CAPITAL IMPACT
PARTNERS

Underwriting Home Care Cooperatives

A Guide to Support Investment Decisions and Bring Home Care Cooperatives to Scale

This guide serves as a foundational document for lenders and impact investors considering providing financial support to private duty home care cooperative agencies. **The goal of this guide is to acclimate potential financial underwriters to the home care cooperative business model and provide an overview of typical debt and capital needs.**

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Introduction

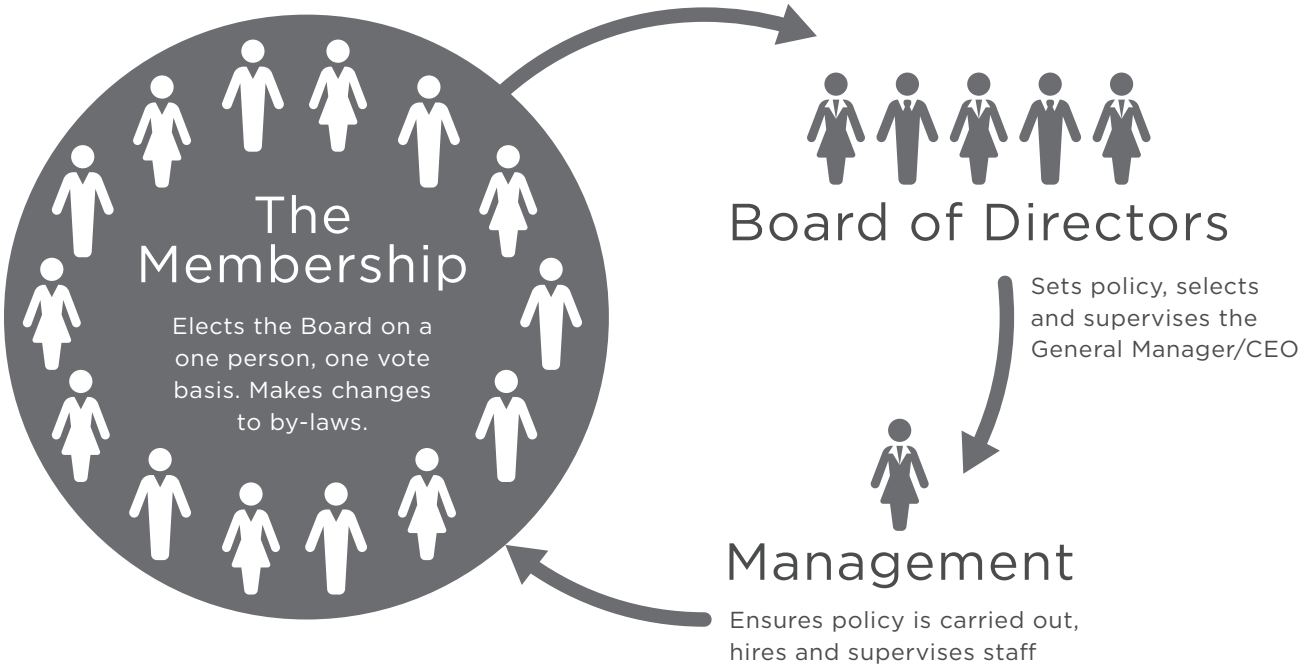
With a rapidly aging population and an increased demand for in-home care, the home care industry is experiencing significant growth. In parallel, home care cooperatives have emerged as a solution to increased demand for high-quality, in-home care for seniors and adults living with disabilities. The purpose of this guide is to introduce potential lenders to the home care cooperative industry and the industry's specific financing needs.

This guide provides an overview of the following key areas:

1. Current landscape of home care cooperatives
2. Industry benchmarks for the home care industry
3. Revenue sources in home care
4. The five Cs of credit and how they apply to home care cooperatives
5. Debt and capital needs of home care cooperatives and the opportunities and challenges these present for prospective lenders

What is a home care cooperative, and how do they operate?

At their most basic level, cooperatives are simply businesses that are owned and controlled by the people who benefit from them. Worker-owned cooperatives, including those providing home care services, are businesses that are both owned and controlled by the employees of the business who voluntarily elect to join the cooperative. Worker-owned cooperatives are democratically governed, with every member having one equal vote to decide upon important issues. The board of directors (typically comprised of worker-owners) of the cooperative are elected by the worker-owners, and the board is responsible for setting policy and hiring and supervising management. Management ensures that policy is carried out, hires and supervises staff, and oversees most day-to-day operations. For more information on democratic governance see Appendix A.



In worker-owned cooperatives, profits (and losses) from the business are allocated to the worker-owners based upon the method selected by the cooperative - either gross pay or hours worked. The dual benefits of having a voice in important decisions of the business and sharing in the rewards of success are two critical differences between worker-owned cooperative businesses and traditional businesses or not-for-profits.

While the governance and ownership structure of home care cooperatives differ from conventional business enterprises, the day-to-day operations and financial management of a home care cooperative are no different than a traditional home care agency. Home care cooperatives still succeed or fail based on their ability to develop a competitive advantage in the marketplace. Generally, this is through providing higher quality care, offering a service or combination of services for which there is unmet demand, a lower price point, or some combination of all three. Where home care cooperatives typically outperform their competition is in providing higher quality care. By their very nature, home care cooperatives emphasize engagement, positive treatment, and support of caregivers. Caregivers that are engaged, respected, and supported are happier in their jobs and remain on the job for longer periods, significantly improving employee retention. In an industry with an average annual turnover rate of 67%, maintaining consistent, quality care is a challenge. Those that can retain quality caregivers can offer higher quality care for clients.

As of June 2018, there were 11 cooperative home care agencies in operation across the U.S., with at least two more set to launch within the year and several additional cooperatives under development in markets across the country. See Appendix B for a map of U.S home care cooperative agencies. These 11 home care cooperatives collectively employ approximately 2,500 workers, including both worker-owners and non-owner employees. With more than two million home care workers nationally, this represents 0.12% of the total home care workforce. Existing cooperatives range in size from start-up organizations with only 5-10 caregivers to Cooperative Home Care Associates (CHCA) in the Bronx, the largest worker-owned cooperative in the country with over 2,000 caregivers. The majority of home care cooperatives focus on non-medical personal and household care (bathing, dressing, meal preparation, grocery shopping etc.) as opposed to more medically focused home health care, though the larger cooperative agencies also offer home health services.

Industry Benchmarks for the Home Care Industry

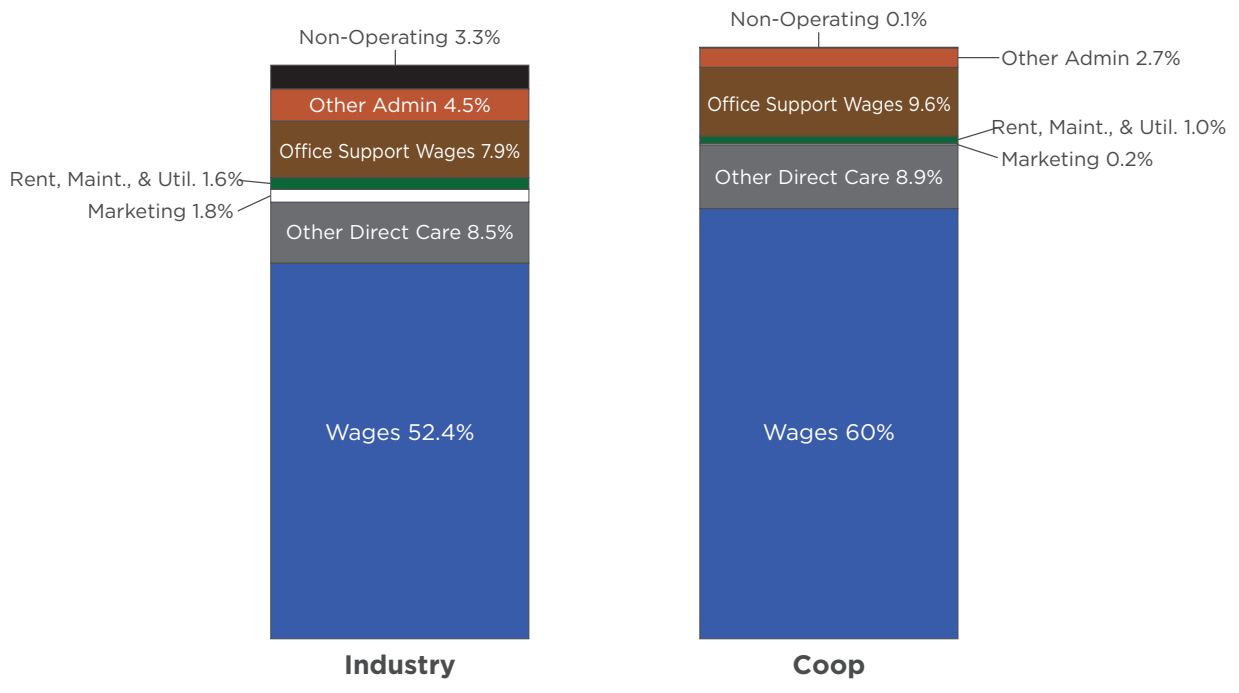
Revenue and Expenses

The home care industry has seen consistent growth over the last five years with expectations that demand will only increase. While there is some risk that changes in Medicare and Medicaid will reduce the long-term industry outlook, these risks are generally outweighed by the long-term growth in demand from an aging population.

Like many service industry businesses, the primary expenses for home care agencies are wages and other personnel costs. The 2018 Home Care Pulse Benchmarking Survey found that wages accounted for 52.4% of home care agency expenses, with the median total cost of direct care personnel reaching 60.9%.[1] Of the remaining median gross profit margin of 39.1% of revenue, overhead typically accounted for 15.8%, with non-operational expenses such as interest and owners' salaries totaling 3.3% of revenue. The survey found minor variation in these percentages across home care agencies by size, with the only significant difference being a small decrease in non-wage personnel costs for the largest agencies (sales of $2.8 million or more).

While often lumped into direct care expenses, travel expenses are an important factor in calculating cost of services in the home care industry. These expenses vary significantly based on the location of a cooperative or agency. Among home care cooperatives, travel expenses can be as high as 7% of total revenue in a rural cooperative and as low as 1% in a cooperative located in a dense city or town. These expenses can vary widely and change frequently based on the location of specific clients and specific funder requirements. In Wisconsin, for example, Medicaid-funded managed care organizations require home care agencies to visit clients for multiple shorter visits rather than longer, single visits, but do not fully cover the additional travel costs. A well-run home care agency or

Key Expenses (% of Revenue)



[1] Home Care Benchmarking Study (2018). Home Care Pulse.

cooperative will track changes in travel expenses over time and adjust schedules accordingly to prevent these costs from eroding its gross margin.

With low fixed costs, most home care agencies have few expenses that can be reduced outside of caregivers' wages (or owners' profit). Some operational improvements may be gained through improved scheduling and coordination; however, these lead to only modest decreases in expenses at best. On the other hand, given that caregivers must travel to their clients' homes to provide services, travel expenses are an item that can easily balloon. For agencies serving rural communities, it is vital for home care agencies to monitor and keep mileage costs in check.

Benchmarks

In general worker-owned cooperatives are subject to the same industry environment and market conditions as more traditional home care businesses. Because of this, the financial and operational benchmarks that apply to home care agencies also apply to home care cooperatives. Differences in benchmarks are driven primarily by the size, location, and revenue of an agency rather than whether a business is a cooperatively owned or traditionally owned agency. A small, rural, private pay home care cooperative is more financially comparable to another rural private pay agency than to a large urban public pay cooperative, for example.

Worker-owned home care cooperatives differ from the typical industry scenario in one key respect: because co-ops are owned by their direct care workers and not by an outside owner, the incentive for co-ops is to pay as high a wage as prudently possible to caregivers. This tends to decrease cooperative agencies' average gross margin by several percentage points relative to industry peers, but given the mission and values of the business, this is not seen as a negative outcome.

Balance Sheet

Home care agencies, like many service sector businesses, have very modest capital needs, spending on average $.02 on capital goods for every $1.00 spent on labor. In a labor-intensive industry with few fixed assets, home care agencies must be particularly adept at managing their current assets such as cash and accounts receivable. According to the most recent IBIS world report on the industry, on average, cash accounts for 24.6% of assets while net receivables account for an additional 28.1%.[2] The average current ratio in the home care industry—an important ratio for businesses that must stay liquid—is 2.0. Managing cashflow is extremely important in the home care industry where poor receivables collection can have dire consequences. The average collection period for receivables in the industry is 33.5 days, although this can be as much as 60 days for certain public payers or private insurances. Agencies must be sure to have enough working capital on hand to meet payroll during this time lag.

Recruitment and Retention

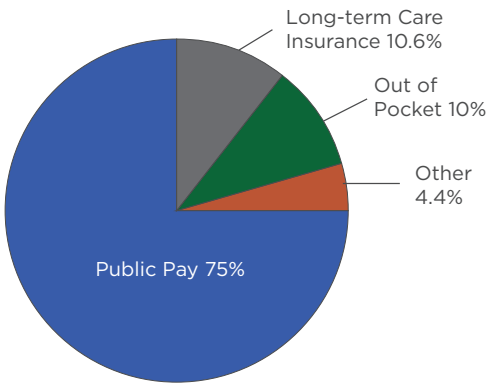
Although not generally an important benchmark in most industries, staff recruitment and retention are of utmost importance in the home care industry. Caregiving is a demanding job, both physically and mentally. Wages are low across the country and the sector, even in the private pay market, is significantly influenced by low public reimbursement rates (see page 6). In addition, benefits are rare, hours and schedules are often erratic and unpredictable, and training and supports are typically inadequate. Staff turnover is, therefore, extremely high in the industry and has been steadily increasing over time. In 2017, caregiver turnover was 66.7%, up from 53.2% in 2013, meaning a typical home care agency's direct care workforce completely turns over every year or two. The average tenure for a caregiver is 15 months nationally, and of those who quit in their first year, 57% do so within the first three months. Home care cooperatives that have been able to turn the advantages of member ownership and governance into better caregiver retention not only save on the costs of recruiting new caregivers, they also gain from having more experienced caregivers who can build long-term relationships with their clients and provide better quality care.[3,4] Most established home care cooperatives have a staff turnover rate of 40% or lower, with several worker-owned agencies as low as 20%, a significant differentiator in the marketplace.

[2] M. Guattery, Home Care Providers in the U.S. (IBISWorld, 2017).
[3] The estimated direct cost of replacing a nursing assistant or home care worker is $2,200 per employee.
[4] Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employees, Paraprofessional Healthcare Institute (2018).

Home Care Revenue

In the home care industry, revenue comes from two basic sources. The first is public payers, typically Medicaid mediated through programs in each individual state; the second is from private payers, including both clients who pay out of pocket and those with long-term care insurance. The public pay market dominates the industry accounting for over 75% of the industry's $92.5 billion in annual revenues. The remaining 25% comes from a mix of private sources, including long-term care insurance at 10.6% and out of pocket pay at about 10%.[5]

Home Care Payment Sources



Public Pay

Dually funded by the federal government and individual states, Medicaid provides financial support for health care services for low-income individuals, including elderly and disabled individuals requiring long term care. To be eligible for Medicaid benefits, individuals must meet federally mandated financial and asset criteria. Medicaid-funded long-term care programs vary significantly in scale and scope by state, but every state is required to offer home-based care as part of their suite of services. Currently there are two types of payment systems through which agencies are reimbursed through the Medicaid program: Capitated Payments or Fee-For-Service payments. Depending on the state the home care agency works in, they will be reimbursed through one of these two payment systems. While rates vary widely by state, Medicaid home care is artificially low in all states, requiring home care agencies to either pay low wages and/or pursue significant scale to take advantage of efficiencies of scale. However, as Medicaid represents more than 70% of home care revenue nationally, it remains an important payment source for most home care agencies, particularly those of scale. Currently, three of the 11 existing home care cooperatives service Medicaid clients, including the two largest cooperative agencies.

In addition to Medicaid, the U.S. Department of Veterans Affairs (VA) is another important public home care payer, and some existing home care cooperatives do service the VA. The VA contracts directly with individual home care agencies to provide home-based services to qualified veterans. Like the Medicaid program, these services cover a wide range of activities of daily living. The VA typically pays higher rates than Medicaid (VA rates also vary by state); however, the VA is known for slow and unpredictable payments, which can cause cash flow issues for provider agencies. On January 3, 2018, the VA announced a series of immediate actions to improve the timeliness of payments to community providers. These improvements will be important to watch for home care cooperatives serving or interested in serving VA clients.

Finally, many states and some large cities also have non-Medicaid funded public programs to support home care client needs; many focus on low-income individuals who do not quality for other public pay programs like Medicaid. Funds are allocated from a variety of sources including state lottery, grants, and donations, and funds are typically channeled through existing community-based senior support services, such as the Area Agencies on Aging, who then contract with individual providers. Rates vary widely as well but are typically low.

[5] M. Guattery, Home Care Providers in the U.S. (IBISWorld, 2017).

Private Pay

While out of pocket dollars currently represent less than 10% of the overall market, private pay rates are the highest in the industry. Additionally, there are significantly fewer regulatory and administrative barriers to home care agencies entering the private pay market. As a result, competition for private pay clients is very high, and new agencies are entering the market at a rapid rate. Despite stiff competition, the higher reimbursement rates and lower barriers to entry in the private pay market have proved more workable for start-up home care cooperatives, and this has been the strategy pursued by the last seven home care cooperatives that have launched in the U.S. As cooperative agencies grow and become better established, however, a more diversified revenue stream offers more business stability and long-term growth opportunity.

Average Public and Private Pay Rates

Nationally, the median hourly payment rates for private pay home care in 2017 were $27.50 per hour for 1-2 hours of care, $23.50 for 3-5 hours of care, $23 for 6-11 hours of care, and $22 for 6+ hours of care. Rates vary widely across the 50 states, however, with average rates as low as $15 and $15.25 per hour in Louisiana (for personal care and home health respectively) and as high as $27.96 per hour for both personal care and home health care in North Dakota. In contrast, among publicly funded programs, the average rate nationally for non-medical home care was $19.01 per hour in 2016. Out of this rate, agencies must pay all direct staff expenses as well as overhead and administration. See Appendix C for a detailed discussion of public pay rates and opportunities.

Private Pay Home Care Rates	
1-2 Hours	$27.50
3-5 Hours	$23.50
6-11 Hours	$23.00
12+ Hours	$22.00

Business Lines and Diversification Opportunities

Today, most home care cooperatives focus on non-medical personal and household care (bathing, dressing, meal preparation, grocery shopping, bill management, etc.). A few have added more complex home health tasks to diversify revenue streams or capitalize on opportunities that arose through important partnerships in their local markets. This strategy is particularly sound for agencies serving public pay markets. The additional costs of employing and training home health aides and a registered nurse to oversee enhanced services, however, is only practical for agencies that have reached a minimum revenue threshold of approximately $1.5 million and can successfully absorb the increased administrative costs. While most home care cooperatives operating in the U.S. today have not reached this threshold, it might be an appropriate future goal for a growing enterprise to aspire to. The addition of other complementary business lines such as case management and durable medical equipment also hold promise for established cooperatives that reach larger scale. Research by industry experts is under way to support home care cooperatives in exploring more novel revenue diversification strategies.

Credit Quality Metrics

From a lender perspective, underwriting cooperatively owned enterprises involves the same steps as underwriting a similar business with a conventional ownership structure, with the addition of a few more questions designed to uncover the strengths or weaknesses of the cooperative structure itself. Understanding the structure of the cooperative – who are its members, what are the obligations of membership, how are profit or other benefits allocated, how is leadership selected and transferred, etc. are all important indications of the strength of the operation and how likely it is to be successful over time.

Generations of lenders have relied on the "5 Cs of credit"—Character, Capacity, Capital, Collateral, and Conditions—to assess business' credit worthiness. It remains as useful an arrangement as any to methodically address the key risk factors that small businesses (including cooperatives) face and focus on the elements that differentiate successful borrowers from less successful ones.

Worker-owned cooperatives are businesses just like any other, so in many ways underwriting them is the same as underwriting a similar business formed under a partnership, limited liability company, or sole proprietor ownership status. From a financial perspective, a "good" cooperative will look much like other "good" privately held companies of the same size in the same industry—it will have sales, cash flow, assets, etc. that can all be analyzed just like any other business. The unique elements of a cooperative are to be found in its broad ownership base, democratic governance structure, and its organizing principle to benefit members and the community, rather than necessarily pursuing the highest profit margin. Understanding how each of these elements work for the cooperative under consideration will help in assessing the strength of the enterprise.

The Five Cs	Traditional Business Metrics	Additional Cooperative Metrics
Character	Credit score Reputation Relationship	Strong governance Perpetual by design & practice Reputation Relationships External technical assistance
Capacity	Cashflow Historical financials Projections Debt coverage ratios Low turnover rate	Patronage Low turnover rate
Capital	Equity from family, friends, & founder	First equity from members (not sufficient) Grants and social impact investments
Collateral	Personal Guarantees Cosigners	No personal guarantee options. Alternatives: 1. Signed Contracts 2. Accounts Receivable 3. Cash on hand
Conditions	Preparation/insulation from regulatory risk Caregiver recruitment and retention	Preparation/insulation from regulatory risk Caregiver recruitment and retention (better than industry) Access to technical assistance support

Character

For a loan to an individual entrepreneur or partnership, the "character" assessment for some lenders is as simple as looking at a credit score. Other lenders might consider additional indicators of trustworthiness or dependability such as market reputation or relationships with customers or suppliers. Since a co-op is made up of many individual owners who may change over time, how does a lender assess character?

For a cooperative, part of the answer will be like other businesses: what is the reputation of the organization? Are customers happy? Prospective cooperative borrowers should also be able to demonstrate history of paying vendors and other obligations on time. For a cooperative, however, a different aspect of the "character" question will also be an assessment of the strength of the common institution that the members have built. Management and leadership are as important for cooperatives as for any other organization, but a strong cooperative also has an identity that is separate and distinct from that of its individual leaders. A cooperative's governance must be democratic, and it also must be perpetual by both design and practice. A cooperative with a strong "character" will be one that has clear and complete organizational documents, a well-ordered way for new members to join the cooperative and departing members to leave, thoughtful and well-written statements of mission and purpose, and a history of membership engagement, including regular communications with members and a well-planned annual meeting.

Capacity

Capacity, or cash flow, is essentially the ability of a business to generate more cash on a regular basis than it needs to pay its debt obligations. Historical sales, market data, as well as projected fixed and variable operating expenses will inform analysis for a cooperative in the same way they would for any similar business. Key elements for a cooperative will also include the degree to which the cooperatives' membership can reduce turnover costs and/or impact sales, the way that surplus or profit is returned to members, and how member's equity structure affects cash flow.

In a cooperative enterprise, cash flow is directly affected by the way in which surpluses, or profits, are passed on to members, as well as how members' equity shares are purchased when new members join and redeemed when they leave. Most cooperatives distribute profits or "patronage," as it is known, at the end of a fiscal year, after all other financial obligations (including loan payments) have been taken care of; some also award quarterly bonuses based on profit. Worker cooperatives have the advantage of the prospect of new capital regularly invested by new members (membership share), but also must plan for how to cash members out when they leave the cooperative.[6] For most worker-owned home care cooperatives, these amounts are modest and are not a significant cash flow issue. Even so, as lenders, it is prudent to require that the cooperative demonstrate the ability to meet all obligations to outside lenders before equity can be taken out by departing members. For a more detailed explanation of patronage allocation and industry best practices, see Appendix D.

Capital

Lenders, of course, also look to a company's balance sheet for additional security that a loan can be paid and to make sure that the owner(s) are sufficiently invested in the project and not over relying on outside debt to finance the business. For most small businesses, initial capital will come from the entrepreneur and perhaps family and friends. For cooperatives, the first equity capital should come from the cooperatives members.

For worker-owned home care cooperatives serving a primarily low-income workforce, however, member investment will seldom be sufficient to finance the costs of starting or expanding their businesses. This does not mean that the cooperative should not require

[6] In cooperatives, members typically make a one-time purchase of a membership share to join the cooperative and become a co-owner. This share is considered a member's equity in the business entity. Membership shares can be nominal or significant depending on the enterprise. In home care cooperatives the average membership share is $100, an investment that is significant for a low-wage home care worker but also not a barrier to entry. Typically, home care cooperatives will offer both the option to pay the membership share in one lump sum or use payroll deductions for a short time.

a capital investment from members—it should. But it is also important to be realistic about expectations. For a home care worker making $10-$12 per hour, for example, an investment of $200 to become a cooperative member/owner likely represents a significant sum. It may not be sufficient for the business start up (which is one function of member equity in a cooperative), but it can certainly act as an indicator of a member's level of seriousness about his or her commitment to the venture, which is another function of member equity. Finally, as a venture with social benefits for the broader community, some cooperatives have been successful in attracting grants or social investments from local individuals and institutions. These can also act as "quasi-equity" for the business.

Collateral

As a human service industry, the home care sector is a challenging one to finance in general because of the high need for working capital relative to the scant base of equipment and other tangible property available to secure a loan. In such situations, in lieu of more tangible assets, most small business lenders routinely require personal guarantees as part of the collateral for any loan to a sole proprietorship or partnership. For a cooperative, however, this can be problematic. Not only would it be cumbersome to secure signed guarantees from potentially dozens of members, but members may also understandably be reluctant to guarantee 100% of a loan when they don't control 100% of the enterprise, and, in fact, get only a single vote for the board of directors. Such a practice puts an unfair burden on co-op leaders (at a time when good organizational leaders should be encouraged, not penalized), and such requirements have proved to be a "deal-breaker" in most, if not all, situations where this occurred.

Considering also that the actual collateral value of personal guarantees from a group of very low-wage workers is likely not material, it is in many ways more sensible to dispense with personal guarantees entirely for worker-owned home care cooperatives, as many lenders do for nonprofit organizations. Instead, an analyst could focus on other indicators of security such as historical sales, reputation with key customers, signed contracts in place, tangible property combined with a discounted assessment of accounts receivable, and perhaps asking cooperative members for their ideas of other ways that they believe they can demonstrate their dependability and good character as an institution. A committed lender could also work with a cooperative customer over time to build up a base of cash savings as collateral to support future loans.

Conditions

The environment affecting home care enterprises in general can be challenging. Wages are low, employee turnover high, and many of the key conditions of both the public and private pay market are determined by factors outside of an individual home care agency's (cooperative or not) ability to influence, let alone control. On the positive side, demand for home care services is strong and growing, and worker-owned home care cooperatives have a distinct advantage over their competitors, given their ability to positively influence both employee retention and quality of care through a concerted effort to engage their member/owners. The degree to which a cooperative makes use of the strength of its membership is an important indicator of its ability to influence the environment in which they work.

U.S. home care cooperatives also frequently have access to a range of cooperative-specific technical assistance resources to assist members with tasks such as financial analysis, strategic planning, and governance; taking advantage of these opportunities is another important way that cooperatives can positively affect their environment. Several experienced nonprofit lenders interviewed indicated that the quality of the technical assistance that a cooperative had access to was a significant factor in its overall risk analysis.

For example, the Northwest Cooperative Development Center has had a significant role in both start-up and ongoing technical assistance for the three home care cooperatives located in Washington. The ICA Group provides ongoing business consulting to several home care cooperatives as well. Nationally, technical assistance providers, consultants, existing home care cooperatives, and other organizations have been working together to build and share resources for home care cooperatives through monthly calls, meetings, and a yearly conference dedicated to home care cooperatives.

Debt and Capital Needs

The financing needs of home care cooperatives, like other small businesses, differ based on their stage of growth as well as the primary market (public vs. private pay clients) served.

Start Up

Funds for start-up operations are usually the first financing need of a new worker-owned home care cooperative and the most "terrifying" ask for a lender, to quote one interviewed for this guide. Start-up funding needs vary significantly based on the target market to be served but would typically include the costs for office set-up, any computer, telephone, software, or other technology needs, initial marketing and outreach costs (including website and collateral design and set-up), and ideally several months of management salaries and other operating expenses in reserve to cover the ramp-up period and make payroll during the period between when services are delivered and payment is received. For the private pay market, payment may be made within a week or two of service (thus lowering the need for working capital); for the public pay market, depending on the vendor, the time period could be weeks or even months. We estimate that for a typical small private pay cooperative start-up funding of approximately $50,000 is necessary to launch the cooperative.

The highly intangible nature of most of these items makes start-up financing one of the biggest barriers to the growth of more worker-owned cooperatives, particularly those like home care cooperatives which employ primarily low-wage workers. Surveyed cooperatives made use of a variety of alternative financing for start up, including local banks, CDFIs, social investors, and foundations. Traditional lenders can certainly have a role in the successful start up of a home care cooperative; working in collaboration with other locally-based organizations or nonprofits is a good place to start.

Sources	
Start-up Loan	$51,543
Paid in Capital	$1,000
Total	$52,543

Uses	
Pre Start-up Expenses	$11,255
• 4 Months Part-time Admin	($6,250)
• Marketing Expenses	($3,005)
• Office Rent	($2,000)
Working Capital*	$27,893
Payroll Buffer^	$13,395
Total	$52,543

* Amount needed to finance operations pre-revenue

^ Two weeks of caregivers wages at 1,800 hours per month (21 clients X 20 hours of billable hours per week per client)

Cooperative Spotlight: Unique Strategies for Start-up Funding

Peninsula Homecare Cooperative in Port Townsend, Washington, got started with the help of a local investment club. Community members made low-interest, flexible loans to help launch the new cooperative. The venture has been successful, and all investors were paid back early.

Cooperative Care of Wautoma, Wisconsin, accessed financing from a community bank on the strength of an 18-month contract with their local county. They have since scaled significantly, bringing on numerous state and county contracts as well as VA and private pay clients.

Both **Cooperative Home Care Associates (CHCA)** in the Bronx and **Home Care Associates (HCA)** in Philadelphia launched with significant grant funding through a nonprofit partner, focused on the development and delivery of high-quality training to caregivers. Overhead for the training program was leveraged early on to offset overhead costs for the cooperative. CHCA and HCA are the two largest worker-owned home care cooperatives in the country.

*See Appendix E for detailed start-up case studies on Peninsula Homecare Cooperative and Cooperative Home Care Associates

Operations/Cash Flow/ Working Capital

One issue that every enterprise working in the home care sector must address is the need for working capital. The primary expense of these businesses is labor, and payroll must be met weekly or bi-weekly, even as some public-sector payers take 4-6 weeks or more to pay invoices. This situation means every business operating in this industry has a more or less permanent need for working capital. In addition, several necessary large annual expenses such as workers' compensation insurance premiums or financial audits required by public sector payers are often billed in lump sum amounts that may or may not correspond to the cooperative's annual cash flow, causing additional cash flow concerns.

For a low-margin business such as home care, unanticipated fluctuations in such working capital demands—even if such changes are not indicative of a serious flaw in the underlying business model—can be potentially catastrophic. Cooperative agency surveys uncovered several examples of unexpected changes in public sector payment policies or other events outside of the cooperative's control that led to alarming cash flow situations for the enterprise. One answer to such market conditions would surely be for the cooperative to keep additional cash reserves on hand. While this is an admirable long-term financial goal, this might not always be possible for a business owned by low-wage workers. Another good alternative is to have a trusted lender who understands the cooperative's market and needs and who is willing to assist them in smoothing out monthly and annual cash flow demands. Access to a stable and sufficient line of credit is an important part of the financial picture for any co-op in this industry. This should be coupled with monitoring of the cooperatives accounts receivable indicators, with appropriate coaching as needed.

Lack of access to an appropriate line of credit for operating needs, a weak collections system, and/or lack of overall planning on the cooperatives' part have led some cooperatives to need a cash infusion structured as a working capital term loan. While the decision to finance working capital in the form of a term loan structure is not ideal, such loans have helped more than one home care

cooperative navigate challenging financial situations and move ahead in a stable and profitable way. The willingness on the part of a lender to look beyond the short-term cash flow predicament and focus on the long-term prospects of an enterprise are key, and in some cases a term loan may be the best answer.

A final operating need of most small businesses is access to a company credit card. For worker-owned cooperatives, these can be surprisingly difficult to obtain. Many lenders ask cooperative leaders to personally sign for a company-based card, the way they would if the business was solely their own. Having to personally guarantee a company credit card thus places board members or managers in a very awkward position. Having staff members routinely use personal credit cards for work purchases is also not a desirable alternative from a "best practices" audit perspective. A better alternative would be for banks or credit unions to treat worker-owned cooperatives similarly to nonprofits, and issue company cards based on the strength of the underlying banking and deposit relationship alone, monitoring as appropriate.

Expansion

Once started, many successful cooperatives will encounter the opportunity to expand their service area and perhaps their menu of services. Assuming a well-thought-out strategy, this is to be encouraged, as there are some modest but meaningful economies of scale to be accessed through a larger, more robust organization, particularly in terms of management expertise.

Costs that may need to be included in expansion financing include software needed to work with a new base of customers, marketing materials and advertising, training, and additional working capital to carry the "float" between service and payment for more employees, as well as to invest in hiring a sufficient number of new caregivers. For a lender, it is important to review the plans for accessing new customers but also new workers and readiness of the management team to take on the challenges. Items that are typically underestimated in expansion planning include the need for more permanent working capital, delays that may be encountered in recruiting workers in an unfamiliar labor market, as well as the cost-benefit analysis of labor-saving technology such as specialized software that may enable a cooperative to get paid much more quickly from a publicly-funded source. An experienced business lender can help and support a worker-owned cooperative in making smart plans for expansion.

Key Financing Opportunities

The challenges facing the home care industry should not be underestimated, but there are also numerous opportunities in this sector.

Increasing Demand

The need for home care services is growing--significantly and steadily, in every market, all over the country. This is a much-needed, if under-valued service, and as such, there is significant opportunity for a well-functioning enterprise with strong local relationships to prosper. Additionally, awareness of the importance (and financial value) of home care services in the healthcare continuum is growing at a rapid rate. New models of client-centered and value-driven care will only increase home care's position in the market.

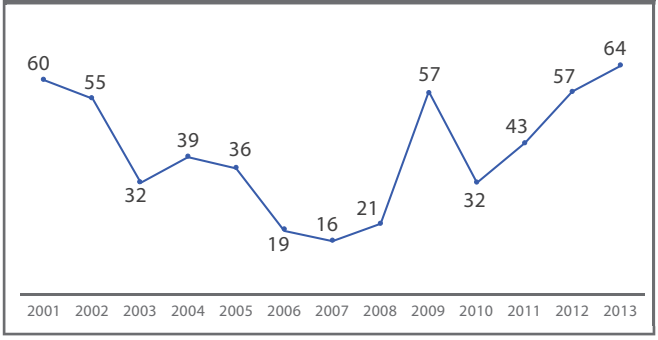
Cooperative Advantage

While far from a guarantee of success, the worker-owned model has much to contribute to the future of the industry. Worker recruitment and retention are the biggest challenges faced by home care agencies. What data there is on the small group of existing worker-owned home care cooperatives show that worker ownership is truly meaningful to home care workers and results in lower turnover and greater job satisfaction. Turnover in the wider industry is more than 67% per year and increasing year over year, while home care cooperatives have shown turnover at less than half that rate. As the costs of staff turnover can be substantial ($2,200 per employee), this is an important point. A related advantage is that worker ownership often leads to higher quality care, as committed workers are given an opportunity to influence care and decision making, and experienced workers stay with the cooperative for longer. Case study evidence has shown again and again that when home care workers can influence key decisions, they make decisions that result in higher quality care and better outcomes for clients.

Conversions

While there are challenges to financing existing and start-up cooperatives, there are opportunities in converting existing home care agencies into cooperatives. A national survey conducted by the ICA Group in 2016 found that 33% of home care agency owners expected to sell their businesses in the next five years and 58% in the next 10 years. ICA research further found that of the home care agencies that are the ideal size for a cooperative conversion (20-100 employees), an average of 40 have sold or closed each year since 2000 (more than 700 potential opportunities). Additional research conducted by the ICA Group into the financial feasibility of home care conversion can be accessed upon request.

Potential Conversions (2000-2013)



Franchise Model

Recently, franchises have experienced significant growth and investment in the home care industry and there has been discussion as to whether a cooperative franchise may be a model to scale home care cooperatives. The benefits of a franchise would include shared branding, start-up materials, and ongoing management resources. Previous research by The ICA Group determined that the legal structure of a franchise is not well-suited to the home care cooperative model. However, a shared infrastructure of management and marketing supports for existing and future home care cooperatives would unquestionably lead to financially stronger cooperative businesses, improving their ability to service debt. The Cooperative Development Foundation, The ICA Group, Capital Impact Partners, existing home care cooperatives, and other cooperative development and technical assistance partners are building the foundation of such a network that will lead to a stronger home care cooperative ecosystem.

Lender Recommendations

Lenders wishing to engage in this sector can offer both capital and business supports to help grow this important sector. The following is a summary of recommendations presented in this guide to assist lenders interested in supporting home care cooperatives.

- Rely on public contracts, government receivables and/or a history of effective collections to collateralize a loan in lieu of personal guarantees.
- Work with cooperatives over time on a plan to build up internal cash reserves to facilitate future borrowing.
- Treat cooperative boards the way your institution would treat nonprofit boards, that is, volunteers engaged in service to a socially-useful purpose, and limit personal exposure entirely based on that reasoning.
- Consider instituting credit checks on card signers in lieu of actual personal guarantees for a company credit card. This way, the lender can maintain some control over exposure without subjecting individual co-op members to personal financial liability.
- Differentiate in loan analysis between cash flow issues that are caused by external constraints (changes in public policy, payment timelines, insurance billing cycles, etc.) versus issues that indicate actual and on-going structural weaknesses in business operations.
- Assist borrowers in assessing and potentially investing in systems to streamline bottlenecks, including software and equipment to make billing or scheduling easier.
- Help cooperatives to anticipate future issues or opportunities by asking members thoughtful questions about their markets and future plans; prompting dialogue and encouraging cooperative leaders to build their business acumen.

For additional insight into the home care cooperative sector, please visit www.seniors.coop or contact Capital Impact Partners and The ICA Group directly.

CAPITAL IMPACT PARTNERS

703.647.2352
www.**capitalimpact**.org

ICA GROUP

617.232.8765
www.**ica-group**.org

Appendices

Appendix A: Democratic Governance Overview

A properly functioning cooperative governance system clearly articulates the roles of the members, the Board of Directors (including a "grievance council"), and the management. If the governance system is to function well, the responsibilities of these groups must be clear, and the groups must have real decision-making power. While each co-op and its culture are unique, generally the roles of each of these groups fall into this general form:

The Membership: The members, or shareholders, are responsible for all corporate matters and significant policy matters. Additionally, the by-laws can specify issues that should be addressed by the membership as a whole.

The Board of Directors: The Board is responsible for all policy and governance matters not handled by the Membership. Specifically, they select key managers, approve the budget, and set the strategic direction of the firm. Home care cooperative boards can include caregiver members and external stakeholders, where beneficial. Members should make up the majority.

Management: Management is responsible for carrying out the regular business of the firm including marketing and sales; financial management (although some cooperatives do also employ outside accountants); HR functions, including staff supervision; and scheduling and other typical functions. Management has influence and will often generate or review policy proposals for the board and membership, but they do not have the authority as managers to set policy.

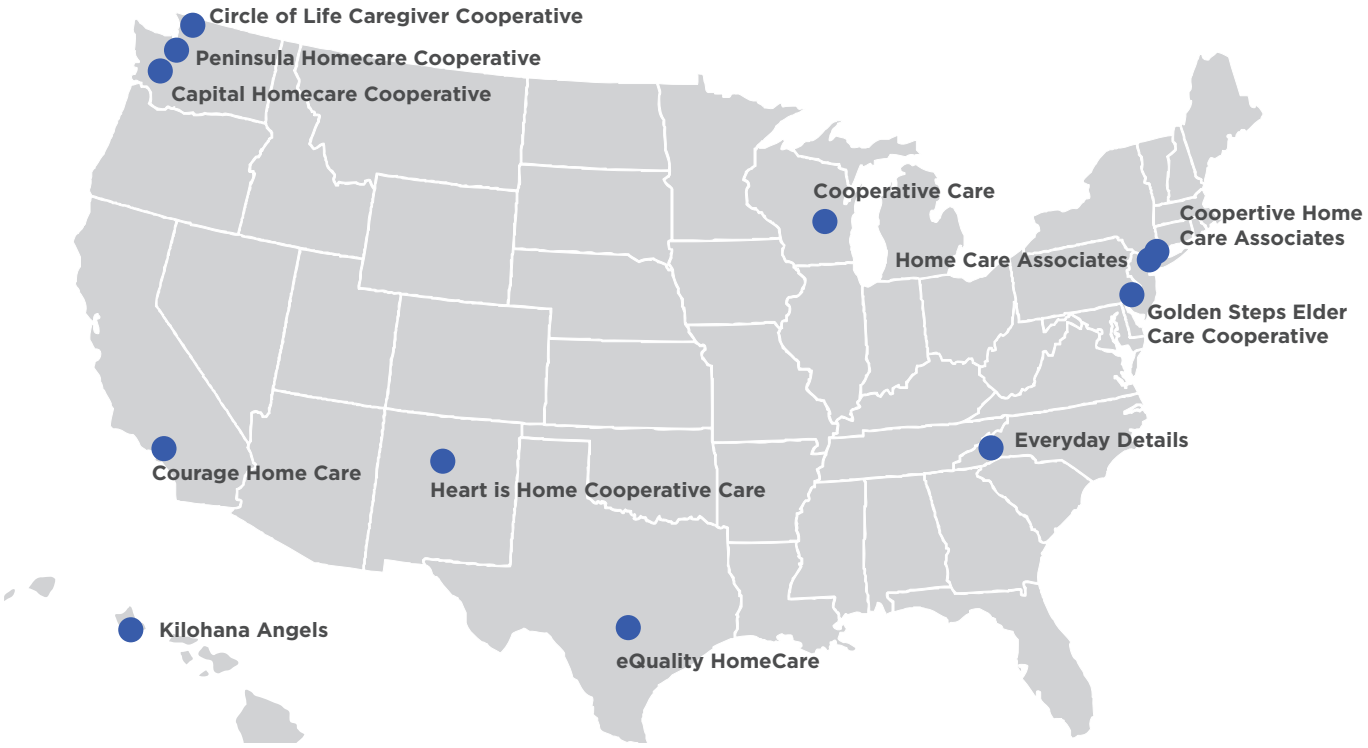
Of course, the devil is in the details, and for each issue that comes up determining whether it's an appropriate issue for the membership to consider, the board to decide, or management to handle can be a challenge. Regular training on decision-making processes and power within a cooperative is advised.

Having a capable manager or managers and a strong, engaged board are critical to the long-term success of a cooperative. Management must be accountable to the board, and the board must be empowered to oversee management. Key elements of a well-functioning system include:

- Clear systems and processes for communication and information sharing between the management and the board, the board and membership, and management and membership
- A predictable and regular schedule of board meetings and member meetings
- A process for addressing grievances
- Regular training on board, membership, and management functions. Board training is best done by external parties.

See: The ICA Group's "Democratic Governance – An Overview" for additional detail.
http://ica-group.org/democratic-governance/

Appendix B: Map of Operational U.S Home Care Cooperatives



Appendix C: Public Pay Overview

Medicaid Overview

Dually funded by the federal government and individual states, Medicaid provides financial support for health care services for low-income individuals, including elderly and disabled individuals requiring long term care (accounting for over 60% of Medicaid spending). Under Medicaid, the federal government provides a base match of 50% for approved Medicaid-provided services, with low-income states eligible for higher reimbursement rates. To be eligible for Medicaid benefits, individuals must meet federally mandated financial and asset criteria.

Beginning in 2014, the Affordable Care Act allowed states the option to expand Medicaid eligibility to all non-elderly adults with income below 138% of the federal poverty line. Under "Medicaid Expansion," the federal government absorbs a larger share of Medicaid costs for new enrollees, covering 100% of costs from 2014 to 2017 and gradually reducing that percentage to 90% from 2017 to 2020. To date, 32 states and the District of Columbia have expanded Medicaid.[7]

Medicaid requires that states provide specific services at a minimum to participate in the program. Required programs include inpatient and outpatient hospital services, physician and laboratory services, nursing home care, and, more recently, home health care. Above the minimum required programs, states may elect to cover additional services and/or expand services to individuals outside of the standard eligibility limits set by the Center for Medicaid and Medicare Services (CMS), the federal governing body. Typically, these additional services are provided under approved "waivers."[8]

[7] Families USA. "A 50-State Look at Medicaid Expansion." https://familiesusa.org (accessed November 2018).
[8] Congressional Budget Office. "An Overview of the Medicaid Program (2013)." https://www.cbo.gov/publication/44588 (accessed November 2018).

The number and type of waivers in each state varies widely, however, common waivers include the 1915 Home and Community Based (HCBS) waivers. Aged and Disabled Waivers (ADW), and Intellectual Disability Waivers (ID). Home care relevant 1915 waivers include:

- 1915(c) Home and Community-Based Waivers (offered in 47 states and DC)
- 1915(i) State Plan Home and Community Based Waivers
- 1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers
- 1915(k) Community First Choice Waivers[9]

1915 (c) HCBS waivers were first introduced in 1983 as a way for states to transition beneficiaries out of costly institutional care settings, and in 2005, became formal Medicaid State plan options.[10] States can offer as many 1915(c) Home and Community-Based Waivers as they elect, provided that they meet the requirements set forth by CMS, and can elect what services to cover under the waivers, however, home health aide, personal care aide; and homemaker services are almost always covered under these programs.[11]

From Medicaid's founding in 1965 until the early 1990s, Medicaid operated under a system of "fee-for-service," where providers were directly reimbursed for services provided, based on rates set by individual states. In the early 1990s however, Medicaid began a transition towards a system known as "managed care" to better manage costs, utilization, and quality. Under Medicaid managed care, state Medicaid agencies contract with independent for profit or nonprofit Managed Care Organizations (MCOs) that accept per member per month payments for health care services, known as "capitated payments." Because payments are "capitated" MCOs are driven to balance the needs of high-need/high-cost beneficiaries with low-need/low-cost beneficiaries and provide care in the most cost-effective manner possible to avoid cost overruns. Early on, managed care was implemented under 1115 Waivers, but in 1997 the Balanced Budget Act gave states more authority to implement managed care programs without waivers.[12] As of March 2017, only 12 states did not have Managed Care programs in place.[13] States that have begun transitions to managed care programs are in varying states of transition. Several states including Tennessee, Hawaii, New Hampshire, New Jersey, Rhode Island, Kentucky, Iowa, Delaware, Florida, and Arizona, operate almost exclusively under managed care programs (over 90% transitioned), including home and community-based services, while others are just beginning this transition.[14] Understanding where specific states fall on this transition is important, as it is directly correlated to how service rates are set, how money flows, and the importance of strategic partnerships, scale, and other factors to home care agency success in a state.

In addition to the transition to managed care, states are increasingly transitioning Medicaid to "value-based" care models by implementing Accountable Care Organizations (ACOs). Dozens of states have implemented ACO programs and the model is expanding rapidly.[15] The goal of ACOs is to "(1) enhance the patient experience of care; (2) improve the health of the population; and (3) reduce the per capita cost of health care." What differentiates an ACO from an MCO are innovative values-based payment structures and carefully defined and tracked data and quality metrics to assess and confirm established value outcomes. The transition to value-based care via the ACO model is an important one for cooperative home care agencies and developers to watch, as higher quality care is a hallmark of cooperative home care agencies and could be an important market differentiator.[16]

Capitated versus Fee-For Service Medicaid

In an increasing majority of states, publicly-supported, long-term, in-home supports are managed by state-contracted MCOs. MCOs typically receive capitated reimbursement rates from the state and then negotiate individual,

[9, 10, 11] The Center for Medicaid and CHIP Services. https://www.medicaid.gov/index.html (accessed November 2018).
[12] Henry J. Kaiser Family Foundation. "Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers." https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf (accessed November 2018).
[13] Henry J. Kaiser Family Foundation. "Total MCO's (2017)." https://www.kff.org/ (accessed November 2018).
[14] Henry J. Kaiser Family Foundation. "Share of Medicaid Population Covered Under Different Delivery Models (2016)." https://www.kff.org/ (accessed November 2018).
[15] Center for Health Strategy, Inc. "Medicaid ACO's: Status Update (2017)." www.chcs.org (accessed November 2018).
[16] Center for Health Strategy, Inc. "Medicaid Accountable Care Organization Programs: State Profiles Brief (2015). www.chcs.org (accessed November 2018).

private contracts with home care providers. In capitation models, MCOs are paid a set amount per member per month for long-term services and supports by the state, based on an expectation of needs. Capitation payment models are thought to encourage preventative care and efficiency. Under managed care models, home care agencies (including cooperatives) can negotiate agency contracts with their area MCOs, potentially securing higher rates for quality care. When financing a cooperative home care agency that is licensed to serve public pay clients, a demonstrated history of negotiating higher reimbursement rates may be an important factor to consider.

The more traditional model of reimbursement is Fee-For-Service (FFS), which is still in place in many states. In FFS systems, state Medicaid offices pay providers based on actual hours of service provided to a patient. Reimbursement rates are typically higher in FFS states due to fewer regulatory barriers and administrative overhead; however, there is also more competition. Another difference is that FFS systems do not place as much value on the quality-of-care provider, which is a differentiating factor for home care cooperatives.

As one business, it is not possible for a home care cooperative to affect the public payment system in place in any state. What home care cooperatives can influence, and what a lender should look for, is the way in which cooperative use their advantages in staff retention and quality of care to influence the stability and profitability of their enterprise.

Medicare

Historically, Medicare reimbursed home health care only and only in cases where a Medicare recipient's doctor ordered home health services to help the recipient recover from an injury or condition that did not require hospitalization. Personal care services were not eligible for reimbursement, and services could only be utilized for a maximum of 21 days, for less than 7 days per week, and less than 8 hours per day. Typically, agencies servicing Medicare clients will be required to offer a full range of Medicare-eligible services, and only Medicare recipients that require skilled level nursing will be eligible (and only in some cases) for the much higher-paying and complex home care support services. As a result, only large and/or diversified home care agencies that can offer a full range of eligible services will typically work with Medicare. As of the writing of this guide, no cooperatively owned home care agency offers Medicare services, and addition of Medicare clientele will remain out of reach for most home care agencies (cooperative or otherwise) for some time.

Changes made as part of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, as part of the Bipartisan Budget Act of 2018, are beginning to change the Medicare long-term care marketplace, however. Specifically, changes in the CHRONIC Care Act will allow Medicare Advantage plans to offer nonmedical supplementary benefits to beneficiaries with chronic illnesses that have "a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits", and eliminate the mandate to provide uniform benefits allowing plans to tailor their benefits to specific needs of chronically ill clients. Guidance by CMS have stated that plans can take advantage of these changes as early as 2018, but it is unlikely plans will pursue programs before 2019 and likely 2020.[17]

Appendix D: Patronage Allocation—A Primer

Ownership structure is the basic building block of any enterprise. It determines how authority, responsibilities, risks, and rewards are distributed in a firm. It also determines how an owner enters and leaves a company. In a worker co-op, ownership and control of the business derive from working in the company, rather than from simply investing capital in it. A central element of this business structure is that labor employs capital, rather than capital employing labor. In this way, worker co-ops are structured to provide a stable source of profitable work for the worker-owners instead of a profitable investment for the shareholder-owners.

In a conventional corporation, dividends are distributed according to each shareholder's capital investment and number of shares, so they are called "capital dividends." In a cooperative, dividends are allocated according

[17] Willink, Amber, Ph.D and DuGoff, Eva H, Ph.D. "Integrating Medical and Nonmedical Services - The Promise and Pitfalls of the CHRONIC Care Act." The New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMp1803292 (accessed November 2018).

to contributed labor or "patronage," so they are called "patronage dividends." Under Subchapter T, earnings allocated to members on the basis of labor patronage can be in the form of cash or written notices of allocation and may not be declared as non-member or unrelated business income. Importantly, a cooperative corporation may allocate a patronage dividend partially or entirely on paper and retain the profits for a period of time to use for any corporate purposes.

In a worker cooperative, it is best practice to manage and distribute member patronage dividends through a system of Internal Capital Accounts (ICAs). In an internal capital account cooperative, the entire net book value of the cooperative is reflected in internal capital accounts, one for each member, and a collective account. Each member's internal capital account records the part of the net book value ultimately to be returned to each member. An individual account consists of a membership fee (contributed capital/equity) and written notices of allocation (retained earnings).

Cooperatives also have a third option when deciding what to do with surplus funds, that of making allocated but nonqualified distributions. In this case, surplus funds are allocated to co-op members rather than the cooperative collectively but are not (yet) distributed to individual member accounts. Such funds act essentially as a collective account, yet the co-op retains the records and the option to distribute these funds to individual member accounts later, based on patronage earned at the time.

When setting a patronage allocation strategy, there are three competing goals that a cooperative must balance:

1. Sustainable Business Growth: By maximizing the firm's collective retained earnings (in the collective account), the cooperative will likely have a higher tax obligation, and, thus, less funds to re-invest in growth. However, funds the cooperative retains can be reinvested in growth or to cover unexpected future expenses without needing to seek outside financing.

2. Long-Term Member Wealth: By maximizing the cooperative's Written Notices of Allocation (WNAs), which are temporarily reinvested in the business free of corporate income tax, these additional funds can then be used to fuel greater growth than if the cooperative simply retained the earnings collectively. However, while WNAs shield the business from corporate tax, they do require that individual members pay income tax on the entire dividend amount, whether it is paid out in cash or retained as equity in the business. The amount retained will also eventually need to be paid out to members, and this creates a cash flow obligation that could negatively impact the cooperative's growth in the future. Further, there is the inherent risk that the position of the business will change over time and allocation of losses to individual accounts will decrease their value. Depending on the needs of the business and the needs of the cooperatives' workers, these pros/cons need to be carefully weighed.

3. Regular Cash Payouts: By maximizing the cash paid out to members, the cooperative increases member income in the short term. However, the cash that the cooperative pays out as patronage dividends cannot be used by the firm to fuel growth or increase productivity, which could negatively impact the firm's growth potential. It should be noted that federal law requires that any WNA must be paid out at least 20% in cash to help members cover the tax liability they will incur.

The other key consideration is how long the co-op will retain written notices of allocation. The best way to think about WNAs is that they are investments members make in the future growth of the business. Therefore, the longer the cooperative can retain the funds (such as 15 years or even as long as retirement), the greater impact this investment can have on future growth. In home care, the tenure of caregivers, even in a cooperative, is shorter than other industries, so this presents a complicating factor.

The split the cooperative chooses will vary with the goals of the cooperative and the related capital needs of the firm, the needs of the firm's employee-owners (i.e. low-wage workers versus higher wage workers), and the length of redemption period for the notices of allocation. A good starting point for determining the split is 50-50, although ICA generally

recommends that at a minimum, 30% of net income is allocated to the collective account. In a volatile and unpredictable industry such as home care, it is wise to reserve some funds to address future unknown expenses. However, more frequent distribution of patronage dividends to members may also be wise, however, given the low-wage status of most caregivers in the industry. A well-run home care cooperative will have given its allocation strategy thorough consideration.

Cooperative Net Profit Distribution

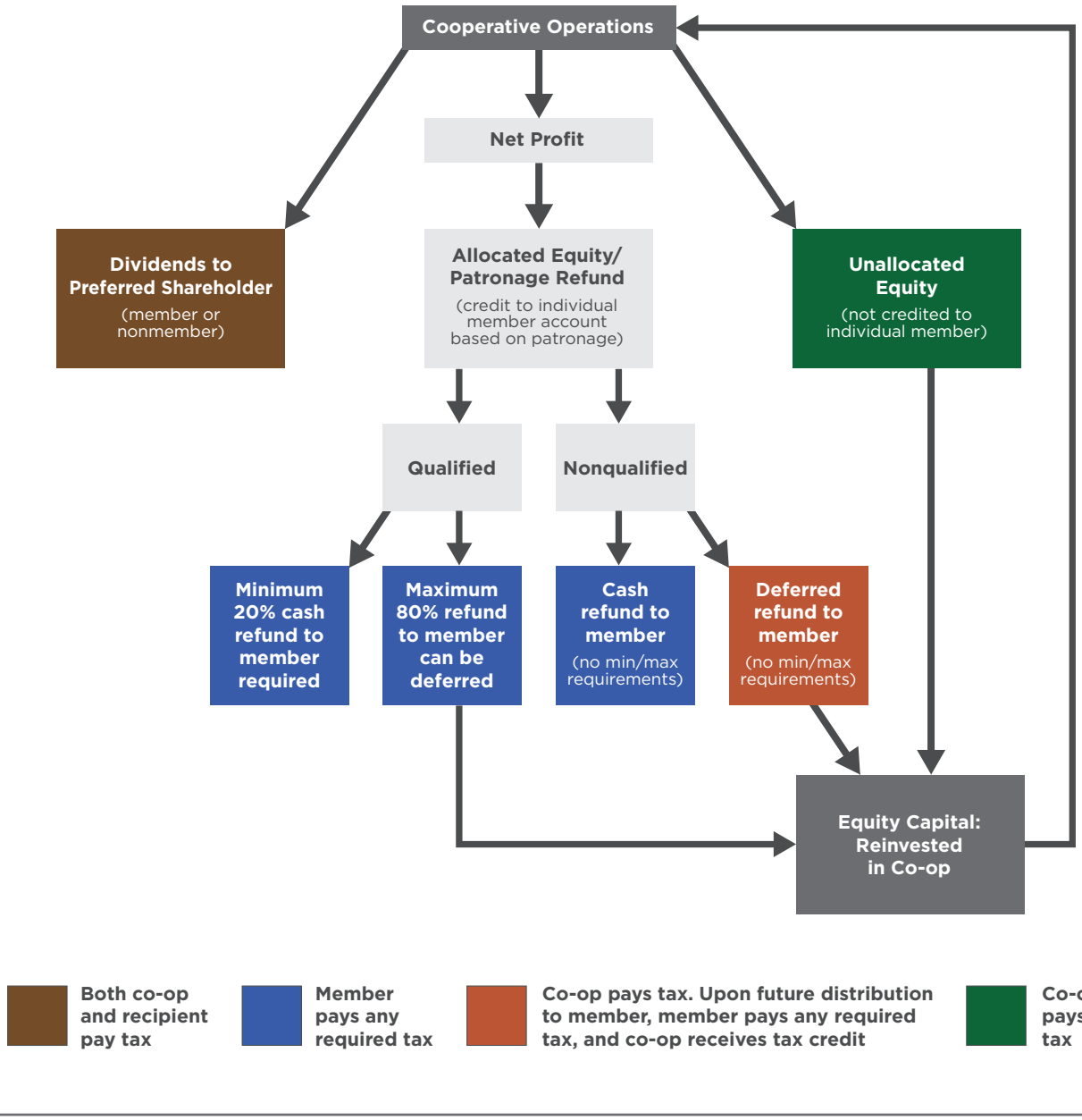


Image credit: **University of Wisconsin Center for Cooperatives**

Appendix E: Home Care Cooperative Case Studies: A Tale of Two Start Ups

Peninsula Home Care, Port Townsend, WA: A private pay model

The idea for Peninsula Home Care (PHC) Cooperative came from a core group of five workers who first heard of the idea of a worker-owned home care cooperative through a chance conversation with the local food cooperative manager, who, in turn, had heard of it through the local cooperative development center, the Northwest Cooperative Development Center (NWCDC). Local home care workers knew that something must be done to improve pay and conditions, and the cooperative model seemed to be just the thing. A call to NWCDC confirmed their interest, and NWCDC quickly sent an experienced cooperative developer, Deborah Craig, to meet with the group and discuss their situation. The fact that a similar group of home care workers had successfully formed their own worker-owned business less than 100 miles away in nearby Bellingham, Washington provided both inspiration and the practical example of a peer organization.

NWCDC staff helped the group to figure out a start-up budget including state licensing fees, office rental, and a few months of payroll for their initial administrative staff. At first, co-op leaders approached their local credit union with a loan request for $35,000 in working capital start-up funds. When the loan officer told them that all co-op members would be required to guarantee the full loan, they decided not to apply. Fortunately, about this same time the group heard about LION, the Local Investment Opportunity Network, a club of Port Townsend area residents willing to make loans to help local businesses grow. PHC Board President, Kippi Waters, made a presentation to the group. Recognizing the importance of quality home care for the area's aging population, four LION members quickly offered help. The group was able to raise their entire start-up budget in a single evening, in low interest (4-5%) notes, with interest-only payments for the first 12-24 months.

Within 10 months of their first organizing meeting in April of 2015, Peninsula Homecare Cooperative was open for business. Four of the five initial organizers became part of the new co-op, joined by 10 more, with additional members joining as the co-op slowly gained momentum and added customers. Within the first five months of operations the co-op had achieved profitability. By the end of 18 months, they had paid all of their LION lenders back.

First year 2016 revenues (10-month year) were about $150,000. This figure grew almost four-fold in their first full year of operations in 2017, and by mid-year 2018, sales were showing another 45% increase.

Technical assistance throughout the start-up period was provided by the staff of the Northwest Cooperative Development Center. The co-op was also fortunate in that co-founder and initial Board President, Kippi Waters, had significant previous business and communications experience, and all the members were experienced caregivers. The co-op was further aided in their smooth start up by members who were willing and able to move hours to the new business on a gradual basis, keeping their old clients and agency assignments until PHC could find them full-time hours. Finally, the co-op was also helped tremendously by a local community that was attuned to the needs of their aging population and willing to make an investment in helping the new co-op to start up.

Cooperative Care, Wautoma, WI: A cooperative serving the public pay market

Waushara County, WI, like many rural areas in America, had lots of wide-open spaces, few stoplights, and an increasingly elderly population. Caring for elders presents a particular challenge in sparsely-populated communities, as clients live far from care institutions, and caregivers spend many hours on the road between client visits. Throughout the 1990s, Waushara County muddled through as best they could, providing a patchwork of care drawing on the limited resources available in the area. At the time, a State of Wisconsin program called Community Options provided in-home services to help keep seniors in their own homes and out of nursing homes. Waushara County used a system of independent caregivers to accomplish this. County staff kept a system of two recipe boxes: one filled with index cards with the names of residents needing care and the other with cards with names of local Personal Care Workers and

Certified Nursing Assistants available and willing to provide basic home care services on call. Workers were paid through a third-party agency and were classified as independent contractors working in the service of the individual clients. Wages were low and benefits nonexistent under this system, but it worked in a rudimentary way, stretching resources as far as possible. Even so, Lu Rowley, the Waushara County director of human services at the time, worried that instead of confronting the problem of inadequate resources, the county was inadvertently perpetuating it and adding to the ranks of the county's working poor rather than trying to craft a more substantive solution.

This situation changed in the mid-1990s when a care worker in a nearby county was injured in a fall at a client's home. The caregiver took the county to court on a workers' compensation claim and prevailed. The court ruled that despite the county's attempt to distance itself through the use of a third-party fiscal intermediary, caregivers were effectively acting as county employees and should be treated as such. This created a substantial new liability for the county involved and arguably for other counties, like Waushara, that used a similar payment scheme. The ruling reinforced Rowley's misgivings about the entire recipe box system and cemented her resolve to find a better alternative for providing home care services for county residents.

Rowley had a different background than many people who held her position in other counties, one which would help her to become the "godmother" of Cooperative Care. In addition to being a social worker, she had taught social work at the graduate level, traveled widely, and had helped run several businesses. She thought about systems from an integrated perspective and was not afraid to try an entrepreneurial approach. When Rowley heard about another successful worker-owned cooperative home care agency, Cooperative Home Care Associates (CHCA) in the Bronx, New York, that had successfully used the cooperative model to improve job quality and worker retention for home health workers in their market, she wondered if the same strategy might work in rural Wisconsin. To find out if such an idea might work, Rowley applied for and received a series of grants totaling $50,000 from the Wisconsin Department of Health and Family Services to explore creative ways to address the recruitment and retention of long-term care workers, including the cooperative option. Social worker Diane Harrington was contracted to conduct the study, and USDA staff member Margaret Bau agreed to assist, providing key education and technical assistance about cooperatives.

In November 1999, Harrington and Bau met with a group of caregivers who had been providing services under the county's former payment model to get feedback on the idea of forming a worker-owned cooperative. For many of the caregivers who were working in isolation at clients' homes, the meeting was the first time that they had gathered together with a group of fellow caregivers. Bau and Harrington presented the idea of organizing into a worker cooperative and it resonated with many of the caregivers. Eighteen of those assembled volunteered to be part of a steering committee to guide the project. This group met monthly for the next 15 months as the feasibility study and business plan evolved.

When an initial business plan developed by a paid consultant proved useless, co-op organizers took on the task of developing the business plan themselves, with the input of caregivers. Staff of CAP Services, a local Community Action Agency, provided key assistance in developing the financial projections. The steering committee continued to meet, drafting a mission statement and discussing how patronage and other decisions would be made in their co-op. Finally, the product was ready to present to the potential membership base for action.

On January 17, 2001, the group voted to proceed and elected their first board. Donna Tompkins, a caregiver with significant previous community service experience, was selected as the initial board president. Her quiet but strong leadership would prove crucial to the success of the new co-op in its early years. Cooperative Care was officially incorporated the following month with 63 initial members.

Key to the feasibility of the new venture was an $850,000 contract the co-op received to provide home and personal care services for Waushara County. On the strength of this contract (and a modest $4,000 in member equity), the co-op was able to borrow $125,000 in working capital from a local bank to begin operations. A retired executive of the local electric co-op provided essential advice and assistance in setting up

administrative systems and hiring staff. The co-op was fortunate that it did not have to expend time and resources in recruiting direct care workers to join the new agency. All 60+ members of the co-op were rolled over from the previous recipe box system to Cooperative Care over a six-week period, effectively making the "start-up" process much more like that of a conversion of an existing agency. On June 1, 2001, Cooperative Care opened for business.

Over the years, Cooperative Care's fortunes have ebbed and flowed, as the organization successfully weathered the challenging transition from an intimate, county-based care system to a new, more competitive system of reimbursement through a network of regional, for-profit Managed Care Organizations (MCOs). Today, the Co-op's 37 caregivers serve a seven-county area, an array of private as well as public pay clientele, and are managed by a core group of experienced member-owners.

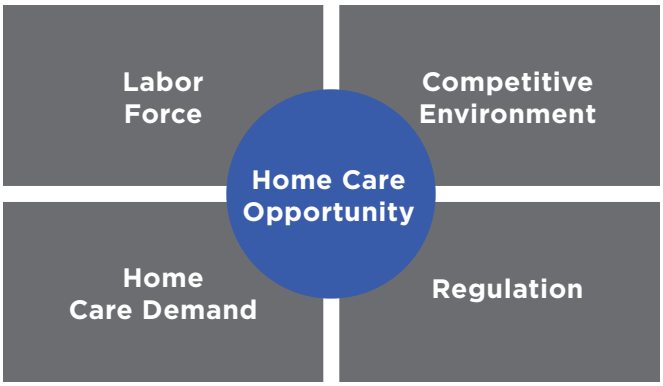
Common themes and observations:

Both examples illustrate the importance of community support to the successful start up of a worker-owned home care agency. Peninsula Homecare was able to rely on community members for the entirety of their start-up funding, while the Cooperative Care team's personal relationships with their community bank and steadfast support from County officials ultimately secured the financing they needed to launch.

At least one other start-up home care cooperative received a working capital loan from a CDFI to augment funds from a single local investor, and yet another relied on significant volunteer labor and funds from family; at least two efforts also reportedly tried crowd funding, with little success. In addition, an earlier effort serving a different rural Wisconsin market ultimately failed, in part because state MCOs were not able or willing to play the supportive role that Waushara County had for their co-op. None of these approaches ended up being able to provide the amount of working capital that was actually needed. So, while the stories of Peninsula Homecare and Cooperative Care offer insight and guidance into potential paths forward for new start-up cooperatives, the role of more traditional lenders for home care start-ups in areas where other local financial support does not exist should not be underestimated.

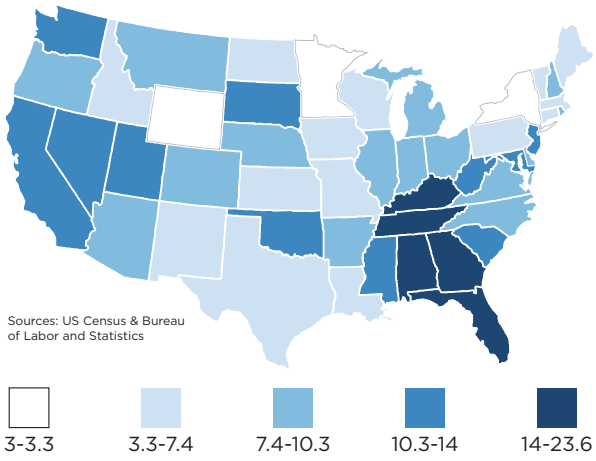
Appendix F: State-Based Opportunities

In 2017, The ICA Group conducted an analysis of the home care markets in seven states: North Carolina, Minnesota, Pennsylvania, New York, Texas, Washington, and New Mexico. A report on the market opportunity in Wisconsin was also written in 2016. Based on these analyses, The ICA Group has developed a framework around the regulatory environment, the aging population, the labor market, and the competitive environment to help determine where the best locations are for home care cooperative development. Not surprisingly, states with existing home care cooperatives such as Pennsylvania, New York, and Washington rose to the top of the list.



In an industry where recruitment and retention are such important factors for the success of a home care business, the ratio of clients to potential caregivers is an important metric. Nationally, there are just over eight clients for every one potential caregiver, but there is wide variation across states. States such as New York, Minnesota, and, to a lesser extent, Pennsylvania are significantly below the national average while many states in the south have a significant undersupply of caregivers. In states with a larger caregiving workforce it will be easier and cheaper for home care cooperatives to add caregivers to their staff and to meet growth opportunities.

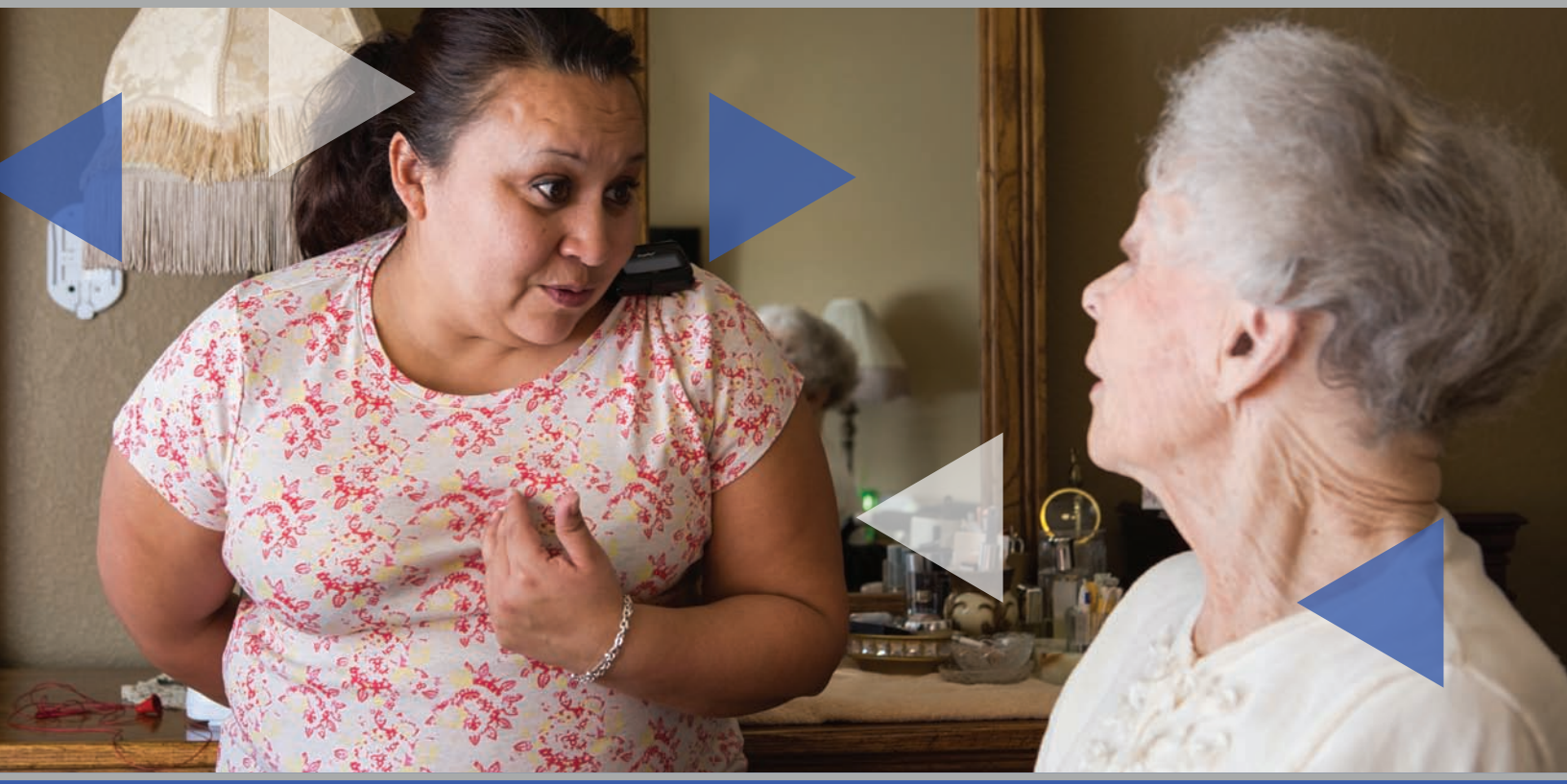
Ratio of home care clients to caregivers by state



The other side of the home care opportunity equation is both the current size and expected growth in demand for home care services. Washington state, for example, has an average size home care population, but the state is expecting rapid growth in its aging population (3.6% more than the national average). The regulatory environment is also incredibly important to evaluating the type of opportunity for a home care cooperative in a state. For example, New York state currently has a moratorium on new home care agency licenses, effectively killing any opportunity to starting a new cooperative. On the other hand, other recent regulatory opportunities in the state significantly incentivize consolidation of home care businesses, increasing the opportunity for financing conversion, acquisitions, and internal growth in the state.

Finally, the market concentration and size of current competitors in a state can significantly impact the ability of a home care cooperative to start up or grow. In general, the home care market is highly fragmented with few large players; on the other hand, future trends point towards significant consolidation. Like many of the factors we look at in the home care market a fragmented market can point to both opportunities and challenges in a state. States with less consolidation and smaller sized home care businesses may signify an easier start-up environment.

BUILDING COMMUNITIES OF OPPORTUNITY
THAT BREAK BARRIERS TO SUCCESS



Cooperative Development Supports Our Larger Vision

Capital Impact Partners champions social and economic justice for underserved communities, transforming them into communities of opportunity that foster good health, economic opportunity, and interconnectedness. Through mission-driven lending, incubating social impact programs, impact investing, and policy reform, we partner with local communities to help create equitable access to health care and education, healthy foods, affordable housing, and dignified aging for those most in need.

2.5 MILLION
PATIENTS
receiving health care at 533 community health centers

253,000
STUDENTS
in 248 high-quality charter schools

1.1 MILLION
PEOPLE
with access to healthy food from 88 local retailers

37,000
ELDERS
aging in their community through 190 communities

38,000
AFFORDABLE HOUSING
units in 246 communities

870,000
COOPERATIVE CUSTOMERS
served by 291 co-op businesses

WE HAVE DEPLOYED OVER **$2.5 BILLION** TO SERVE NEARLY **5 MILLION PEOPLE** AND CREATE MORE THAN **32,500 JOBS** NATIONWIDE IN SECTORS CRITICAL TO VIBRANT COMMUNITIES.

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