Catholic Health
Mercy Hospital of Buffalo

November 30, 2023

Office of the President
Marty Boryszak, President of MHB
Re: 2024 Mercy Hospital of Buffalo, Hospital Staffing Plan
Mercy Hospital of Buffalo

To whom it may concern:

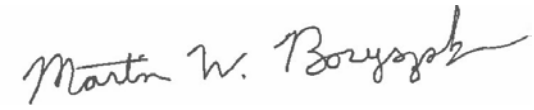
Mercy Hospital of Buffalo (MHB) began a Clinical Staffing Committee (CSC) in January of 2022 in response to the newly signed New York Safe Staffing for Quality Care Act. The majority of the committee is comprised of direct care associates in our bargaining committee Communication Workers of America (CWA) and the hospitals leadership team. This committee has worked closely together to review the staffing plan for the hospital, taking into consideration the many factors that impact patient care including acuity, geography, finances, retention and recruitment, resources and practice patterns. As the Mercy Ambulatory Care Center (MACC) is a campus of Mercy Hospital, this site has also been included in the CSC discussions and staffing plan adoption.

Since the formation of the committee, the MHB CSC group has met regularly on a monthly basis and has accomplished a great deal. In the beginning, the committee adopted a Charter to outline the committee purpose and scope. This charter was reviewed and updated in June and will continue to be reviewed and updated annually. The committee has spent time over the past year discussing recruitment, retention, quality, financial stewardship and hospital staffing plans at MHB and the MACC in accordance to the CWA CBA, Article 40 (see attached). With clinical unit staffing grids already in place, the MHB CSC was able to focus discussions on individual characteristics and challenges of each nursing unit, including but not limited to patient acuity, measures to maintain and ensure patient and associate safety and the impact on staffing plans for planned and unplanned absences of the workforce.

Staffing is evaluated continuously at the MACC and all efforts are made to recruit staff to fulfill our commitment to our staffing ratios as outlined in the CBA and our staffing grids. Variances from the plan are reviewed by the committee as per the regulations.

In June 2023, the committee endorsed the enclosed 2024 MHB Staffing Plan, including the plan for the MACC by consensus. We are submitting for your review and per your request. The MHB CSC is in position to meet regularly to continue to carry out the activities and deliverables outlined in the New York Safe Staffing for Quality Care Act.

Sincerely,



Martin Boryszak
SVP of Acute Care, Catholic Health &
President, Mercy Hospital of Buffalo

Article 40
Staffing/Clinical Staffing Committee

Section 1. The Employers/Hospitals agree to staff all nursing units/departments with RN/LPN/ancillary staff using patient ratios. The Union and the Employers agree that increasing current staffing levels to the agreed upon ratios will require time to implement. Therefore, the parties agree to the following implementation schedule:

a. 25% of staffing ratio by April 1, 2022;

b. 50% of staffing ratio by July 1, 2022;

c. 75% of staffing ratio by October 1, 2022; and

d. 100% of staffing ratio by January 1, 2023.

Immediately upon ratification of this Agreement, the Employers/Hospitals will aggressively recruit to fill the FTEs required to meet the staffing ratios as outlined in Sections 9-11 at a minimum rate of five percent (5%) per month.

Section 2. A Clinical Staffing Committee (CSC) will be formed at each of the three (3) acute care hospitals, for the purpose of implementing the ratios outlined in Sections 9-11 below as well as complying with the responsibilities outlined in New York State Legislation SO1168-A/S6346.

a. At least one-half (1/2) of the members of the committee shall be Registered Nurses, Licensed Practical Nurses, and ancillary staff members of the front-line team currently providing or supporting direct care and up to one-half (1/2) of the members will be hospital administration, which will include but not be limited to the President, Chief Financial Officer or designee, the Vice President of Patient Care Services and department/unit managers or directors.

b. The Union will select the employees in the job titles and number it desires, as its representatives. The selected employees must represent a range of departments/units.

c. Where possible, participation in the CSC by employees will be on scheduled work time and such employees will be compensated at their current rate of pay, including any applicable differentials. Where participation cannot be on scheduled work time, employees will be compensated for their time at the meeting. It is understood that the employees' departments/units shall not be short-staffed due to participation.

d. If CSC meetings are scheduled on an employee's work time, the employee/CSC member will be fully relieved of all other work duties during meetings of the committee and shall not have work duties displaced to other times as a result of their committee responsibilities.

e. Members of the CSC will be appointed within two (2) weeks of ratification of this agreement.

f. CWA's designated Staffing Committee Directors will receive up to eighteen (18) eight (8) hour days per month of the Employers'/Hospitals' paid time for the purpose of coordinating the work of the CSC on behalf of the union for the first six (6) months the committee is functioning. The days will be distributed as follows:

- KMH Director 6 days per month;
- MHB Director 8 days per month;

- SJC Director 4 days per month.

Thereafter, the CSC will determine the amount of time needed based upon the workload of the committee. Employees will not be denied the excused absence time required for the purpose of performing work related to the CSC.

g. The CSC will meet within thirty (30) days of ratification of this agreement. The Committee's initial responsibilities will include but not be limited to:

- Assessment of all existing staffing grids/plans and the staffing ratios;
- A determination of the number of positions needed to meet the established ratios outlined in Sections 9-11;
- Development of ratios not currently defined in Sections 9-11;
- Implementation of the staffing ratios;
- Resolve issues related to the implementation of ratios;
- The development of a program to consistently cover lunches and breaks; and
- Development of initiatives to deal with AACN's Healthy Work Environment, Recruitment and Retention.

h. In addition to the responsibilities listed in g.) above, the CSC will also be responsible for the following functions on an annual basis:

- Development and oversight of implementation of an annual clinical staffing plan. The staffing plan will be based upon ratios as outlined in Sections 9-11. The staffing plan shall include specific staffing for each patient care unit and work shift and shall be based on the needs of patients. Staffing plans shall include specific guidelines, ratios, matrices or grids indicating how many patients will be assigned to each Registered Nurse and the number of nurses and ancillary staff to be present on each unit and shift and shall be used as the primary component of the hospital staffing budget.
- Factors to be considered and incorporated in the development/review of the plan shall include, but are not limited to:

  i. Census, including total number of patients on the units and activity, such as patient discharges, admissions and transfers;

  ii. Total number of beds for each unit and department, Average Daily Census (ADC), position control sheets based upon the total number of beds on the unit/department, the total number of FTEs needed to staff each unit/department based upon the ratios as outlined in Sections 9-11;

  iii. The appropriate time frames for measuring the ADC (including the frequency) as determined by the CSC;

  iv. Measures of acuity and intensity of all patients and nature of the care to be delivered on each unit and shift;

  v. Skill mix;

  vi. The availability, level of experience and specialty certification or training of nursing personnel providing patient care, including charge nurses on each unit and shift;

vii. The need for specialized or intensive equipment;

viii. The architecture and geography of the patient care unit, including but not limited to, placement of patient rooms, treatment areas, nursing stations, medication preparation areas and equipment;

ix. Mechanisms and procedures to provide for one-to-one patient observations, when needed, for patients on psychiatric or other units as appropriate;

x. Other special characteristics of the unit or community patient population, including age, cultural and linguistic diversity and needs, functional ability, communications skills and other relevant or socio-economic factors;

xi. Measures to increase worker and patient safety, which could include measures to improve patient through-put;

xii. Staffing guidelines adopted or published by other states or local jurisdictions, national nursing professional associations, specialty nursing organizations and other health professional organizations;

xiii. Availability of other personnel supporting nursing services on the unit;

xiv. Waiver of plan requirements in the case of unforeseeable emergency circumstances as defined in subdivision fourteen of this section;

xv. Coverage to enable Registered Nurses, Licensed Practical Nurses and ancillary staff to take meal and rest breaks, planned time off and unplanned absences that are reasonably foreseeable as required by law or the terms of an applicable collective bargaining agreement, if any, between the hospital and representative of the nursing ancillary staff;

xvi. The nursing quality indicators required under New York State Legislation SO1168-A/S6346;

xvii. Hospital finances and resources, and

xviii. Provisions for limited short-term adjustments made by appropriate hospital personnel overseeing patient care operations to the staffing levels required by the plan, necessary to account for unexpected changes in circumstances that are to be of limited duration.

- Semiannual review of the staffing plan against patient needs and known evidence based staffing information, including the nursing sensitive quality collected by the hospital.
- Review, assess and respond to complaints regarding potential violations of the adopted staffing plan, staffing variations, or other concerns regarding the implementation of the staffing plan within the purview of the committee.

Section 3. Effective upon ratification of this Agreement, Catholic Health commits to the following:

a. Extra time, overtime and staffing incentives will be utilized to entice employees to pick up additional time in order to bring the scheduled number of employees up to the ratio needed to meet the number of open beds or budgeted visits;

b. Through the current language in the collective bargaining agreements, down-staffing can be done on a shift basis to achieve the staffing needed to meet the number of filled beds;

c. Immediately begin recruiting employees to fill the current vacancies and to meet the schedule for hiring outlined in Section 1. above.

d. The Employers/Hospitals will fill all vacant positions in the units/departments covered by this Article. The Employers/Hospitals will also increase the core staffing on each unit/department to meet the agreed upon ratio for that unit/department.

e. In addition to the process in a. above, the Employers/Hospitals commits to increasing its staffing resources to ten percent (10%) above the average daily census, as determined by the CSC. These increased staffing resources will be applicable to medical/surgical, Emergency Department, critical care areas, and will include ancillary staff (nurses' aides, ITAs) at Kenmore Mercy Hospital and Mercy Hospital of Buffalo. The increased staffing pool will not apply to perioperative services.

f. The staffing resources currently in place at Sisters of Charity Hospital-St. Joseph Campus will remain in place. Any change in staffing resources at SJC will be determined by the CSC.

g. The CSC will assess budgeted census based upon a monthly look back that consists of a 90-day rolling average and adjust both core staffing and any increased staffing resources based on the rolling average daily census (e.g. On March 1st, the CSC will assess average daily census for December, January and February and make adjustments to staffing grids if necessary). It is agreed that the ratios included in Sections 9-11 will be maintained.

h. If a Hospital falls below its established staffing level based on actual census in any quarter, the Hospital will pay employees picking up extra shifts in the following quarter an additional four dollars ($4.00) per hour for Registered Nurses and three dollars ($3.00) per hour for all other employees, over what they would normally be paid under Article 42, Staffing Incentives.

i. The potential mechanisms and sources for the increased staffing resources would be additional float premium pay (see Section 5 below), additions to an existing float pool, additional flex positions (FT/PT) where applicable, and the establishment of float pools for the service and other areas where float pools do not currently exist. The CSC will explore and exchange ideas on other means to achieve the increased staffing resources.

j. Float pool positions will not impact or reduce the staffing plans/grids developed from the ratios outlined in Sections 9-11.

k. Float pool personnel will be utilized to cover sitter assignments on the nursing units. Core staff may be temporarily utilized to accommodate a patient change in status until float pool relief is provided. Staff will not be assigned to sit in 1:1 situations from the ratios outlined in Sections 9-11.

l. Any employee in the nursing float pool will receive a $2/hour premium for all hours worked.

Section 4. Definitions:

a. "RN" shall mean a registered professional nurse licensed pursuant to article one hundred thirty-nine of the education law.

b. "LPN" shall mean a licensed practical nurse pursuant to article one hundred and thirty-nine of the education law.

c. "Nursing Care" shall mean that care which is within the definition of the practice of nursing, pursuant to section six thousand, nine hundred and two of the education law, or otherwise encompassed with the recognized standards of nursing practice, including assessment, nursing diagnosis, planning, intervention evaluation and patient advocacy.

d. "AS"/Ancillary Staff shall include any employee who is not a nurse or other persons licensed, certified or registered under title eight of the education law whose principal responsibility it is to carry out patient care for one or more patients or provides direct assistance in the delivery of patient care (e.g.: ITA, CNA, NA).

Section 5. The Employers/Hospitals agree to schedule to the staffing ratios outlined in Sections 9-11. Only RN/LPN/AS staff providing direct patient care shall be included in the ratios. There shall be no averaging of the number of patients and the total number of RN/LPN/AS on the unit.

Section 6. Nurse administrators, nurse supervisors, nurse managers, charge nurses and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when the licensed nurses are engaged in providing direct patient care. When a nurse administrator, nurse supervisor, nurse manager, charge nurse or other licensed nurse engage in activities other than direct patient care, that nurse shall not be included in the ratios.

Section 7. Nothing in this Article shall prohibit RN/LPN/AS from assisting with the specific tasks within the scope of his or her practice for a patient assigned to another RN/LPN/AS. "Assist" means that an RN/LPN/AS may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited.

Section 8. The Employers will use an acuity system to assess patient acuity levels, nursing care requirements and to improve patient acuity balancing across assignments.

Acuity Tool:

a. A sub-committee of the CSC will be formed for the purpose of reviewing the Acuity Tools. A subject matter expert will provide a detailed presentation to the CSC. Union representatives will be included in this sub-committee.

b. It is agreed to and understood by the parties that once an acuity tool is implemented, it will be utilized along with the ratios as outlined in Sections 9-11 to provide adequate staffing and appropriate assignments throughout the hospitals.

c. The CSC will put the implementation of the acuity tool on the meeting agenda as a standing item and reports will be received monthly.

Section 9. Staffing Ratios for Mercy Hospital of Buffalo

a. Emergency Department

	Charge Nurse	1
	RN	1:4 or 1:1 / 1:2 if critical patient
	Lead RN	1 (11a-11p)
	Triage RN	2
	Triage ITA	1
	AS	1:5
	PIT RN	1 (7a), 2 (9a), 3 (11a) [cumulative]
	PIT AS	1 (7a)
	Internal/External RN	1 (7a), 2 (11a) [cumulative]
	Internal/External AS	1 (11a)
	Clerical	1.5
	Respiratory	1 [in addition to 2Care if open]
b.	ICU	
	Charge	1
	RN	1:1 or 1:2
	AS	1:5
	Clerical	1 (7:30a – 7:30p)
	Respiratory	2
c.	CVICU	
	Charge	1
	RN	1:1 or 1:2
	AS	2
d.	Neuro (7E)	
	Charge	1
	RN	1:4
	AS	1:6
	Clerical	1 (9a-9p)
e.	Step Down (8E, 7W)	
	Charge	1
	RN	1:3
	AS	1:6
	Clerical	1 (9a-9p)
f.	Medical/Surgical Telemetry - High acuity (4N)	
	Charge	Night charge takes an assignment
	RN	Days 1:4 / Nights 1:4
	AS	Days 1:6 / Nights 1:6
g.	Medical/Surgical (telemetry capable) (2 Care, 5E, 5W, 5N, 5C, 6E, 6W, 6S)	
	Charge	1
	RN	Days 1:4 / Nights 1:5
	AS	Days 1:8/ Nights 1:6
	Clerical	1
h.	NICU	
	Charge RN	1 (may have a modified assignment)

	RN 1	2-3 newborns (requiring intermediate care)
	RN 1	1-2 Newborns (requiring intensive care)
	AS	shared with Mother Baby
i.	Labor & Delivery	
	Charge RN	1 (may have a modified assignment)
	RN - First Stage of Labor	1:2
	RN - Second & Third Stage of Labor	1:1 *
	Transition/Del RN	1:1 *
	*(1 RN can care for both Mother and the baby when both mother and baby are stable)	
	Surg Tech	1 per unit
	Clerical	1 per unit
j.	Mother Baby Unit/Post-Partum	
	Charge RN	1 (may have a modified assignment)
	RN	1:3 couplets
	Lactation Consultant	1:15
	Clerical	1 per unit
	AS shared with NICU	1 per 15 mothers.
k.	Operating Room	
	Charge RN	1
	RN	1:1
	Service Line Leaders	4
	Surgical Technologist	1:1
	Periop Attend (will be a surg tech)	1
	Anesthesia Technicians	3
	Center Hall Lead Tech	1
	Clerical	1 (6a-6p Mon-Sat)
	EVS	3 (Days)
l.	PACU	
	Charge RN	1
	RN – Adult	1:2 or 1:3 if holding
	RN – Pediatric	1:1
	Critical Care	1:1
	AS	1 (12 hours, Mon-Fri)
m.	Ambulatory Surgical Unit	
	Charge RN	1
	Pre-Procedure RN	1:1 until patient prepped
	Post-Procedure RN	1:3
	AS	1 – 2 on unit based on volume
	Clerical	1
n.	GI Lab	
	Charge RN	1
	RN Pre-Procedure	1:3
	RN Procedure	1:1 (2:1 if moderate sedation)
	RN Advanced Procedure	3:1

	RN Recovery	1:2
	NA / Endoscopy Tech	1
	Clerical	1
o.	Dialysis	
	RN	1:2
p.	Mercy Cath / IR	
	RN (responsible for conscious sedation if given)	1:1
	Radiologic Technologist	1:1
	Circulator (RN or Radiologic Technologist, only if conscious sedation is given)	1:1
q.	SNF/OLV	
	RN (RCC)	1-3
	LPN	1/unit
	AS	12/days, 10/eves, 4/nights
	Clerical	2 (Mon-Fri)
	Rehab Aide	2 (Mon-Fri)
r.	Mercy Interventional Unit	
	Charge RN	1
	RN Immediately post	1:3 for post anesthesia; 1:1 for first 30 min
	RN Overnight non critical	1:4
	RN Overnight critical	1:2
	AS	1
s.	Stress Lab	
	RN	1
	Echo Tech	1
t.	Mercy Ambulatory Care Center	
	Charge Nurse	1 with modified assignment
	Triage	1
	RN	1:4
	AS	2 (7a-11a), 3 (11a-3p), 2 (3p-11p), 1 (11p-7a) [Mon-Fri; cumulative] 1 (7a-11a), 2 (11a-3p), 2 (3p-11p), 1 (11p-7a) [Sat-Sun; cumulative]
	Fast Track/Internal Waiting RN	1 (10a-10p)
Section 10.	Staffing Ratios for Kenmore Mercy Hospital	
a.	Emergency Department	
	Charge Nurse	1
	RN	1:4 or 1:1 / 1:2 if critical patient
	Triage	1
	AS	3 days / 3 eves / 2 nights

	Fast Track RN	1:8
	Resource RN	1 [assignment]
	Clerical	1
b.	ICU	
	Charge	1
	RN	1:1 or 1:2
	AS	1:5
c.	Telemetry (3 East)	
	Charge	1
	RN	Days 1:4 / Nights 1:5
	AS	Days 1:8 / Nights 1:6
	Unit clerk/monitor tech	1 [on dedicated Telemetry Unit]
d.	Medical/Surgical (2 West, 2 East)	
	Charge	1
	RN	Days 1:5 / Nights 1:5
	AS	Days 1:5 / Nights 1:6
	Clerical	1 (7a-7p)
e.	Post-Surgical Orthopedic (2 South)	
	Charge	1
	RN	Days 1:4 / Nights 1:5
	AS	Days 1:8 / Nights 1:6
	Clerical	1 (7a-11p)
f.	Operating Rooms	
	Charge RN	1
	RN	1:1
	Surgical Technologist	1:1 non ortho / or 2:1 ortho holder
	Center Hall assignment	1
	Anesthesia Tech	1
	AS	2
	Clerical	1
	EVS	2
g.	PACU	
	Charge RN	1:2
	RN – Adult	1:1 or 1:2
	RN – Pediatric	1:1
	Critical Care	1:1
	AS	1 and 2 at peak
h.	Ambulatory Surgery Unit	
	Charge RN	1
	RN	1:4
	AS	1 and 2 at peak
	Clerical	1 (10a-6p)
i.	GI Lab	

	Charge RN	1 + assignment
	RN Pre-Procedure	1:3
	RN Procedure	2:1
	RN Post-Procedure	1:2
	Scope tech	1
j.	MRU	
	Charge	1
	RN	Days 1:5 / Nights 1:6
	AS	Days 1:6 / Nights 1:6
	Clerical	1 (7a-3p Mon-Fri)
k.	Interventional Radiology	
	RN	1
	RN Conscious Sedation	2:1
	Radiologic Technologist	1:1
l.	Stress Lab	
	RN	1
	Echo Tech	1
m.	Pre-Surgical Testing	
	RN	1:1
n.	Dialysis	
	RN	1:2

Section 11. Staffing Ratios for Sisters of Charity Hospital-St. Joseph Campus

a.	Emergency Department	
	Charge Nurse	1
	RN	1:4 or 1:1 / 1:2 if critical patient
	Triage	1
	AS	1:5
	Fast Track RN 6 Pts	2
	Fast Track NA 6 Pts	1
	Clerical	1
b.	Surgical – Hall 4	
	Charge RN	1 with assignment
	RN	1:4

*as volume increases, AS staffing will be reviewed by the CSC.

c.	Operating Rooms	
	Charge RN	1
	RN	1:1
	Surgical Technologist	1:1 or 2:1
	Anesthesia Assistant	1
	AS	1
	EVS	3 (all of Periop)

d.	PACU	
	Charge RN	1:2
	RN – Adult	1:2 (Phase I patients)
	RN – Pediatric	1:1
	Critical Care	1:1
	AS	1
e.	Ambulatory Surgery Unit	
	Charge RN	1
	RN	1:4
	AS	2
	Clerical	1
f.	GI Lab	
	Charge RN	1
	RN Pre-Procedure	1:3
	RN Procedure	2:1
	RN Advanced Procedure	3:1
	RN Recovery	1:2
	NA / Endoscopy Tech	2
	Clerical	0.5 (days)

Section 12. The parties agree that if during the life of this agreement the patient population changes on any unit noted in Sections 9-11 above, the CSC will evaluate and review any impact regarding the ratios above.

Section 13. In the event that the ratios for all job titles on a unit falls below the established ratio levels on a given shift, the Employer will re-establish the agreed upon number of nurses through methods including utilization of float pool nurses, floating existing staff under current contractual provisions, overtime, per diems and traveler/agency nurses. If the recruiting method is not successful, the employee may complete a Protest of Assignment form.

Section 14. CWA and Catholic Health believe that creating a healthy work environment (HWE), which enables nurses and other healthcare workers to provide the highest standards of compassionate patient care, is essential. It is also critical that employees be respected while they are at work. A healthy work environment leads to better nurse staffing and retention, less moral distress and lower rates of workplace violence.

There are six (6) standards that are fundamental to a healthy work environment:

1. Skilled Communication: Skilled communication can save lives. Promoting open and effective conversation among team members optimizes patient outcomes and encourages essential collaboration. It also helps newer nurses get up to speed more quickly. Among units implementing the six (6) HWE standards, 89% of nurse survey respondents claim RNs are as proficient in communication skills as they are in clinical skills.

2. True Collaboration: A team that works together succeeds together. Collaboration among nurses and staff ensures more efficient, effective patient care and a more supportive environment where team members can develop in their practice. It's no surprise that 92% of survey respondents who work in units implementing the six HWE standards report high rates of collaboration among nurses.

3. Effective Decision Making: Improving patient care starts with empowering the people who care for those patients. When nurses have a seat at the table alongside other healthcare professionals and organization leaders, we have an opportunity to design protocols that benefit both team members and patients. Optimal outcomes and greater job satisfaction are more likely when nurses actively influence decisions that impact the quality of patient care.

4. Appropriate Staffing: Appropriate staffing is clearly linked to the health of the work environment. It affects everything in your unit, including nurse performance and retention, quality of care, patient outcomes and hospital costs. It's time for a new staffing model that meets the needs of patients, families and the nurses who care for them. These HWE critical elements and evidence-based resources can help the nurses in their journey to appropriate staffing, better patient outcomes, and a healthy work environment

5. Meaningful Recognition: A healthy work environment starts with recognizing team members for the value they bring to the organization. Although nursing is one of the most rewarding professions, it can also be among the most challenging. Having systems in place to recognize nurses in a way that is individualized, and meaningful can help provide a well-deserved honor and enhance a sense of value, leading to greater nurse fulfillment

6. Authentic Leadership: A good leader sets the tone for the unit. AACN's research shows that healthy work environments are much more likely to have nurse leaders who fully embarrass the six HWE standards, creating a culture of compassionate care for team members and patients. Authentic leadership also equips nurses with the skills and encouragement they need to grow their practice. The result is a more knowledgeable, cohesive unit that consistently elevates patient care.

CWA and Catholic Health agree to the following steps to create and foster a HWE for employees:

1. Hire a subject matter expert whose job it would be to implement and see this project to completion.

2. Perform an assessment of current environments and culture utilizing the AACN HWE assessment tool.

3. Review assessment results with team members.

4. Provide education and professional development on HWE standards, utilizing AACN resources.

*From the American Association of Critical-Care Nurses (2005). AACN standards for establishing and sustaining healthy work environments: A journey to excellence. Available at: aacn.org

MACC ED staffing plan		
CN	1	
Triage RN	1	
RN	1:4	
ITA	1:5	
Fast Track/Internal	1 RN	10a-10p

Staffing Plan

Time	# RN	# ITA M-F
7a	3	2
9a	1	
10a	1	
11a	NA	1
12p	2	
3p	2	
7p	3	1

ITA Sa-Su
1
1
1
