

In the  
**Supreme Court of Ohio**

DIALYSIS CLINIC, INC.,

Appellant,

v.

RICHARD A. LEVIN,  
TAX COMMISSIONER OF OHIO,

Appellee.

: Case No. 2009-2310  
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: On Appeal from the  
: Ohio Board of Tax Appeals,  
: Case No. 2006-V-2389  
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**APPELLEE'S MEMORANDUM IN OPPOSITION TO  
APPELLANT'S MOTION FOR RECONSIDERATION**

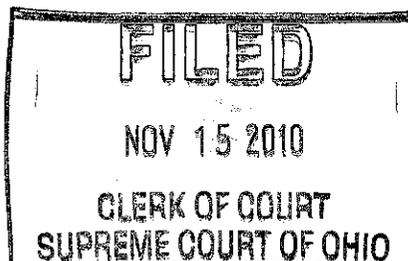
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## MEMORANDUM IN OPPOSITION

### A. Introduction

In its merit decision dated October 26, 2010, *Dialysis Clinic, Inc. v. Levin*, Slip Opinion No. 2010-Ohio-5071 (“*Dialysis*”), this Court reasonably and lawfully affirmed the Board of Tax Appeals (“BTA”) decision and order below, *Dialysis Clinic, Inc. v. Levin* (Nov. 24, 2009), BTA No. 2006-V-2389 (“*BTA Decision and Order*”). In a 4-3 decision authored by Justice Lanzinger, a majority of the Court agreed with the BTA and the Commissioner that the appellant, Dialysis Clinic, Inc. (“DCI”) failed to meet its affirmative burden of proof of showing by “clear and convincing evidence” that its West Chester dialysis clinic qualified for real property tax exemption. Specifically, the Court affirmed the BTA’s findings that DCI: (1) was not a “charitable institution” within the meaning of R.C. 5709.121, and (2) did not use its West Chester facility “exclusively for charitable purposes” within the meaning of R.C. 5709.12(B). Thus, the Court held that the West Chester facility did not qualify for “charitable” real property tax exemption under either R.C. 5709.12 or R.C. 5709.121. *Dialysis* at ¶¶ 1-2.

### B. DCI’s motion for reconsideration is based solely on a mischaracterization of this Court’s merit decision and identifies no factual or legal analysis or argument that the Court failed to consider in that decision.

DCI’s motion for reconsideration and memorandum in support offer no factual or legal analysis that this Court failed to consider in its merit decision. Instead, DCI seeks reconsideration solely on the basis of two asserted faults in the Court’s rationale. First, DCI claims that the Court’s majority effectively “put blinders on” in denying the exemption, by allegedly relying only on DCI’s express indigency policy (under which DCI expressly states that its provision of treatment to its patients is not “charity” and that it “reserves the right to refuse and admit a patient who has no ability to pay”). *Dialysis* at ¶ 11. Second, DCI claims (without any supporting facts or analysis) that, if the Court’s majority had looked beyond DCI’s indigency

policy to examine DCI's actual activities, the nature of DCI's activities as "charitable" would have been clear.

DCI's criticisms of the majority's merit decision are entirely unwarranted. The Court's merit decision sets forth a detailed and comprehensive factual discussion of DCI's actual activities. DCI overlooks the Court's detailed "Fact" section, ¶¶ 1-15; and the BTA's cogent factual findings and analysis upon which the Court's Fact section is based, *BTA Decision and Order*. DCI's "anti-charity" indigency policy is only one of many strands in a comprehensive web of evidence in support of the BTA's ultimate factual findings adopted by the Court.

The Court's ultimate factual findings were that DCI's "core activities" were not "charitable" and that, accordingly, DCI was not a "charitable institution"; and, since nothing about the operation of the clinic in West Chester differs from the core activities of DCI, the property itself was not used for a charitable purpose. See ¶ 46 (holding that "the record contains sufficient support for the BTA's ultimate findings[]") and ¶ 36 (identifying the BTA's ultimate findings to be that: (1) "DCI has not proven that it qualified as a charitable institution under R.C. 5709.121" and (2) "DCI does not qualify for exemption under R.C. 5709.12(B) as an institution that uses the property exclusively for charitable purposes[]," quoting *BTA Decision and Order* at 12); see also ¶ 1-2, cited supra.

Far from failing to consider and evaluate DCI's "actual" activities, this Court's merit decision devotes several Sections of its "Analysis" to that very topic. The Court first noted that an institution's "core activities" must be charitable in order for the institution to qualify as a "charitable institution" within the meaning of R.C. 5709.121. See particularly, ¶¶ 27-30, captioned "B. An institution is 'charitable' under R.C. 5709.121 only if its **core activities** qualify as charity under the standards for determining the charitable use of property pursuant to R.C.

5709.12(B) (emphasis added).” Next, the Court held that, in order for specific property of an institution to qualify as “exclusively charitable” within the meaning of R.C. 5709.12, the “core activities” conducted on the premises must be charitable. See ¶¶ 36-37, captioned “D. The operation of the West Chester facility does not qualify as an exclusively charitable use of property under R.C. 5709.12(B).”

DCI’s motion does nothing more than constitute a “reargument” of the case, for it presents no argument, or factual or legal analysis, that this Court’s decision failed to consider. Thus, DCI’s motion for reconsideration fails to meet the requirements of this Court’s Rules of Practice. See S.Ct.Prac.R. 11.2(B), which provides that the motion must not “constitute a reargument of the case.” Even without the Commissioner showing that DCI’s bare assertions about its “actual” activities are erroneous, the Court should properly deny DCI’s motion for reconsideration.

Further, an affirmative review of the actual facts as adduced in the evidentiary record and as found by the BTA and this Court easily refutes DCI’s bare assertions concerning its “actual” activities. As noted, the Court’s merit decision emphasized that an essential element of any “charitable institution” is the requirement that the institution must have “provided its service ‘**on a nonprofit basis to those in need, without regard to race, creed, or ability to pay** [ ]’” (emphasis added), ¶ 30 (quoting *Church of God*). As we set forth in the following Section C, those facts fully support this Court’s holding that DCI did *not* qualify as a “charitable institution” because DCI failed to meet this essential requirement.

C. **DCI failed to meet its affirmative burden of establishing an essential element for qualifying as a “charitable institution” -- that its service must be “provided on a non-profit basis to those in need without regard to \*\*\* ability to pay.”**

1. **The evidentiary record fully supports this Court’s affirmance of the BTA’s factual findings that DCI operated its business on a “for profit” model identical to its for-profit corporation competitors and thereby generated substantial profits.**

The BTA’s detailed factual analysis of the “for-profit” nature of DCI’s business operations concluded with the powerful statement that DCI operates identically to its competitors that are organized as “for-profit” corporations, except to the extent of its use of certain “excess revenues” for alleged donations to research, as follows:

The **only** distinction we can find between DCI’s clinics and **for-profit** dialysis clinics [i.e., those of DCI’s competitors organized as for-profit corporations] is the manner in which a portion of the excess revenue is used. From the limited record, it appears that the owner’s intent is to raise funds from its clinic operations to apply in part toward further clinic development and alleged research.

(Emphasis added.) *BTA Decision and Order* at 13.

The business model adopted by DCI made such substantial profits virtually inevitable, because DCI charged far more than cost for those patients who do not have health insurance and therefore do not have the government or private insurance companies to negotiate on their behalf, while receiving profitable reimbursement from insurers for the costs of those with private health insurance. When patients walked in the doors of DCI’s clinics without any governmental (i.e., Medicare and/or Medicaid) or private insurance coverage, they were charged the maximum rate of **\$800** per visit. Supp. 193-194; Tr. 185-187. The maximum charge of \$800 is referred to as the “commercial rate charge.” Supp. 194; Tr. 186. By contrast, those patients with private health insurance were typically billed between **\$175 to \$475**, depending on the rate negotiated by the insurer. Supp. 193-194; Tr. 185-186. When true bargaining took place, DCI ended up charging a lot less for its services. In this most revealing of ways, DCI charged “what the market

would bear” -- the same as its competitors organized as “for profit” corporations. See also the Commissioner’s merit brief (“TC.Br.”) at 13-15.

As to those patients that DCI treated who were covered by Medicare and Medicaid, the evidentiary record is devoid of any probative evidence of whether or not DCI derived a profit from providing dialysis treatments. Instead, the record reflects merely that the charge for the treatment was slightly less than the range charged by DCI to private insurers. See Supp. 188, 193; Tr. 165, 184 (testimony that the Medicare-fee schedule for patients covered by Medicare was \$160/visit and the Medicaid-fee schedule for patients covered only Medicaid was \$155/visit); and *BTA Decision and Order* at 8, n. 5.

Consistent with the “for-profit” operation of DCI’s business, the Court expressly adopted the BTA’s finding that DCI generates profits in operating its business. The Court quantified the substantial profits that DCI generated from its operation of the dialysis business for the taxable periods at issue, in the “Fact” section of its merit decision, as follows: “DCI’s federal tax filings showed an excess of revenues over expenses of \$6,306,492 in 2003 and \$32,167,517 in 2004.” *Dialysis* at ¶ 5. The reason for such profit generation may be reasonably inferred from the record: DCI charged its patients without health care far above the costs of the service, and charged those with health insurance (either private or governmental) at a level that generated profits.

And more to the point, DCI failed to meet its affirmative burden of proof adducing a “clear and convincing” evidentiary record affirmatively demonstrating that it operated in a non-profit, charitable manner. See, e.g., *Youngstown Metropolitan Housing Authority v. Evatt* (1944), 143 Ohio St. 268, 273 (holding that “he who seeks exemption of property from taxation must show by clear and convincing proof his right thereto. In all doubtful cases exemption is denied[.]”); and

*Anderson/Maltbie Partnership v. Levin*, Slip Opinion No. 2010-Ohio-4904, quoting *Youngstown Metropolitan* with approval.

As noted, DCI's motion for reconsideration completely ignores the "for profit" nature of DCI's business. DCI then compounds that failure by likewise omitting any discussion of this Court's merit decision's rejection of the two ways that DCI attempted to end-run the "for profit" nature of its business operations.

**2. Neither DCI's filing as a §501(c)(3) non-profit organization for federal income tax purposes nor its donations to others for research change the for-profit operation of DCI's business to a non-profit, charitable one for real property purposes.**

In its merit briefing, DCI made no attempt to directly dispute the "for-profit" nature of its business operations. Instead, DCI relied on its filing status as a §501(c)(3) under the Internal Revenue Code, 26 U.S.C. 501(c)(3), and its donations to others for kidney dialysis research. The Court strongly rejected both of these attempts. First, in following its previous established precedent, the Court held that §501(c)(3) filing status cannot be a substitute for non-profit, charitable activities. *Dialysis* at ¶¶ 19-21 (citations omitted). Second, the Court rejected the notion that DCI's donation of a portion of its substantial profits ("surplus revenues") to other organizations for "research" somehow entitled DCI to a "vicarious" charitable exemption. *Id.* at ¶ 33 (citations omitted).

In its motion for reconsideration, DCI makes no attempt to dispute either of the foregoing holdings. Instead, it follows the now familiar path of ignoring them. In other words, DCI's motion for reconsideration tacitly has abandoned the very grounds it asserted in its merit briefing for claiming that its activities are "non-profit" that it asserted in its merit brief, but fails to provide any other grounds to replace them. Nor does DCI provide any legal or factual analysis for establishing another key aspect defining "charitable" activities -- that the services provided

must be made to those in need “without regard to \*\*\* the ability to pay.” *Dialysis* at ¶ 30 (citations omitted).

**3. DCI’s actual activities showed it failed to provide its services “to patients in need without regard to \*\*\* ability to pay.”**

DCI ignores this Court’s adoption of the BTA’s finding that “DCI charged all patients at the West Chester site -- and most patients at its other facilities -- for the services it provides.” *Id.* at ¶ 32. Thus, DCI admitted that it provided no free or reduced-fee care to any patients -- whether indigent or not -- at the West Chester facility at issue here. Further, at an institutional level, DCI failed to probatively establish the extent, if any, to which it provided free or reduced-fee care to indigent patients.

Instead, as this Court’s and the BTA’s factual analysis emphasized, DCI actively pursued collection of its medical bills, foregoing none of its billings for dialysis treatment as bad debt write-offs for any patients at its West Chester clinic, and writing off only 1.27% of its billing charges nationally as bad debt *Dialysis* at ¶¶ 6,7, 14 (noting DCI’s admission that it “stated that it did provide ‘charity care’ for persons who are ineligible for or waiting to qualify for Medicare or Medicaid, but it did not quantify such aid”); and ¶ 10 (finding that “there had never been any such free or reduced-fee patients at the West Chester facility”). The absence of any such West Chester clinic patients is explained in large part by where DCI chose to locate the clinic: in a “middle class to higher than middle class” area of greater Cincinnati. *Supp.* 185; *Tr.* 153. Further, the West Chester clinic does not advertise the availability of its services to citizens in the greater Cincinnati area that may be in need of dialysis treatment. *Supp.* 182; *Tr.* 140. In other words, from a demographic and advertising standpoint, DCI chose to provide care in a geographic area uniquely unsuited for providing indigent patient care.

As the BTA expressly found: “[b]ased on a review of the record, we find no evidence quantifying any meaningful act of DCI “giving” anything to patients.” *BTA Decision and Order* at 15. It necessarily follows from this uncontroverted fact that DCI’s West Chester clinic did not administer to any indigent patients and, thus, failed to meet this Court’s established requirements. See *Dialysis* ¶ 42 (holding that “an institution must not take on so many paying patients that it cannot accommodate a ‘usual and ordinary number of indigent patients applying for admission[],’” quoting *O’Brien v. Physician’s Hosp. Assn.* (1917), 96 Ohio St. 1, paragraph six of the syllabus).

**4. The mere fact that DCI provided services to Medicaid and Medicare patients does not satisfy its burden of providing services to “patients in need without regard to \*\*\* ability to pay.”**

DCI argues that the Court found that DCI’s provision of care to Medicaid and Medicare patients constitutes a *per se* charitable activity and, therefore, that the Court contradicts its conclusion that DCI failed to satisfy its burden of establishing entitlement to exemption. But the Court made no such finding. In fact, the Court expressly concluded that “[t]he General Assembly, rather than the courts, must determine whether Medicare providers should enjoy a property-tax exemption, and if so, the scope of such an exemption.” *Dialysis* at ¶ 35. This is particularly true in the case of dialysis clinics, which receive Medicare reimbursement for all patients who satisfy the eligibility requirements and apply for it, regardless of financial status.

In discussing Medicare and Medicaid reimbursement, the Court clearly was referring only to that segment of the Medicare and Medicaid population that qualified as indigent. “In the age of Medicare and Medicaid, **the usual and ordinary indigent patient** may have access to government benefits, and the modern healthcare provider is not required to forego the pursuit of

those benefits to qualify for charitable status.” (Emphasis added.) *Dialysis* at ¶ 42.<sup>1</sup> Moreover the Court further qualified its characterization of care to Medicaid and Medicare indigent patients as only meeting the charitable test “to some extent” noting that, “a person at the West Chester facility who lacks financial means to pay is usually entitled to benefits under Medicare or Medicaid or both. DCI’s decision to serve these patients **to some extent** qualifies as the provision of care to persons who otherwise lack the means to afford it.” (Emphasis added.) *Dialysis* at ¶ 38.

And even if healthcare to indigent Medicare and Medicaid patients constitutes charitable care “to some extent,” DCI never, by probative evidence, demonstrated any actual quantifiable care to this patient population.<sup>2</sup> Coupled with the fact that DCI “charged all patients,” *Dialysis* at ¶ 32; that DCI’s policy “explicitly reserved the right to refuse to treat indigent patients,” *Dialysis* at ¶ 34; and that the West Chester facility was located in a neighborhood of middle to upper-middle class families that made service to indigent Medicare and Medicaid patients less likely, the Court correctly affirmed the BTA.

#### **D. Conclusion**

DCI’s motion for reconsideration presents no arguments within the scope of S.Ct.Prac. R. 11.2(B). Instead of presenting the Court with legal and factual analysis that the Court failed to

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<sup>1</sup> For example, Medicaid coverage has been extended to the working poor. The *USA Today* in an August 1, 2005 article entitled “Medicaid insures historic numbers,” stated that “[t]oday, a family of four can earn as much as \$40,000 a year in most states and get government health insurance for children. The nation’s median household income was \$43,318 in 2003, the Census Bureau says.” Appx. 1-2. The website, [www.workingpoorfamilies.org](http://www.workingpoorfamilies.org), contains data for Ohio’s working poor for 2007. A low-income family is one that has family income below two hundred percent (200%) of the poverty level. For 2007, the poverty threshold was \$20,951 for a family of four. 27.2% of Ohio families were classified as low-income working families for 2007. See [www.workingfamilies.org/states/popups.ohio.html](http://www.workingfamilies.org/states/popups.ohio.html), Appx. 3.

<sup>2</sup> As the BTA noted, the only patients DCI attempted to quantify as indigent was a handful of patients for which it received **no** reimbursement, *BTA Decision and Order* at 16.

consider in its merit decision, DCI mischaracterizes the Court's holdings and rationale. Even if the Court considers the Appellant's restatement of its previous arguments, the Court previously rejected them in its October 26, 2010 merit decision in this matter. Thus, the Court should deny the motion for reconsideration.

Respectfully Submitted,

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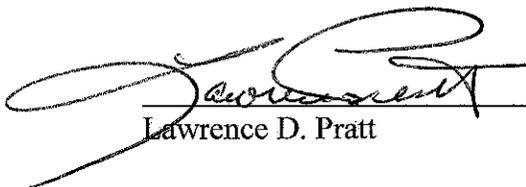
## CERTIFICATE OF SERVICE

I certify that a copy of the Memorandum Opposing Motion for Reconsideration of Appellee Richard A. Levin, Tax Commissioner of Ohio, was served by U.S. mail this 15<sup>th</sup> day of November 2010, upon the following counsel:

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I also sent courtesy copies to counsel of record for all known amici curiae on this 15<sup>th</sup> day of November, 2010.



Lawrence D. Pratt



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## Medicaid insures historic number

By Dennis Cauchon, USA TODAY

The nation has so vastly extended taxpayer-funded Medicaid to the working poor this decade that it has produced the biggest expansion of a government entitlement since the Great Society was launched in the 1960s, a USA TODAY analysis has found.

With little notice, the medical care program paid by federal and state taxpayers has grown from covering 34 million people in 1999 to 47 million in 2004, an examination of government data shows. (Related story: [Living with 'The Card'](#))

The expansion has cemented government's role as the nation's primary health insurer. About 100 million people — 1 in 3 — now have government coverage through Medicaid, Medicare, the military and federal employee health plans. More than 10 million others are eligible for Medicaid but have not signed up.

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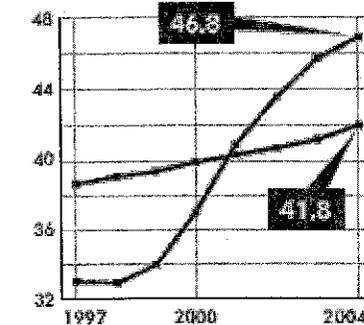
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### Medicaid grows faster than Medicare

■ Medicaid    ■ Medicare

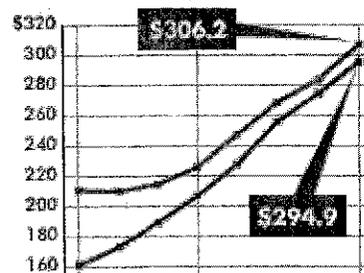
**ENROLLMENT (in millions)**



The expansion has won bipartisan support in Washington and state capitals, as a consensus has emerged to provide medical care for the poor, especially children. President Bush has proposed spending \$1 billion over two years to encourage eligible families to sign up for Medicaid.

Medicaid's growth has continued despite debates about spiraling costs and controversial efforts in Tennessee and Missouri to scale it back. The growth is an aftershock of welfare reform, which since 1997 has pushed individuals off welfare and into the workforce. To support low-wage workers, Congress and state legislatures expanded coverage to low-income working families. Medicaid previously had gone primarily to welfare recipients.

**SPENDING (billions of dollars)**



Today, a family of four can earn as much as \$40,000 a year in most states and get government health insurance for children. The nation's median household income was \$43,318 in

2003, the Census Bureau says.

The expansion has had far-reaching consequences:

**More children insured.** The portion of children without insurance fell from 14.8% in 1997 to 11.7% in 2004, the Health and Human Services Department reports. The rate of young children being vaccinated has increased from 72% in 2000 to a record 81% in 2004.

**Higher costs.** Medicaid spending grew from \$159 billion in 1997 to \$295 billion in 2004. That 85% increase is nearly twice the rise in Medicare, which insures seniors. Washington pays 59% of Medicaid's cost; states pay the rest.

**Reduced private insurance.** Many low-income workers are choosing Medicaid over employer insurance because it is less expensive and often covers more. Medicaid is free or nearly free for recipients. Out-of-pocket costs and the range of services covered vary by state. The percentage of children covered by private insurance fell from 65% in 1999 to 59% in 2004, while those on Medicaid rose from 22% to 29%.

Critics of Medicaid's expansion say it is adding to the federal budget deficit — \$412 billion in 2004 — and luring people from employer-offered insurance.

"Shame on us for creating perverse incentives that cause people to give up private coverage for Medicaid," says Michael Cannon, director of health care studies at the libertarian Cato Institute in Washington.

But supporters say most Medicaid recipients have no other option and need coverage to keep working. John Begala, a member of the Ohio Commission to Reform Medicaid, says Medicaid's expansion "is one of the great policy success stories of the decade."

▪ [REPRINTS & PERMISSIONS](#)

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## Working Poor Families Project State Data Snapshot

[Print this page]

	OHIO	State %	State Rank	US%
<b>1</b>	Low-Income* Working Families	27.2	25	28
<b>2</b>	Low-Income Minority Working Families	42.1	21	40.8
<b>3</b>	Low-Income Working Families with No HS Degree/GED	19.4	9	32.3
<b>4</b>	Low-Income Working Families with No Postsecondary Experience	53.9	25	57
<b>5</b>	Low-Income Working Families Paying 1/3 or More for Housing	56.3	26	60
<b>6</b>	Low-Income Working Families with Parent without Health Insurance	26.4	9	39
<b>7</b>	Children in Low-Income Working Families	30.9	23	32.5
<b>8</b>	Low-Income Families That Work	67	43	72
<b>9</b>	Adults 18-64 with No HS Degree/GED	10.7	23	13.7
<b>10</b>	Jobs in Occupations Paying Below Poverty	24.4	25	22.7

Low-Income is defined as a family income below 200% of poverty. In 2007, the poverty threshold was \$20,951 for a family of four and thus the low-income threshold was \$41,902.

Data sources: All data from American Community Survey, 2007 except #6 from Current Population Survey, 2006-2008 and #10 from Occupational Employment Statistics, BLS 2008.

See the Framework of Indicators for more information.

WFPF

[www.workingpoorfamilies.org](http://www.workingpoorfamilies.org)