an administrative function or grouping of an employer's operation. *International Paper Co*., 96 NLRB 295, 298 fn. 7 (1951). Here, all petitioned-for unit employees, including the nurse practitioners and physician, primarily perform their work at the Lincoln Center Clinic, an administrative unit of the Employer. While the Employer has a centralized reporting structure, the Lincoln Center Clinic remains an identifiable administrative unit at the Employer as evidenced by its leadership structure, including its day-to-day operations oversight by Senior Director of Operations Pitre. All the petitioned-for Lincoln Center Clinic employees primarily work with patients admitted to the Lincoln Center Clinic. While nurse practitioners and physicians are hired into the hospital, their assigned primary role is the Lincoln Center Clinic and their patient assignments come

exclusively from the clinic.[16] When Lincoln Center Clinic providers take calls for the hospital once a week, they do so either from the Lincoln Center Clinic or remotely. Overall, I find this factor weights in favor of finding a shared community interest.

b. Employee skills and training; distinct job function and distinct work; interchange with other employees

Like other petitioned-for professional employees, providers have special training, licensing, and educational requirements for their positions. While some training is particular to providers, other training is required across multiple job classifications. Providers also use the same medical records system as other employees.

Providers are the only classification of employees that are responsible for entering medication and treatment orders. They are also solely responsible for ordering the admission or discharge of patients. They must also maintain their privileges at all Employer hospitals in Wisconsin. Because of the nature of their positions, there is no interchange between providers and other classifications. However, like other professional classifications in the unit, providers are essential members of the treatment team. Like other professionals, they interact with patients daily at the Lincoln Center Clinic, primarily in person. There is also no evidence that their hours vary significantly from that of other employees at the Lincoln Center Clinic, other than when they take calls for the West Allis Hospital.

While there are differences between providers and other employees in their skills and duties, I do not find them to be entitled to significant weight under the circumstances here. These same differences are present between nearly all professional employees that the parties agreed should be included in the unit. For example, therapists and registered nurses working at Lincoln Center Clinic have distinct training, job functions, and do not appear to interchange, but the parties agreed that those classifications share a community of interest. Because I do not find these factors indicative of whether there is a community of interest under the circumstances here, I do not give any of these factors significant weight.

c. Functional Integration

Functional integration exists when employees must work together and depend on each other to accomplish their overall duties. *Walt Disney Parks and Resorts,* 373 NLRB No. 99 (2024), slip op. at 6. Here, providers work as critical members of the treatment team alongside therapists, behavioral specialists, registered nurses, and mental health or behavioral health technicians. They serve the same patient population within the Lincoln Center Clinic. Their offices are located near other professional employees. Because they

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[16] The two Lincoln Center Clinic experiential therapists also appear to be technically employed through the hospital, but there is no contention that they do not share a community of interest with other employees at the Lincoln Center Clinic.

are an integral part of the treatment team, I find that this factor strongly supports finding a community of interest between the providers and the other petitioned-for employees.

d. Frequent Contact with Other Employees

Providers have regular contact with employees in the petitioned-for unit. For example, providers attend weekly "staffing" meetings with the treatment team to discuss how a patient is progressing through treatment. These meetings are typically held in person. The Lincoln Center Clinic also has its own Teams channels where employees interact. Providers and other professionals in the proposed unit work at the same job site and have offices on the same floor and have frequent contact with employees. I find that this factor favors finding a community of interest.

e. Distinct Terms and Conditions of Employment

Unlike other classifications within the petitioned-for unit at Lincoln Center Clinic, providers are hired pursuant to an employment agreement. Provider compensation is also separately evaluated yearly by a compensation committee. Providers are subject to medical staff bylaws and must maintain their privileges at all the Employer's hospitals as part of their employment.

However, there are also some shared working conditions. Health insurance is the same among employee classifications. All the petitioned-for employees primarily work in person at the Lincoln Center Clinic and appear to work similar hours across classifications. Providers are subject to the same human resources policies, including leave policies. Providers must follow the same protocols related to the clinic.

Overall, because providers are the only classification within the petitioned-for unit to have individual employment agreements, I find that this factor weighs slightly against finding a community of interest.

f. Supervision

Lincoln Center Clinic providers are separately supervised onsite by Dr. Mateen Khazi. Among the petitioned-for classifications, only providers are supervised by Dr. Khazi who reports up to the Chief Medical Officer for the West Allis campus, which includes the Lincoln Center Clinic and West Allis Hospital. The record is unclear how much, if any, supervision of providers is performed by operational management.

I find that this factor weighs against finding a community of interest, though its significance is dampened by the fact that other employees in the petitioned-for professional classifications have some supervision that is unique to their job classification.

g. Conclusion

Weighing each of the community-of-interest factors in this case, I find providers have community of interest with the other petitioned-for employees. More specifically, I find that the administrative grouping, the frequency of employee contact, and providers' functional integration with other job classifications all strongly support finding that providers share a community of interest with the petitioned-for unit. I give the factors of employee skill and training, distinct work, and interchange minimal weight given for the reasons described above. While I find that providers' distinct terms and conditions of employment and their separate supervision cut against a community of interest finding, those factors are outweighed by the significant functional integration, frequent employee contact, and a shared administrative grouping at the Lincoln Center Clinic. Taken together, these factors establish that the petitioned-for unit of employees at the Lincoln Center Clinic, including the providers, is an appropriate unit for purposes of collective-bargaining.

IV. CONCLUSIONS

Based upon the entire record in this matter and in accordance with the discussion above, I conclude and find as follows:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are 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 in this case.[17]

3. The Petitioner is a labor organization within the meaning of Section 2(5) of the Act and claims to represent certain employees of the Employer.

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 following employees of the Employer constitute appropriate units for the purpose of collective bargaining within the meaning of Section 9(b) of the Act:

18-RC-380431 LINCOLN CENTER CLINIC

VOTING GROUP A (Professional Unit)

All full-time, regular part-time, and per diem professional employees employed by the Employer in the following job classifications at the Employer's Lincoln Center

[17] The parties stipulated: "During the last twelve months, a representative period, the Employer derived gross revenues in excess of $250,000 and purchased and received at its facilities in the State of Wisconsin goods valued in excess of $5,000 directly from points outside the State of Wisconsin."

Clinic located in West Allis, Wisconsin: Nurse Practitioner, Physician Psychiatrist, Therapists I (including without limitation Therapist 1 Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2 Hourly and Therapist 2 Hourly SUD); Experiential Therapists (including without limitation Experiential Therapist II and Experiential Therapist Music Movement); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Case Specialists (including without limitation Case Specialist and Case Specialist SUD); Case Manager MHAR (Mental Health Addiction Recovery), *excluding* managerial employees, nonprofessional employees, confidential employees, and supervisors as defined in the National Labor Relations Act.

OTHERS PERMITTED TO VOTE IN VOTING GROUP A (Professional Unit)

At this time, no decision has been made regarding whether employees in the classification of "lead therapist" or "dietician" are included in, or excluded from, the bargaining unit. Individuals in these classifications may vote in the election but their ballots shall be challenged since their eligibility has not been resolved. The eligibility or inclusion of these individuals will be resolved, if necessary, following the election.[18]

VOTING GROUP B (Nonprofessional Unit)

All full-time, regular part-time, and per diem nonprofessional employees employed by the Employer in the following job classifications at the Employer's Lincoln Center Clinic located in West Allis, Wisconsin: Clinical Support Coordinator I; Clinical Support Coordinator II; Behavioral Health Technician I; Behavioral Health Technician II, *excluding* managerial employees, professional employees, confidential employees, and supervisors as defined in the National Labor Relations Act.

If a majority of the professional employees in Voting Group A vote "Yes" to the first question as to whether they desire to be included in a unit with nonprofessional employees, they will be so included and their votes on the second question will be counted together with the votes of the nonprofessional employees in Unit B to decide the question concerning representation for the overall unit in Unit C, described below:

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[18] The parties stipulated to vote these classifications subject to challenge. The parties further stipulated that lead therapists are professional employees within the meaning of Section 2(12) of the National Labor Relations Act. The parties did not specifically stipulate regarding the professional status of dieticians. However, the unit description set forth in the Petitioner's petition for the Madison Clinic includes dieticians in the professional group, and the Employer did not contest that assertion. Further, the Board has generally found dieticians to be professional employees. See, *Mason Clinic,* 221 NLRB 374, 376 (1975); *Sutter Community Hospitals*, 227 NLRB 181, 188 (1975).

VOTING GROUP-UNIT C (Overall Unit)

All full-time, regular part-time, and per diem professional and nonprofessional employees employed by the Employer in the following job classifications at the Employer's Lincoln Center Clinic located in West Allis, Wisconsin: Nurse Practitioner, Physician Psychiatrist, Therapists I (including without limitation Therapist 1 Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2 Hourly and Therapist 2 Hourly SUD); Experiential Therapists (including without limitation Experiential Therapist II and Experiential Therapist Music Movement); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Case Specialists (including without limitation Case Specialist and Case Specialist SUD); Case Manager MHAR (Mental Health Addiction Recovery), Clinical Support Coordinator I; Clinical Support Coordinator II; Behavioral Health Technician I; Behavioral Health Technician II, *excluding* managerial employees, confidential employees, and supervisors as defined in the National Labor Relations Act.

On the other hand, if a majority of the professional employees voting in Unit A do not vote "Yes" to the first question, their ballots will be counted separately to decide the question concerning representation in a separate Unit A.

18-RC-380683 MADISON BEHAVIORAL HEALTH TREATMENT CENTER

VOTING GROUP A (Professional Unit):

All full-time, regular part-time, and per diem professional employees employed by the Employer in the following job classifications at the Employer's Madison Behavioral Health Treatment Center located in Madison, Wisconsin: Therapists I (including without limitation Therapist 1 Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2; Hourly and Therapist 2 Hourly SUD); Experiential Therapists (including without limitation Experiential Therapist II); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Behavioral Specialist II; Case Manager MHAR (Mental Health Addiction Recovery), *excluding* managerial employees, nonprofessional employees, confidential employees, and supervisors as defined in the National Labor Relations Act.

OTHERS PERMITTED TO VOTE IN VOTING GROUP A (Professional Unit):

At this time, no decision has been made regarding whether employees in the classification of "lead therapist" or "dietician" are included in, or excluded from, the bargaining unit. Individuals in these classifications may vote in the election but their ballots shall be challenged since their eligibility has not been resolved. The eligibility

or inclusion of these individuals will be resolved, if necessary, following the election.[19]

VOTING GROUP B (Nonprofessoinal Unit):

All full-time, regular part-time, and per diem nonprofessional employees employed by the Employer in the following job classifications at the Employer's Madison Behavioral Health Treatment Center located in Madison, Wisconsin: Behavioral Health Technician III and Clinic Assistant; *excluding* managerial employees, professional employees, confidential employees, and supervisors as defined in the National Labor Relations Act.

If a majority of the professional employees in Voting Group A vote "Yes" to the first question as to whether they desire to be included in a unit with nonprofessional employees, they will be so included and their votes on the second question will be counted together with the votes of the nonprofessional employees in Unit B to decide the question concerning representation for the overall unit in Unit C, described below:

VOTING GROUP-UNIT C (Overall Unit)

All full-time, regular part-time, and per diem professional and nonprofessional employees employed by the Employer in the following job classifications at the Employer's Madison Behavioral Health Treatment Center, located in Madison, Wisconsin: Therapists I (including without limitation Therapist 1 Hourly and Therapist 1 Hourly SUD); Therapist II (including without limitation Therapist 2; Hourly and Therapist 2 Hourly SUD); Experiential Therapists (including without limitation Experiential Therapist II); Registered Nurse IOP PHP (Intensive Outpatient Programs; Partial Hospitalization Programs); Behavioral Specialist; Behavioral Specialist II; Case Manager MHAR (Mental Health Addiction Recovery), Behavioral Health Technician III, and Clinic Assistant; *excluding* managerial employees, confidential employees, and supervisors as defined in the National Labor Relations Act

On the other hand, if a majority of the professional employees voting in Unit A do not vote "Yes" to the first question, their ballots will be counted separately to decide the question concerning representation in a separate Unit A.

V. ORDER SEVERING CASES

An Order Consolidating Cases for Hearing and Setting Statement of Position Due Date issued on February 11, 2026. Based on the conclusion of the hearing and the undersigned having fully considered the matter,

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[19] The parties stipulated to vote these classifications subject to challenge, as discussed in more detail above.

IT IS HEREBY ORDERED that Case 18-RC-380431 be, and it hereby is, severed from Case 18-RC-380683.

VI. DIRECTION OF ELECTION – CASE 18-RC-380431 LINCOLN CENTER CLINIC

The National Labor Relations Board will conduct a secret ballot election among employees in each of the voting groups in the Lincoln Center Clinic unit as identified above. Employees in the unit will vote whether they wish to be represented for purposes of collective bargaining by the National Union of Healthcare Workers.

A. Election Details

The election will be held on **Wednesday, April 22, 2026, from 6:30 a.m. to 9:00 a.m. and from 3:30 p.m. to 5:30 p.m.**, in the first floor conference room at the Employer's facility located at 2424 S. 102nd Street, West Allis, Wisconsin.[20]

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **Friday, April 10, 2026**, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible to vote are all employees in the units who have worked an average of four (4) hours or more per week during the 13 weeks immediately preceding the eligibility date for the election. In a mail ballot election, employees are eligible to vote if they are in the unit on both the payroll period ending date and on the date they mail in their ballots to the Board's designated office.

Employees engaged in an economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike that commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Unit employees in the military services of the United States may vote if they appear in person at the polls.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the designated payroll period, and, in a mail ballot election, before they mail in their ballots to the Board's designated office; (2) striking employees who have been discharged for cause since the strike began and who have not been rehired or reinstated before the election date; and (3) employees who are engaged in an economic strike that began more than 12 months before the election date and who have been permanently replaced.

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[20] The Petitioner waived all 10 days it is entitled to have the voter lists prior to the election.

C. Voter Lists

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names (that employees use at work), work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters. **The Employer must provide a separate voter list for each Voting Group. The Employer must also include in a separate section of the list for Voting Group A the same information for those individuals who, according to this direction of election, will be permitted to vote subject to challenge.**

To be timely filed and served, the lists must be *received* by the Regional Director and the parties by **April 16, 2026.** The list must be accompanied by a certificate of service showing service on all parties. **The Region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the lists in the required form, the lists must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the lists will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the lists shall be filed electronically with the Region and served electronically on the other parties named in this decision. The lists may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election(s) whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list(s) within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list(s) for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election accompanying this Decision in conspicuous places, including all places where notices to employees in the units found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In

addition, if the Employer customarily communicates electronically with some or all of the employees in the units found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the elections and copies must remain posted until the end of the elections. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution. Failure to follow the posting requirements set forth above will be grounds for setting aside the elections if proper and timely objections are filed.

VII. DIRECTION OF ELECTION – CASE 18-RC-380683 MADISON BEHAVIORAL HEALTH TREATMENT CENTER

The National Labor Relations Board will conduct a secret ballot election among employees in each of the voting groups in the Madison Behavioral Health Treatment Center unit as identified above. Employees in the unit will vote whether they wish to be represented for purposes of collective bargaining by the National Union of Healthcare Workers.

A. Election Details

The election will be held on **Wednesday, April 22, 2026, from 6:30 a.m. to 9:00 a.m. and from 3:30 p.m. to 5:30 p.m.**, in the basement conference room at the Employer's facility located at 406 Science Drive, Suite 110, Madison, Wisconsin.[21]

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **Friday, April 10, 2026**, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible to vote are all employees in the units who have worked an average of four (4) hours or more per week during the 13 weeks immediately preceding the eligibility date for the election. In a mail ballot election, employees are eligible to vote if they are in the unit on both the payroll period ending date and on the date they mail in their ballots to the Board's designated office.

Employees engaged in an economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike that commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Unit

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[21] The Petitioner waived all 10 days it is entitled to have the voter lists prior to the election.

employees in the military services of the United States may vote if they appear in person at the polls.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the designated payroll period, and, in a mail ballot election, before they mail in their ballots to the Board's designated office; (2) striking employees who have been discharged for cause since the strike began and who have not been rehired or reinstated before the election date; and (3) employees who are engaged in an economic strike that began more than 12 months before the election date and who have been permanently replaced.

C. Voter Lists

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names (that employees use at work), work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters. **The Employer must provide a separate voter list for each Voting Group. The Employer must also include in a separate section of the list for Voting Group A the same information for those individuals who, according to this direction of election, will be permitted to vote subject to challenge.**

To be timely filed and served, the lists must be *received* by the Regional Director and the parties by **April 16, 2026.** The list must be accompanied by a certificate of service showing service on all parties. **The Region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the lists in the required form, the lists must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the lists will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the lists shall be filed electronically with the Region and served electronically on the other parties named in this decision. The lists may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election(s) whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list(s) within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list(s) for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election accompanying this Decision in conspicuous places, including all places where notices to employees in the units found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition, if the Employer customarily communicates electronically with some or all of the employees in the units found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the elections and copies must remain posted until the end of the elections. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution. Failure to follow the posting requirements set forth above will be grounds for setting aside the elections if proper and timely objections are filed.

RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 10 business days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review must be E-Filed through the Agency's website and may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001, and must be accompanied by a statement explaining the circumstances concerning not having access to the Agency's E-Filing system or why filing electronically would impose an undue burden. A party filing a request for review must serve a copy of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board

together with the request for review. Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board.

Dated: April 14, 2026

/s/ Jennifer A. Hadsall

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