

KINDRED HOME CARE: CHOOSING GROWTH OPTIONS

Ramasastri Chandrasekhar wrote this case under the supervision of David Barrett solely to provide material for class discussion. The authors do not intend to illustrate either effective or ineffective handling of a managerial situation. The authors may have disguised certain names and other identifying information to protect confidentiality.

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In June 2017, Billy English, chief executive officer (CEO) of Kindred Home Care (Kindred), a home care provider in the province of New Brunswick, in eastern Canada, was evaluating the five-year growth plan that he had just finalized. His goal was to reach an annual revenue of CA\$50 million¹ from the present \$13 million by 2022. An integral part of the revenue target was an increase in the number of weekly service hours from 12,000 to 35,000 and expansion of the workforce from 490 to 1,500 (see Exhibit 1).

English also wanted to improve Kindred's profit margin. While the direct labour and related expenses as a percentage of revenue had dropped from 94 per cent in 2012 to 84 per cent in 2017, English was keen to increase the margin further. However, it would be difficult to do so because the provincial government of New Brunswick was regulating the business of home care so closely that it not only fixed the billing rate for service providers like Kindred but also made the billing rate non-negotiable.

English was trying to choose from three options for scaling up his business. The first option was to scale up with franchising. Franchising was a common business model in home care in North America, and, by sheer chance, English had just obtained a fast-track model for deployment. The second option was to scale up Kindred with acquisitions. The company was familiar with integrating acquisitions, and there were takeover targets readily available in an industry that was witnessing consolidation. The third option was to scale up Kindred by establishing a footprint in the United States. The market, located right across the border, seemed attractive, particularly if Kindred were to go after private clients in rural America.

English's dilemma was compounded by lack of access to external capital. Kindred did not have tangible physical assets in terms of either brick-and-mortar facilities or plant and machinery, making it difficult to borrow money from banks to fund its growth plan. However, the company had internally accrued funds of \$2 million to finance scaling up. English wondered which of the three approaches to scaling up would make the best use of the resources Kindred had.

CANADIAN HEALTH CARE INDUSTRY

Canada had what was known as a universal health care system, in which the costs of health care were borne in large part by the government. The country had been spending over 10 per cent of its gross domestic

¹ All amounts are in Canadian dollars unless otherwise stated.

product (GDP) annually on health care. In 2017, for example, Canada spent \$243.3 billion on health care,² equivalent to 10.4 per cent of its GDP.³

Other high-income countries that also provided universal health care included Australia, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom. Canada differed from them in some ways. It was the only country among the nine where private financing for “medically necessary” services was disallowed and where the private sector was involved in delivering only “non-medical” services.⁴ The ability of outpatient and inpatient specialist physicians to practise both in publicly funded universal settings and in private settings was also severely restricted in Canada. The country also had fewer physicians (230 for every 100,000 people),⁵ fewer acute-care beds (260 for every 100,000 people), and higher wait times (an average of 21.2 weeks) than its peers.⁶

In 2017, Canada had 6.2 million people above the age of 65. This group made up 17 per cent of the national population and represented 34 per cent of hospital cases and 58 per cent of hospital stays. The Canadian Institute for Health Information estimated that Canadians 65 years of age and above accounted for a disproportionate 46 per cent of national health care dollars spent by the provinces and territories.⁷

IBISWorld estimated that the number of Canadians 65 years of age and above would increase at an annualized rate of 3.4 per cent, whereas the general population would increase at 0.8 per cent, signifying that the elderly would make up an increasingly large share of the total Canadian population.⁸ In turn, because the elderly preferred home care to institutional care,⁹ the increase in the elderly population would fuel the demand for home care services.

Seniors were, however, a diverse group. Older seniors (those who were 75 years of age and above) numbered 2.6 million, comprising 7 per cent of the population. It was this segment that relied more heavily on health care services. In 2016, for example, per-person spending per annum for seniors increased considerably with age: \$6,481 for those 65–69 years of age, \$8,348 for those 70–74 years of age, \$11,081 for those 75–79 years of age, and \$20,397 for those who were 80 years of age and older.¹⁰ The population of 75-plus seniors was expected to more than double over the next 20 years.¹¹

² Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2018* (Ottawa, ON: Canadian Institute for Health Information, 2018), accessed December 22, 2018, www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report-2018-en-web.pdf.

³ World Health, “Current Health Expenditure (% of GDP),” World Bank Organization Global Health Expenditure Database, accessed December 22, 2018, <https://data.worldbank.org>.

⁴ Bacchus Barua, *Waiting Your Turn: Wait Times for Health Care in Canada, 2017 Report* (Vancouver, BC: Fraser Institute, 2017), accessed December 22, 2018, www.fraserinstitute.org/sites/default/files/waiting-your-turn-2017.pdf.

⁵ “Canada’s Doctor Supply Has Grown Faster than the Population for the Past Decade,” Canadian Institute for Health Information, September 28, 2017, accessed December 22, 2018, www.cihi.ca/en/canadas-doctor-supply-has-grown-faster-than-the-population-for-the-past-decade.

⁶ Barua, op. cit.

⁷ Canadian Institute for Health Information, *Seniors in Transition: Exploring Pathways across the Care Continuum* (Ottawa, ON: Canadian Institute for Health Information, 2017), accessed June 10, 2019, www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf.

⁸ IBIS World, *Home Care Providers in Canada: Market Research Report* (Industry Report 62161CA), October 2018, accessed November 27, 2019, www.ibisworld.com/canada/market-research-reports/home-care-providers-industry.

⁹ Canadian Life and Health Insurance Association Inc., CLHIA Report on Long-Term Care Policy, 6, July 29, 2014, accessed on December 6, 2019, [www.clhia.ca/web/clhia_ip4w_ind_webstation.nsf/page/3C342451F891CF1D85257A240044F961/\\$file/LTC_Policy_Paper_1_EN.pdf](http://www.clhia.ca/web/clhia_ip4w_ind_webstation.nsf/page/3C342451F891CF1D85257A240044F961/$file/LTC_Policy_Paper_1_EN.pdf) accessed November 29, 2019.

¹⁰ Canadian Institute for Health Information, *National Health Expenditure Trends*, op. cit., 26.

¹¹ Canadian Institute for Health Information, *Seniors in Transition*, op. cit., 7.

HOME CARE SEGMENT

Revenue from the home care industry in Canada had grown at 3.2 per cent per annum over the previous five years to reach \$4.2 billion in 2017. The total number of employees had grown at an annualized 3 per cent to reach 66,329 in 2017. The number of establishments providing home care had grown at an annualized rate of 6.3 per cent over those same five years to reach 3,726 in 2017.¹²

Home care consisted of health and support services provided at homes and retirement communities, and in other community settings. The target group consisted of people with acute, chronic, palliative, or rehabilitative health care needs. The care provided encompassed a range of services, including help with light shopping, cleaning, and housekeeping; therapeutic care like nursing and rehabilitation; and personal care like bathing and dressing. It also often included administration of medication and access to 24-hour emergency help.¹³ Some home care services specialized in non-medical care like meal preparation, grooming, bathing, transportation, and companionship for seniors; some offered post-surgical assistance, post-partum care (care after childbirth), staffing solutions, child care, and even pet care as part of their general services.

The *Canada Health Act* considered home care services as part of what it called “extended health care services” and, therefore, outside the purview of universal health care.¹⁴

The home care industry was in the growth stage of its life cycle. Between 2013 and 2023, the industry’s contribution to the overall economy was forecast to grow at an annualized rate of 3.7 per cent. In comparison, Canadian GDP was expected to grow at an annualized 1.9 per cent during the same period, indicating that the industry was growing faster than the Canadian economy.¹⁵

The increasing popularity of home care services was due to advances in medicine that promoted independence among the elderly. Also, advances in biomedical technology had not only enabled remote digital monitoring but also allowed for more health care procedures to be carried out in homes.

The industry was highly fragmented, with many small operators offering a wide variety of services. Sixty-two per cent of home care providers were non-employing sole proprietorships. Due to the relative ease of establishing a home care business, along with the lack of necessity for formal accreditation, individuals who could find and secure clients could easily get a start in the industry. Home care was also a high-churn business, with the bulk of industry exits happening within the first 60 days.¹⁶

Larger, consolidated industry operators did prevail, but the labour-intensive and low-capital nature of the business provided little incentive for operators to seek significant economies of scale. The larger players included ParaMed Home Health Care (ParaMed), Bayshore HealthCare (Bayshore), CBI Health Group (CBI), Nurse Next Door Professional Home Care Services Inc., and Home Instead. In 2017, ParaMed had revenue of \$434 million; Bayshore, \$273 million; and CBI, \$252 million.¹⁷

NEW BRUNSWICK

New Brunswick was a maritime province in eastern Canada, bordering on the US state of Maine and known as the old-age capital of Canada (see Exhibits 2 and 3). Out of a total population of 756,780, New Brunswick

¹² IBIS World Industry, op. cit.

¹³ Canadian Institute for Health Information, *Seniors in Transition*, op. cit., 34.

¹⁴ Ibid, 10.

¹⁵ IBIS World Industry, op. cit., 12.

¹⁶ Ibid.

¹⁷ Ibid.

had 147,929 seniors, equivalent to 19.5 per cent of the population. The provincial government forecasted that by 2038, seniors would represent 31.3 per cent of New Brunswick's population, in contrast to the projected national average of 24 per cent.¹⁸

There were three major population challenges facing New Brunswick: lower birth rates, out-migration of youth, and a growing number of seniors. The province's birth rate had declined from 0.94 per cent in 2006 to 0.87 per cent in 2016.¹⁹ The phenomenon of youth out-migration prevailed among those who were 15–35 years of age. Youth were leaving New Brunswick to work and settle in other parts of Canada and the world, taking with them their energy, skills, and innovation and affecting the province's economy, tax base, and social system.²⁰ With fewer births and more of those born in the province leaving, the ratio of seniors in New Brunswick was projected to grow by 43 per cent from 2010 to 2020,²¹ marking one of the most significant demographic shifts in the province's history and the fastest rate of aging in Canada.

In 2014, the New Brunswick government had announced a three-year “Home First” strategy aimed at helping seniors in the province remain in their homes and communities for as long as possible. The strategy tried to keep hospital admissions, lengthy hospital stays, and direct transfers from hospitals to long-term care facilities as last resorts.²²

KINDRED HOME CARE—COMPANY OVERVIEW

The company was founded in 1986 in St. Stephen by long-time resident Paul English to provide family support services and teach life skills to local parents. St. Stephen was a rural town in Charlotte County, New Brunswick, situated on the east bank of the St. Croix River, which ran across a section of the border with the United States. The company's offerings soon expanded into home care for seniors—not only because there was a growing need for it in St. Stephen but also because the provincial government had asked the company to step in and supplement its own ongoing efforts regarding senior care. Over the next two and half decades, Paul English expanded the business to employ 225 care givers serving communities in different rural locations of the province. The company was known for its friendly, local approach to home care.

Seeking retirement in 2013, Paul English and his wife sold the business to their son Billy English, who became the new CEO. English brought in Will Bernard as his business partner and chief operating officer.

The new owners were clear that Kindred would continue to focus on serving rural communities—an approach that they both believed was part of the company's foundation. Rural orientation was a competitive advantage, as they saw it, on two grounds: Many of the company's peers in the province were focused on cities, thus leaving a white space in the countryside. There was also lower employee turnover and less customer churn among rural communities, making relationship building—a crucial component of business success—that much easier.

¹⁸ Government of New Brunswick, *We Are All in This Together: An Aging Strategy for New Brunswick*, January 2017, 15, accessed June 5, 2019, www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/Seniors/AnAgingStrategyForNB.pdf.

¹⁹ Claudine Provencher, Anne Milan, Stacey Hallman, and Carol D'Aoust, *Fertility: Overview, 2012 to 2016* (Ottawa, ON: Statistics Canada, 2018), accessed December 23, 2018, www150.statcan.gc.ca/n1/pub/91-209-x/2018001/article/54956-eng.htm.

²⁰ Government of New Brunswick, *New Brunswick Population Growth Strategy 2013–2018* (Fredericton, NB: Province of New Brunswick, 2013), accessed December 23, 2018, www2.gnb.ca/content/dam/gnb/Departments/petl-epft/PDF/PopGrowth/NBPG_Strategy_2013-18.pdf.

²¹ Government of New Brunswick, *New Brunswick Population Growth Strategy*, op. cit., 2.

²² Government of New Brunswick, “Details of First-Year Investments in the Home First Strategy Revealed,” press release, May 14, 2014, accessed November 27, 2019, www2.gnb.ca/content/gnb/en/news/news_release.2014.05.0550.html.

English and Bernard had grown up using technology as part of their day-to-day living, and they were struck by how the province's home care industry was conservative in this regard and slow to adapt to technology. They were also struck by the manual nature of Kindred's own working practices: employee schedules were recorded in spreadsheets and stored in different locations, without coordination; systems were not tight-knit; and it was difficult to centrally access customer data, affecting not only timely billing but also quality of customer service. The duo decided to leverage innovations in mobile technologies to modernize and expand the business.

English introduced a software platform from Salesforce.com Inc. (Salesforce), an information technology vendor that specialized in developing customized customer relationship marketing packages for small and medium-sized companies. Salesforce's cloud platform, known as Chatter, enabled Kindred employees, who both worked from their homes and were perpetually on the move, to collaborate closely on day-to-day operations and update files in real time, thus replacing email messaging. If a caregiver did not show up at a customer's home within minutes of the designated time, the system would alert the team, and a replacement would be found and dispatched immediately. By incorporating digital tools into a non-technology-savvy industry that relied on legacy systems, Kindred was able to not only maintain exceptional patient care but also pursue new possibilities for business growth. Employee productivity went up: within the first six months, response times to customer inquiries improved by 300 per cent.

English introduced two other changes. He changed the customer billing cycle from monthly to weekly and the employee pay cycle from weekly to biweekly. These changes brought down outstanding receivables and improved cash flow.

The company was soon data driven. It was beginning to collect statistics on business issues like what caused a long-standing customer to go to the hospital, how long the individual stayed in the hospital, and whether the patient was enrolled at a long-term care facility or returned home. Kindred was cross-referencing the information with other data points in the system in an effort to fine-tune its growth strategy.

Kindred did not have brick-and-mortar locations in the communities it served, except for its head office in St. Stephen. It had regional managers who worked from their homes and coordinated the activities of caregivers in the field.

Of the company's 400 clients, more than 90 per cent had been referred to Kindred by the New Brunswick Department of Social Development. The department would send a social worker to assess the client and brief Kindred on the department's expectations. The department determined both the rate that Kindred could charge its clients and the minimum it could pay to its workers.

Kindred was providing non-medical care. Unlike many of its peers, Kindred did not provide nursing care. Its services ranged from light housekeeping to assistance with cooking, grooming, bathing, and dressing. Buying groceries, doing errands, and medication reminders were also part of its offerings. Its caregivers would not administer medication but stepped in to do activities that did not require the skills and attention of designated nurses, such as cleaning a catheter. Designated nurses were part of Extra-Mural, a government-run program that employed nurses and occupational therapists in New Brunswick.

In addition to seniors, Kindred provided home care services to veterans, adults with disabilities, and adults recovering from illness or injury. It also provided partners and families with an occasional break from constant care.

By June 2017, Kindred had 490 caregivers on its payroll, 95 per cent of whom were female. Many of them were mothers whose kids had left home and who wanted to supplement their pensions with hourly pay of \$13.50 at Kindred. Some were personal support workers who were already serving on the front lines of provincial health care. Kindred required new hires to live locally, only a short commute from the clients in their area.

Although Kindred employees did not require medical skills, they still required a level of training similar to those required by employees at a special care home or nursing home. New hires were enrolled at a mobile training school named PeakForm Health and Safety Academy (PeakForm), which the company had set up to offer both online and offline training to anyone, anywhere in the province. The trainers were nurses who were certified to offer the personal care aide (PCA) training course. PeakForm had become a profitable addition to Kindred, training more PCAs—for both Kindred and its competitors—than any other approved training institution in the province of New Brunswick.

In 2016, Kindred had revenues of \$11.1 million and net income of \$424,735 (see Exhibit 4). It had reserves of \$1 million and a cash surplus (see Exhibits 5 and 6).

In 2016, English started billing twice a month (as opposed to once a month), and changed it within months to weekly, which led to a substantial drop in receivables for the year.

ISSUES WITH SCALING UP

The partners had two major motivations in scaling up. First, as a business proposition, senior care would never run out of customers. There would always be households seeking to provide quality home care for their aging family members, and there would always be seniors seeking to maintain their independence as they aged. Second, senior care also meant helping the community. People at Kindred felt good about what they were doing, however varied, because it meant that they were helping others and making a difference in people's lives; therefore, those who worked in the industry, in whatever capacity, would be self-motivated.

In choosing a new geographical area for scaling up, English had some basic considerations. The first was the general population size of the targeted area; the number of seniors in the area would be secondary. The area had to have a radius of 50 kilometres so that the manager heading the region could move 25 kilometres in either direction. Another factor to consider was the level of competition in the area. The presence of home care services was a clear indicator of demand. If there was a company with 60–70 employees already working the region, English was keen on having a footprint because Kindred could then make a mark of its own.

Franchising

Senior care was a natural fit for franchising because it involved what were known as “high-touch” interactions with individual customers: relationships were person to person rather than relying on automated, self-serve, or online systems. Franchising was a tried and tested business model. Several small franchised home care companies, in both Canada and the United States, were making gross annual revenues of more than \$1 million and realizing gross margins of 30–40 per cent.

The main attractions of franchising for English were twofold: Kindred did not have to make investments up front because the start-up costs would be borne by the franchisee, and English could also set in motion an income stream for Kindred consisting of a combination of a non-refundable franchisee fee (as the price of entry) and a percentage of annual billings (as royalty). However, Kindred would not own the business of the franchisee and would therefore not be involved in day-to-day operations.

English also had three major factors to consider with franchising. First, if the goal was to reach \$50 million in enterprise-wide sales, franchising would likely be the fastest way to do so; but if the goal was to reach \$50 million in corporate sales on Kindred's own account, as was indeed the case, franchising would not be the best route—that is, unless the number of franchisees in the system were proportionately large.

Second, franchising opportunities could only be explored outside of New Brunswick. They would not work in New Brunswick because the provincial government set the bill rate, which was also non-negotiable. The margins, already low at less than 8 per cent, would have to be shared with the franchisee. It was not surprising that New Brunswick did not have a single franchisor in home care.

Nova Scotia seemed a good province for Kindred to commence its franchise model. Like New Brunswick, it was maritime and largely rural; unlike New Brunswick, it had better margins because of private clients. Nova Scotia would provide a learning ground before moving to other provinces. Ontario would be attractive because, notwithstanding higher wage rates, the bill rate would be higher. Quebec would not be part of English's expansion plans because of its unionized environment in which, English anticipated, client care would likely become secondary to employee welfare.

The third consideration was that it would normally take a year to build internal systems, develop business structures, and put together training manuals. It would be another year for the first few franchisees to stabilize operations and begin to grow organically. It would not be until the third year that the business would begin to gather momentum.

However, English had an opportunity to reduce the lag to 10 months. He had been interviewing candidates for a business director role, with a mandate to spearhead the business in Nova Scotia. One of the applicants he was in touch with was Lori Mackenzie, who had built and recently sold a successful 90-unit national franchise in Canada called Massage Addict Inc.

English saw merit in leveraging Mackenzie's track record in franchising massage therapy—a recognized health care treatment in its own right—to launch Kindred's own entry into franchising. Mackenzie would bring in her previous business partner, Chris Harker, together ensuring that the processes, which seemed fully replicable, were in place. The duo had also suggested that Kindred launch an independent company for the franchising business with a name that was not medical, corporate, or sterile (as most home care companies were). English and Bernard, together with the duo, had decided, in consultation with a branding company in Toronto, on the name Viva Home Living (Viva), which meant “long live home living” and sounded “joyful and celebratory.”

An important requirement was to build a software program for deployment in the franchise model that could leverage the Salesforce platform already being used at Kindred. It would cost \$100,000 to develop the software—the only major investment in the new line of business. A separate subsidiary would be set up to own the intellectual property (IP) associated with the software, and the subsidiary would also be eligible for technology grants from the government. The investment in IP would be recouped through an annual technology fee of a few hundred dollars per month, paid by the franchisees. The one-time franchise fee would be \$49,000; it would be non-refundable.

The initial investment required on the part of a franchisee to open a single senior care franchise was between \$92,500 and \$143,000 (see Exhibit 7). Franchisees did not need office space or a lot of equipment. They could break even within six months because the billing rates in Nova Scotia were not determined by the provincial government. Kindred was free to set its rate such that it would have a 30–40 per cent gross margin. Viva could sign up one or two franchisees per month, averaging about 20 per annum over a four-year period, with each franchise achieving \$1 million in sales.

English was keen on selling two to three dozen franchises and testing the model for a year in Canada before taking it to the United States. He was targeting several hundred franchises in the long run.

Taking the Acquisition Route

According to English, the home care industry was ripe for consolidation. Many business owners, usually a husband and wife team, were in their sixties. They had reached the limits of their potential, as they saw it, and were not interested in investing in technology or growing further. According to English, these business owners were keen on cashing out. His own acquisition of the company from his parents was an example.

A home care company in Halifax, the largest urban area in Atlantic Canada, with \$4 million in sales would have multiple buyers, but one that was doing \$3 million in annual sales in a rural area would not have many buyers. As someone who had developed his competence in rural home care, English saw rural home care as an opportunity. He had reached out to brokers focused on the East Coast (like Deloitte Touche Tohmatsu Ltd. and Grant Thornton LLP) to let them know that Kindred was looking to make strategic acquisitions in rural areas in Nova Scotia and the United States.

As it happened, English was soon evaluating two acquisition opportunities simultaneously. One was in Halifax; the other in New Brunswick. The former had \$3.5 million in annual sales, with 150 employees and 220 customers. The owner's asking price was \$3 million, but English was willing to pay the industry norm of three times the net earnings, which amounted to \$1.6 million and was well within the funds he had set aside for scaling up. The company in New Brunswick had annual sales of \$4 million, with 180 employees and 250 customers. The owner was asking for \$1 million, at three times the net earnings.

English was keen on moving into Nova Scotia to free Kindred from the stranglehold of non-negotiable bill rates in New Brunswick. English could also tap into private clients in Nova Scotia. However, in spite of the lower billing rates and margins, the new opportunity in New Brunswick was compelling because it would add \$4 million in annual billings right away.

While he was grappling with the two choices, a new expansion opportunity surfaced—with no up front costs. A home care company with nationwide presence in Canada was not renewing its contract with the province of New Brunswick. The reason it cited was that the official rate was not sustainable and that the company was finding it difficult to hold on to its business in New Brunswick. The provincial government had asked Kindred if it would step in and fill the void. Kindred had to absorb the 250 employees who were soon to be out of work and take over the services where the national chain had left off. Kindred would gain about 400 customers. English thought he could pull it off and make a small profit because he knew the local market in New Brunswick—a strength he could not bring to pursuing the option of a national chain.

English now had three acquisition options to choose from.

Expanding into the United States

An expansion into the United States would be into the country's rural, rather than urban, communities. The United States was a huge market, with 10,000 people turning age 65 each day.²³ Like Canada, the United States was a fragmented market, with no major players having a dominant market share. It was also different in the sense that there was a distinction there between home care and home health care.

²³ Russell Heimlich, "Baby Boomers Retire," Pew Research Center, December 29, 2010, accessed November 29, 2019, www.pewresearch.org/fact-tank/2010/12/29/baby-boomers-retire/.

The US home care industry, valued at about US\$5.4 billion in 2017, was concerned with sustaining people's quality of life in their homes and keeping them safe and comfortable in their natural habitats. It involved personal services such as help with housekeeping, meal preparation, bathing and dressing, taking medications, and doing errands like grocery shopping. This would be Kindred's domain. On the other hand, the US home health care industry was a larger market, valued at about US\$89.2 billion in 2017. It was concerned with helping individuals get back to normal after an event like a hospital stay. It involved skilled nursing and physical therapy.²⁴

The dilemma before English was whether to bide his time and take the franchising route to the United States once Viva Home Living had acquired some brand recognition in Canadian home care, or take the acquisition route right away. There were potential acquisitions in places like New Hampshire, Rhode Island, Vermont, and Massachusetts. Canadian companies like Nova Leap Health Corp. had set some benchmarks with their American acquisitions. A medium-sized home care company (with sales between US\$3 million and \$4 million, 250 employees, and 400 customers) could be acquired for about US\$300,000. The breakdown of the cost of acquisition would be \$60,000 for customer lists, \$180,000 for goodwill, and \$60,000 for assets. A foothold in the northeastern United States could be a gateway to more prosperous geographies like Arizona, Florida, and the rural Midwest, which also had large senior populations.

There were some broad areas of concern. The United States was a more competitive market—although the rural locations that Kindred was keen on getting into were relatively less so. The country was also litigious, and the costs of insurance premiums would be higher than in Canada. Other things to consider included different labour laws and higher wage rates—although margins would be better because the billing rates would be higher. Billing cycles were, however, longer, at 30–60 days in contrast to the weekly cycle in New Brunswick. The American political landscape, of late, favoured protectionism, but that was manageable because Kindred would be employing locals and creating and sustaining American jobs.

English was cautious about the foray into the United States. He did not want Kindred to take on more than it could handle.

With franchising, acquisitions in Canada, and expansion into the United States all viable options, English needed to decide which route would be the best approach to scaling up Kindred now.

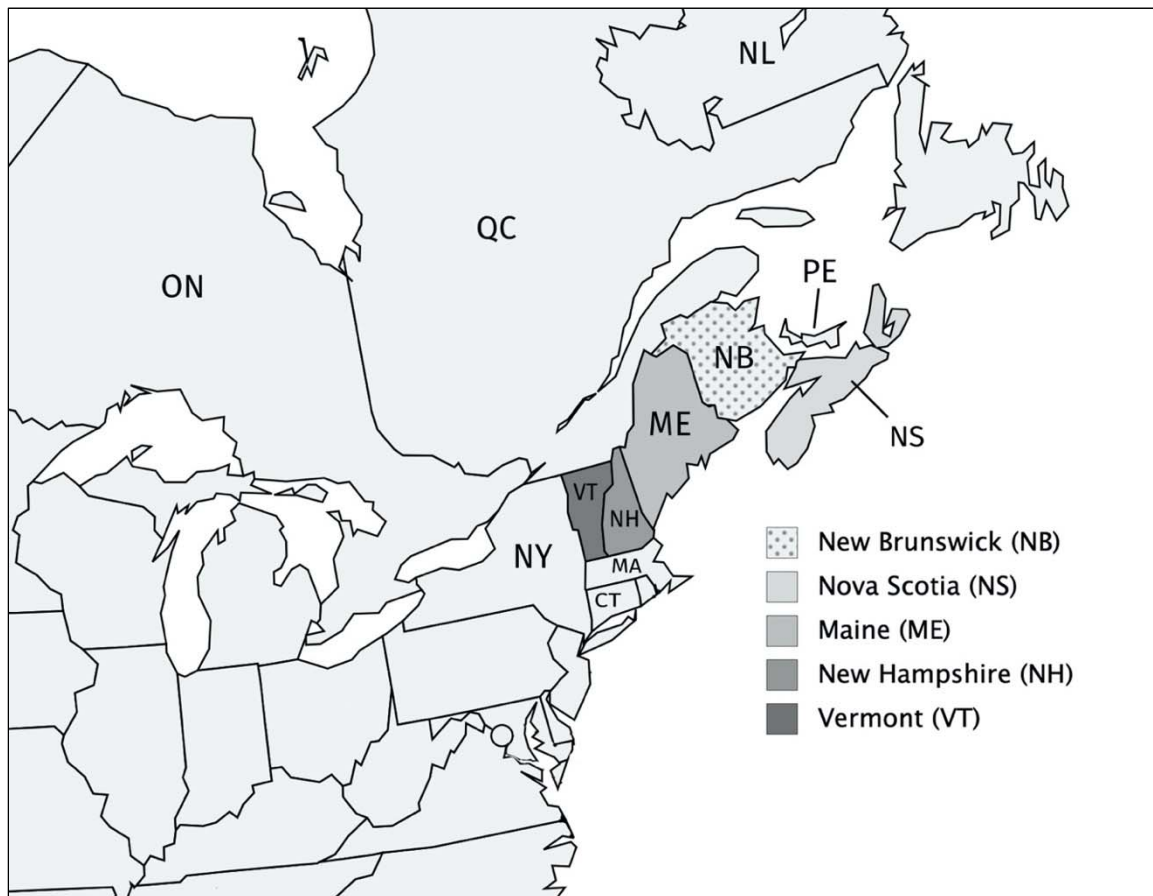
²⁴ "Home care in the US," Statista, accessed November 29, 2019, www.statista.com/topics/4049/home-care-in-the-us/.

EXHIBIT 1: KINDRED HOME CARE

	2012	2013	2014	2015	2016	2017	2022 (Target)
Revenue (CA\$)	4,422	6,961	9,002	9,147	11,147	12,482	50,000,000
Labour and other costs (CA\$)	4,161	...	...	...	9,010	11,125	
Labour and other costs as % of revenue	94	...	...	...	81	84	
Labour hours per week:	5,634				10,558	12,327	
• home care							35,000
• family support	5,334	...	...	...	9,908	11,627	
	300				650	700	
No. of employees	225	...	...	...	420	490	1,500

Source: Company files.

EXHIBIT 2: NEW BRUNSWICK AND SURROUNDINGS



Note: NL = Newfoundland and Labrador, ON = Ontario, PE = Prince Edward Island, QC = Quebec, Canada; CT = Connecticut, MA = Massachusetts, NY = New York, United States.

Source: Created by the case authors using map reproduced under Creative Commons licence BY-SA 4.0 from MapChart.net, accessed November 27, 2019, <https://mapchart.net>.

EXHIBIT 3: POPULATION, MEDIAN AGE, AND PERCENTAGE OF SENIORS IN CANADIAN PROVINCES

Province	1986			1996			2006			2015		
	Pop. (in '000s)	Median Age (in years)	Seniors (as %)	Pop. (in '000s)	Median Age (in years)	Seniors (as %)	Pop. (in '000s)	Median Age (in years)	Seniors (as %)	Pop. (in '000s)	Median Age (in years)	Seniors (as %)
Newfoundland & Labrador	568.3	27.9	8.7	551.8	34.1	10.7	505.5	41.3	13.5		45.0	18.4
Prince Edward Island	126.6	30.6	12.6	134.6	34.7	12.9	135.8	40.3	14.6		43.7	18.6
Nova Scotia	873.2	31.0	11.8	909.3	35.7	12.9	913.5	41.2	14.6		44.4	18.9
New Brunswick	709.4	30.4	11.0	738.1	35.4	12.5	730.0	41.1	14.3		44.8	19.0
Quebec	6,532.5	31.8	9.8	7,138.8	36.1	12.0	7,546.1	40.5	13.9		41.9	17.6
Ontario	9,101.7	31.9	10.7	10,753.6	35.0	12.2	12,160.3	38.4	13.0	13,448.5	40.6	16.0
Manitoba	1,060.0	31.1	12.4	1,113.9	34.5	13.6	1,148.4	37.6	13.6		37.7	14.8
Saskatchewan	1,009.6	30.0	12.6	990.2	34.2	14.5	968.1	37.9	14.9		37.0	14.6
British Columbia	2,883.4	32.8	11.9	3,724.5	35.4	12.5	4,113.5	40.1	14.1		42.0	17.5
Yukon	23.5			30.7			30.4					
Northwest Territories	52.2			64.4			41.4					
Nunavut							29.4					
Canada		31.4	10.5		35.2	12.1		38.9	13.2	35,151.7	40.5	16.1

Note: Pop. = population.

Source: Statistics Canada, "Table 17-10-0118-01: Selected Population Characteristics, Canada, Provinces and Territories," CANSIM, accessed January 10, 2019, www150.statcan.gc.ca; and Richard Saillant, *A Tale of Two Countries: How the Great Demographic Imbalance Is Pulling Canada Apart* (Halifax, NS: Nimbus Publishing, 2016), 26.

EXHIBIT 4: KINDRED HOME CARE INCOME STATEMENT (CA\$)

Year Ending December 31	2012	2013	2014	2015	2016
Revenue	4,422,251	6,961,859	9,001,899	9,147,368	11,146,572
Less: Direct Labour	NA	NA	7,340,207	7,211,203	9,009,963
Gross Profit	...	...	1,661,692	1,936,165	2,136,609
Less: Expenses					
Accounting & Legal	7,699	71,663	82,865	54,310	82,069
Advertising & Promotion	22,629	34,558	25,384	32,567	55,394
Amortization	11,565	60,475	79,567	83,450	72,062
Bad Debts	...	6,643	14,616	77,286	58,642
Computer Expenses	...	...	...	...	175,993
Insurance	8,584	11,373	23,688	23,072	36,825
Interest & Bank Charges	13,887	34,121	37,269	16,904	12,926
Office Expenses	36,390	128,868	206,046	238,772	49,795
Training & Development	4,251	30,675	80,238	49,306	29,236
Rent	14,978	19,515	56,526	40,568	47,950
Repairs & Maintenance	25,360	8,822	7,761	2,822	4,389
Salaries & Benefits	3,942,332	6,024,521	541,489	532,491	660,466
Shop Supplies	2,907	8,624	22,178	38,608	32,897
Travel	218,563	171,740	220,753	255,022	95,224
Utilities	50,602	43,225	65,422	48,603	83,336
(Other Income)	...	...	...	26,000	12,121
Income before Taxes	62,504	306,236	197,890	416,384	527,284
Net Income	52,342	249,299	153,275	367,000	424,736

Note: NA = Not Available.

Source: Company files.

EXHIBIT 5: KINDRED HOME CARE BALANCE SHEET (CA\$)

Year Ending December 31	2012	2013	2014	2015	2016
Assets					
Current					
Cash	...	...	27,976	55,808	1,042,747
Accounts Receivables	656,115	1,360,524	1,168,014	1,055,813	471,247
Prepaid Expenses	3,321	3,321	14,431	61,935	43,666
Due from Shareholders	22,000	...	88,152	178,661	...
Long Term					
Investments	...	...	...	...	30,901
Due from Related Party	...	...	...	...	4,138
Property	132,012	133,166	145,241	117,787	170,016
Goodwill	1	145,001	145,001	145,001	145,001
Other Assets	135,621	234,309	165,662	108,747	18,125
Future Income Taxes	...	...	...	25,807	20,031
Total Assets	949,070	1,876,321	1,754,477	1,749,559	1,945,962
Liabilities					
Current					
Bank Indebtedness	48,174	92,996	...	...	...
Accounts Payable	124,656	245,399	388,155	500,147	586,000
Unearned Revenue	...	...	...	1,198	33,109
Line of Credit	322,000	476,000	233,000	...	...
Note Payable	...	100,000	...	...	...
Income Tax Payable	9,649	56,637	69,344	79,226	96,772
Due to Shareholder	...	21,399	...	...	...
Current Portion of Debt	...	75,000	135,531	50,000	...
Long Term					
Long-Term Debt	...	115,000	81,275	...	186,357
Future Income Taxes	5,184	5,184	5,184	...	...
	509,663	1,187,615	912,489	630,571	902,238
Shareholder Equity					
Share Capital	2	2	9	9	9
Retained Earnings	439,405	688,704	841,979	1,118,979	1,043,715
	439,407	688,706	841,988	1,118,988	1,043,724
Total Liabilities	949,070	1,876,321	1,754,477	1,749,559	1,945,962

Source: Company files.

EXHIBIT 6: KINDRED HOME CARE CASH FLOW STATEMENT (CA\$)

Year Ending December 31	2012	2013	2014	2015	2016
Operating					
Net Income	52,342	249,299	153,275	367,000	424,736
Items Not Affecting Cash					
• Amortization	11,565	60,475	79,567	83,450	72,062
• Future Income Taxes	513	-	-	(30,991)	5,776
• Impairment Loss				26,000	12,121
	64,420	309,774	232,842	445,459	514,695
Change in Non-Cash Items					
Accounts Receivable	(121,066)	(704,409)	192,510	112,201	584,566
Prepaid Expenses	(3,321)	-	(11,110)	(47,504)	18,269
Accounts Payable	33,480	120,743	142,756	111,992	85,853
Unearned Revenue	-	-	-	1,198	31,911
Note Payable	-	100,000	(100,000)	-	-
Income Taxes	(7,055)	46,988	12,707	9,882	17,546
	(33,542)	(126,904)	469,705	633,228	1,252,840
Financing					
Line of Credit	143,000	154,000	(243,000)	(233,000)	-
Advances	-	-	(109,544)	(90,509)	(360,880)
Repayment of Debt	-	-	(113,194)	(166,806)	(50,000)
Issuance of Share Capital	-	-	140,000	-	-
Dividends Paid	-	-	-	(90,000)	(500,000)
Long-Term Debt	-	190,000	-	-	-
	143,000	344,000	(325,738)	(580,315)	(189,120)
Investing					
Advances	27,468	43,399	-	-	-
Purchase of Property	(6,171)	(13,217)	(24,675)	(12,517)	(76,781)
Other Assets	(129,572)	(147,100)	1,680	(12,564)	-
Goodwill	-	(145,000)	-	-	-
	(108,275)	(261,918)	(22,995)	(25,081)	(76,781)
Cash (Decrease) Increase	1,183	(44,822)	120,972	27,832	986,939
Cash at Beginning of Year	(49,357)	(48,174)	(92,996)	27,976	55,808
Cash at End of Year	(48,174)	(92,996)	27,976	55,808	1,042,747

Source: Company files.

EXHIBIT 7: ESTIMATED COSTS OF VIVA HOME LIVING FRANCHISE

Elements of Cost	Estimated Range (CA\$)	
	Low	High
Initial Franchise Fee	49,000	49,000
Real Estate/Lease Deposit	-	5,000
Leasehold Improvements	-	5,000
Equipment Purchases	2,000	5,000
Software/IT Setup	2,000	4,000
Signage	-	5,000
Opening Inventory & Supplies	500	1,000
Insurance	3,000	6,000
Uniforms	1,000	2,000
Training Expenses	3,000	5,000
Legal & Accounting	3,000	5,000
Opening Advertisement	10,000	20,000
Miscellaneous (Licences, etc.)	1,000	5,000
Working Capital	20,000	30,000
Total	92,500	143,000

Note: IT = information technology.

Source: Company files.