Health Impact Assessment and Competitive Effect Analysis of Proposed Acquisition of St. Elizabeth Care Center by the Ensign Group, Inc.

Professor Christopher Whaley

Submitted to:
The Office of the California Attorney General

July 10, 2026

Table of Contents

I. Scope of Report

The Office of the California Attorney General ("OCAG") is reviewing the proposed acquisition of St. Elizabeth Care Center ("St. Elizabeth") by the Ensign Group, Inc. ("Ensign").[1]

St. Elizabeth is a skilled nursing facility ("SNF") located in North Hollywood, Los Angeles County.[2] SNFs typically provide 24-hour inpatient skilled nursing and rehabilitative care for patients who need ongoing medical supervision. Usually, this care cannot be delivered in a less intensive setting.[3] St. Elizabeth provides skilled nursing, occupational therapy, physical therapy, recreational therapy, speech therapy, and ancillary services supporting these treatments.[4]

St. Elizabeth is owned and operated by Providence Health & Services ("Providence"), a nonprofit religious corporation.[5] Providence has a broad range of healthcare facilities and services with different acuity levels in Southern California, including eleven hospitals and three SNFs in addition to St. Elizabeth.[6]

Ensign is a publicly traded company that provides skilled nursing, assisted living, therapy, and other post-acute care in more than 300 SNFs.[7] It owns or operates 80 SNFs in California, 22 of which are in Los Angeles County.[8, 9]

---

1 *See, e.g.,* Notice of Proposed Submission and Request for Consent by Providence Health System – Southern California, July 7, 2025 ("Providence Notice"), p. 2 ("Providence undertook a competitive bid process to sell St. Elizabeth and its non-California facilities, … [and] Providence selected Ensign, through certain subsidiaries, to be the buyer and new operators of the facilities, including St. Elizabeth[.]").

2 Providence Notice, p. 6.

3 "A Skilled Nursing Facility (SNF) provides 24 hour inpatient care and, includes but is not limited to physician, skilled nursing, dietary, pharmaceutical services and an activity program." "Glossary," *California Department of Social Services*, https://www.ccld.dss.ca.gov/carefacilitysearch/Glossary, accessed Feb 9, 2026. *See also,* "Fact Sheet: Post-acute Care," *American Hospital Association*, https://www.aha.org/system/files/media/file/2019/07/fact-sheet-post-acute-care-0719.pdf, accessed February 9, 2026 ("Following care in a general acute-care hospital, such as a surgery, some patients are referred for PAC [(post-acute care)] for services focused on regaining the level of function needed to go home. … [PAC] includes long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF) and home health (HH) agencies.").

4 These ancillary services include dietary services, housekeeping, patient activities, pharmacy services, and social services. *See* Section 4.2 (1), "Facility Revenue Information," 2024 Medi-Cal Cost Report of Providence St. Elizabeth Care Center, available at https://reports.siera.hcai.ca.gov/. *See also,* Response to Notice of Deficiency and Supplemental Letter dated September 8, 2025, October 13, 2025 ("Response to First Notice of Deficiency"), p. 2.

5 Providence Notice, p. 6.

6 Providence Notice, p. 6. *See also,* Figure 1 below.

7 Providence Notice, p. 7.

8 *See* Appendix Figure A1. The 80 SNFs exclude St. Elizabeth, which Ensign started managing in June of 2025. Ensign owns and manages 76 of the 80 SNF businesses. The four SNF businesses Ensign purportedly manages but does not own are Buena Vista Care Center, Huntington Park Nursing Center, Shoreline Care Center, and Valley of the Moon Post Acute. In contrast, Ensign owns the real estate where the SNF is located for 12 of the 80 SNFs. *See* Schedule 1.a, Schedule 1.b, and Schedule 1.c in Response to Request for Additional Information dated June 15, 2026, June 30, 2026, pp. 6-9, 13-16.

9 I understand that Ensign represents that it owns and/or operates these locations through wholly owned independent subsidiaries. However, because Ensign retains ultimate control over these subsidiaries, I refer to Ensign and/or its subsidiaries, individually or collectively, as "Ensign" throughout this report. *See* "February 2026 Investor Presentation,"

The proposed acquisition of St. Elizabeth is part of a broader transaction in which Ensign would acquire seven additional Providence skilled nursing and assisted living facilities in Alaska, Oregon, and Washington.[10] This report focuses on the proposed acquisition of St. Elizabeth because it is the only California facility included in the transaction.

Providence states that it has faced "persisting operational and economic challenges" in operating St. Elizabeth, which "require[s] continuous maintenance and modernization."[11,12] It further states that it is unable to provide the capital needed to meet these requirements and that selling St. Elizabeth is necessary to "support the future needs of its residents and caregivers" and "best ensure continued access to high-quality, patient-centric care."[13]

The OCAG asked me to assess the competitive effects of the proposed acquisition and potential impact on patients. Specifically, OCAG asked me to assess whether the proposed acquisition poses a risk of negative effects on the quality of services.

The OCAG also asked me to recommend potential conditions for it to consider addressing any concerns raised by my analysis.

I reviewed and considered the following materials in preparation of this report:[14]

- St. Elizabeth's Notice to the OCAG, as well as supplemental information provided by the parties.
- OCAG's interview notes with selected payers and hospitals.
- Medi-Cal claims for services rendered by California SNFs from 2018 to 2024.[15]
- Medicare and commercial claims from California Department of Health Care Access and Information for California residents from 2018 to 2023.[16]

Ensign, February 2026, pp. 2-3, available at https://s203.q4cdn.com/190017989/files/doc_financials/2025/q4/Investor-Presentation-Q4-2025.pdf, accessed March 13, 2026. It also appears that Ensign affiliated facilities enter into management or centralized services agreements with Ensign Services, Inc. ("Ensign Services"), a subsidiary of Ensign. Such agreements include terms that would facilitate Ensign Services's ability to coordinate contracts with payers across multiple Ensign affiliates. *See* Response to Third Notice of Deficiency dated April 23, 2026, April 23, 2026 ("Response to Third Notice of Deficiency"), pp. 2-3 ("[The Ensign Group] is the sole owner of [Ensign Services]. … [Ensign Services] serves as 'the Service Center,' which provides management and administrative services to [the Ensign Group]'s affiliates."), 56-58 ("[Ensign Services] [a]ssists Facility staff with negotiating and entering agreements with Accountable Care Organizations, Managed Care Organizations and health care insurers for the purpose of establishing revenue generating provider agreements.").

10 Providence Notice, pp. 1-2.

11 Providence Notice, p. 2.

12 Providence states St. Elizabeth's challenges have included reimbursement rates that lag inflation, labor shortages, rising costs, and slow recovery from the COVID-19 pandemic. Providence Notice, p. 7.

13 Providence Notice, pp. 1-2.

14 The Appendix describes data sources and data processing steps for claims data (**Appendix C**), Medicare Compare data (**Appendix F**), and Medicare Cost Report data (**Appendix F**).

15 Medi-Cal is California's Medicaid program. *See* "Medi-Cal and Seniors", California Health Care Foundation, April 2025, p.1, available at https://www.chcf.org/wp-content/uploads/2025/04/MediCalSeniors_PolicyAtAGlance.pdf.

16 I focus on Medicare (including Medicare Advantage and Medicare fee-for-service) claims in my analyses. In the below, whenever I refer to "Medicare claims," it includes both Medicare Advantage and Medicare fee-for-service claims.

- Medicare Compare data with claim-based quality metrics for California SNFs from 2015 to 2025.
- Medicare Cost Report data with patient volume and staffing metrics for California SNFs from 2015 to 2024 ("CMS SNF Cost Report").
- Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data ("Medi-Cal Cost Report") for SNFs and Hospitals.
- Centers for Medicare & Medicaid Services ("CMS") SNF Enrollments database and SNF Ownership database.

II. Qualifications

I am an Associate Professor in the Department of Health Services, Policy and Practice at the Brown University School of Public Health. I received my PhD in Health Economics from the University of California, Berkeley. My research focuses on healthcare price transparency and market structure and has been published in clinical, health policy, and economics journals. My research has been covered in the New York Times, the Wall Street Journal, Forbes, and CNN. I have presented research results to state and federal policy makers, including the US Congress, California State Assembly, Texas House Select Committee on Health Care Reform, Executive Office of the President, Congressional Budget Office, and the Federal Trade Commission.

III. Executive Summary

Based on the analysis presented in the report, I find that the proposed acquisition is unlikely to individually pose significant risks to competition and quality of care. These findings include that:

- In the short term, the proposed acquisition of St. Elizabeth by itself is unlikely to substantially lessen competition in the relevant horizontal market.[17] I define the relevant horizontal market as SNFs operating within 10 miles of St. Elizabeth. St. Elizabeth and Ensign SNFs are not close substitutes, as indicated by the low diversion ratios between them. Furthermore, the proposed acquisition would result in only a minimal increase in SNF market concentration that is not structurally presumptively anticompetitive under the federal Merger Guidelines. These results do not, however, establish that the transaction raises no competitive concerns. Rather, they indicate that the acquisition by itself is not part of a pattern of acquisitions that has materially increased concentration in the area immediately surrounding St. Elizabeth. This analysis is limited to concentration among SNFs near St. Elizabeth and does not assess whether Ensign's broader and historical acquisition strategy may increase concentration in other geographic areas or ultimately allow it to exercise market power vis-à-vis Medi-Cal or Medicare managed care payers. Any such assessment would require separate, market-specific analyses on the cumulative impacts of acquisitions.
- I find no immediate risk of upward Medicare or Medi-Cal pricing adjustment at St. Elizabeth following the proposed acquisition. St. Elizabeth's revenue per patient day ("per diem") is currently higher than per diems of Ensign SNFs within 10 miles for both Medi-Cal and Medicare.[18] St. Elizabeth's Medicare managed care per diems as a percentage of Medicare fee-for-service per diems are also higher than

[17] *See* **Section VIII.A**.

[18] *See* **Section VI.B**.

that of Ensign SNFs within 10 miles.[19] This appears facilitated by St. Elizabeth's affiliation with the Providence Health System.[20] In addition, evidence suggests no systematic change in Medicare per diem following prior acquisitions by Ensign.[21] And it does not appear that as of today, the acquisition would result in Ensign exercising cross-geography market power, because based on the available information regarding Los Angeles County, Ensign does not appear to engage in all-or-nothing negotiations across different geographies.[22]

Still, Ensign operates approximately 10 percent of the SNF beds in Southern California. Consequently, there is a risk that Ensign could exercise cross-geography market power in the future, given Ensign's continued cross-geography growth, the ability of a centralized Ensign affiliate (i.e., Ensign Services) to facilitate payer negotiations on behalf of multiple facilities,[23] and the risk that Ensign changes its negotiating practices in the future.[24]

- Evidence suggests no systematic reduction in quality of care or overall staffing levels following prior acquisitions by Ensign. However, there is evidence of Ensign substituting registered nurse and licensed practical nurse hours toward lower-skilled nursing aide hours.[25]
- Ensign increased overall SNF patient days by approximately 10 percent following prior acquisitions. However, the increase appears to have been driven by an increase in Medicare patients, rather than an increase in Medi-Cal patients, who are generally of lower income.[26] Consistent with this pattern, on average, Ensign SNFs treat lower shares of Medi-Cal patients compared to other SNFs operating in the same areas.[27]
- The proposed acquisition includes lease payments and service fee payments from St. Elizabeth to two related entities under common ownership of Ensign. This compensation structure introduces a potential risk that financial resources could be diverted away from patient care and therefore may warrant oversight or conditions. That is especially the case when rent is above market value, which appears to be the case in this acquisition.[28]
- The proposed acquisition would see St. Elizabeth leaving the Providence Health System and joining Ensign. Because Providence Health System offers both acute hospital care and post-acute care, the proposed acquisition could eliminate certain cross-service effects that resulted from St. Elizabeth

---

19 I explain in **Section VI.B** that Medicare Advantage per diem as a percentage of Medicare fee-for-service per diem is a price metric for Medicare Advantage adjusted for differences in cost, coding intensity, and treatment intensity across facilities.

20 *See* **Section VIII.D.iii**.

21 *See* **Section VIII.B.iii**.

22 *See* **Section VIII.D.i** and **Section VIII.D.ii.**

23 *See* Response to Third Notice of Deficiency, pp. 2-3 ("[The Ensign Group] is the sole owner of [Ensign Services]. … [Ensign Services] serves as 'the Service Center,' which provides management and administrative services to [the Ensign Group]'s affiliates."), 56-58 ("[Ensign Services] [a]ssists Facility staff with negotiating and entering agreements with Accountable Care Organizations, Managed Care Organizations and health care insurers for the purpose of establishing revenue generating provider agreements.").

24 *See* **Section VIII.D.ii**.

25 *See* **Section VIII.B.ii**.

26 *See* **Section VIII.B.ii**.

27 *See* **Section VI.A**.

28 *See* **Section VIII.C**.

being part of Providence. Removing these cross-service effects could in theory reduce prices at St. Elizabeth and promote more competition among SNFs for patients from the nearby Providence Saint Joseph Medical Center.[29]

In summary, the proposed acquisition is by itself unlikely to harm competition or increase prices at St. Elizabeth in the short term. However, the acquisition structure still raises risks concerning payments to related parties and reductions in the supply of SNF services, particularly services provided to Medi-Cal patients in the local area in the long term. And the transaction also creates the potential for some long-term competitive risks. To mitigate these long-term risks, the OCAG may want to consider the following conditions:

- **Require St. Elizabeth to continue to provide access to Medi-Cal patients**

  Because St. Elizabeth and Ensign SNFs serve lower shares of Medi-Cal patients than other SNFs in the area around St. Elizabeth, OCAG may want to consider conditions to mitigate the risk that Ensign reduces access for Medi-Cal patients post-transaction. For example, OCAG could require St. Elizabeth to maintain a patient mix that resembles the patient mix of the broader community or its historical average patient mix.[30] In conjunction with, or as an alternative to, such a condition, OCAG may want to monitor St. Elizabeth's shares of Medi-Cal patients post-acquisition by comparing it with the shares of Medi-Cal patients receiving SNF care in the surrounding community.[31]

- **Implement safeguards on rental agreement**

  The proposed acquisition imposes above-market rent obligations on St. Elizabeth. Specifically, the proposed acquisition requires St. Elizabeth to pay annual rent of $725,616 to Toluca Way Health Holdings LLC ("Toluca Way").[32] Toluca Way is a subsidiary of Ensign's real estate investment trust ("REIT"), Standard Bearer Healthcare REIT, Inc.[33] As I describe in **Section VIII.C**, Providence's consulting firm, [redacted], estimated the property's fair market rent at approximately [redacted] per year. In addition, as I describe in **Section VIII.C**, the proposed rent is higher relative to the property's value than is typical for SNFs.

  As I discuss in **Section VIII.C**, above-market rent can harm local SNF competition and the state in several ways. Therefore, OCAG may want to consider implementing safeguards to mitigate these risks. For example, it could require an independent third-party assessment of fair market rent for the property to be adopted in the lease agreement.

  In addition, OCAG could prohibit Ensign from encumbering St. Elizabeth with debt, or other liabilities, to the point of placing the short-term or long-term financial viability at substantial risk of closing and/or reducing staffing levels.

  As part of such conditions, OCAG could monitor St. Elizabeth and affiliated entities for heightened risk of insolvency, such as through a periodic review of financial statements or revenue- and

---

29 *See* **Section VIII.D.iii**.

30 I found that 69 percent of SNF patients in St. Elizabeth's market (SNFs within 10 miles) were insured by Medi-Cal. *See* Figure 6.

31 As there is not up-to-date publicly available data on patient mix, St. Elizabeth may need to provide periodic reports of its census data so that OCAG could conduct this monitoring.

32 *See* **Section IV.C.i**.

33 See **Section IV.B** and **Section IV.C**.

utilization-related metrics. Such measures would help reduce the likelihood of financial distress and the state's exposure in the event of financial distress.

- **Implement safeguards on service agreement**

The proposed acquisition requires St. Elizabeth to pay Ensign Services, Inc. ("Ensign Services"), another related party affiliated with Ensign, a service fee equal to five percent of its gross revenue. This is in addition to the fees paid from Ensign's REIT to Ensign Services based on the REIT's total revenue (i.e., including income from facilities like St. Elizabeth).[34] There is the risk that these fees, particularly in combination with above-market rental rates, may reduce St. Elizabeth's ability to make needed investments or continue as a going concern.[35]

OCAG may want to consider safeguards to mitigate these risks, including limiting Ensign's ability to increase the service fee or impose additional affiliated-party fees without prior approval and monitoring St. Elizabeth and affiliated entities for heightened risk of insolvency.

IV. Background on the Proposed Acquisition

A. St. Elizabeth and Providence

St. Elizabeth is approximately 12 miles from downtown Los Angeles, in Los Angeles County.[36] It is licensed for 52 beds,[37] and its occupancy rate was approximately 80 percent in 2024.[38]

Figure 1 below shows Providence's 11 hospitals in Southern California. Providence also operates three SNFs in addition to St. Elizabeth in Southern California, each of which is located on the campus of one of the hospitals shown in Figure 1.[39]

---

34 See **Section IV.B** and **Section IV.C**.

35 See **Section VIII.C**.

36 "Providence St. Elizabeth Care Center to Downtown Los Angeles," *Google Maps*, available at https://www.google.com/maps/dir/Providence+St.+Elizabeth+Care+Center+-+North+Hollywood,+10425+Magnolia+Blvd,+North+Hollywood,+CA+91601/Downtown+Los+Angeles,+Los+Angeles,+CA, accessed March 13, 2026.

37 Providence Notice, p. 6.

38 On average, approximately 42 of St. Elizabeth's 52 licensed beds were occupied. *See, e.g.,* 2024 Medi-Cal Cost Report of Providence St. Elizabeth Care Center, available at https://reports.siera.hcai.ca.gov/, accessed March 18, 2026.

39 Providence also has a hospital-based SNF located on the campus of Healdsburg Hospital, which is a critical access hospital in Northern California. *See* "2023 Community Benefit Annual report," *Healdsburg Hospital*, available at https://www.providence.org/-/media/project/psjh/providence/norcal/files/healdsburg/2023cbrhealdsberg.pdf.

Figure 1
Providence Hospitals and SNFs in Southern California

Hospital	Approx. Driving Distance from St. Elizabeth	Has SNF
Providence Saint Joseph Medical Center	2.5	No
Providence Holy Cross Medical Center	11	Yes
Providence Cedars-Sinai Tarzana Medical Center	12	No
Providence Saint John's Health Center	18	No
Providence Little Company of Mary Medical Center - Torrance	33	Yes
Providence Little Company of Mary Medical Center - San Pedro	37	Yes
Providence St. Jude Medical Center	42	No
Providence St. Joseph Hospital	44	No
Providence Mission Hospital Mission Viejo	64	No
Providence Mission Hospital Laguna Beach	67	No
Providence St. Mary Medical Center	91	No

Notes:
[1] Providence SNFs are those with "Affiliation Entity Name" of "PROVIDENCE HEALTH & SERVICES" in the CMS SNF Enrollments data.
[2] Driving distances are based on Google Maps.

Sources:
[1] "Hospitals in Southern California," Providence, available at https://www.providence.org/about/southern-california.
[2] CMS SNF Enrollments, March 2026.

B. Ensign

Ensign provides post-acute care, including skilled nursing and rehabilitative care.[40] As of February 2026, it operates 378 locations across 17 states with more than 42,000 beds. Across the 378 locations, Ensign owns 160 properties.[41] Of these, 154 are owned by Ensign's REIT.[42] Ensign's subsidiary Ensign Services provides

[40] "February 2026 Investor Presentation," Ensign, February 2026, p. 7, available at https://s203.q4cdn.com/190017989/files/doc_financials/2025/q4/Investor-Presentation-Q4-2025.pdf, accessed March 13, 2026.

[41] "February 2026 Investor Presentation," Ensign, February 2026, p. 5, available at https://s203.q4cdn.com/190017989/files/doc_financials/2025/q4/Investor-Presentation-Q4-2025.pdf, accessed March 13, 2026.

[42] REITs are companies that own income-producing real estate assets, such as office buildings, shopping malls, and healthcare facilities. REITs are required to distribute at least 90 percent of their taxable income through shareholder

management services to SNFs and its REIT, including payer contracting and acquisition support.[43, 44] In particular, Ensign's REIT has contracted with Ensign Services to oversee its acquisition strategies.[45]

Ensign appears to have direct control over the operations of its REIT and Ensign Services, given their common executive leadership. [46, 47]

Figure 2, below, reports Ensign's total revenue, net income, and SNFs for 2016–2025. Ensign reported approximately $5.1 billion in total revenue and $344 million in net income for calendar year 2025. Ensign's revenue grew approximately 15 percent annually during this period.[48]

dividends. REITs are typically able to deduct distributed taxable income from their corporate taxable income. As a result, most REITs pay out 100 percent of their taxable income to their shareholders and avoid corporate income taxes. *See* "Investor Bulletin: Real Estate Investment Trusts (REITs)," *Securities and Exchange Commission*, December 2011, pp. 1-2, available at https://www.sec.gov/files/reits.pdf, accessed March 2, 2026.

"February 2026 Investor Presentation," Ensign, February 2026, pp. 6, 22, available at https://s203.q4cdn.com/190017989/files/doc_financials/2025/q4/Investor-Presentation-Q4-2025.pdf, accessed March 13, 2026. Standard Bearer is a REIT owned by Ensign, according to page 21 of this source.

43 *See* **Section IV.C.i** below for fee arrangements between St. Elizabeth, Ensign's REIT, and Ensign Services.

44 "Company Info, Teams," *Ensign Services,* available at https://ensignservices.net/company-info/#managed-care ("Our Managed Care team works with a diversified group of managed care organizations. … We coordinate with local operations in each market to initiate, maintain and enhance relationships with our insurance partners. … We coordinate with operations and local leadership teams for contracting needs. … We collaborate with our local field leadership and provide them with subject matter expertise that is related to acquisitions").

45 *See* "Exhibit 2(B) Management Agreement Between Ensign Services, Inc. and Standard Bearer Healthcare REIT, Inc.," in Response to Third Notice of Deficiency, p. 24.

46 For example, Chad Keetch, who is Executive Vice President and Secretary of Ensign, is on Ensign Services's "Investment Committee" that oversee and consult the REIT's acquisitions. *See* "Exhibit 2(B) Management Agreement Between Ensign Services, Inc. and Standard Bearer Healthcare REIT, Inc.," in Response to Third Notice of Deficiency, p. 23.

47 Chad Keetch is Executive Vice President and Secretary of Ensign, Secretary of Ensign Services, and President of Ensign's REIT; Barry Port is CEO and Chairman of the Board of Ensign, sole Director of Ensign Services and Ensign's REIT. *See* "Management," *The Ensign Group,* available at https://investor.ensigngroup.net/governance/management/default.aspx. *See also,* Response to Third Notice of Deficiency, pp. 2-3.

48 The compound annual growth rate of Ensign's total revenue from 2016 to 2025 is ($5,057.8 / $1,437.6)$^{1/9}$ – 1 = 15.0 percent.

Figure 2
Ensign's Total Revenue, Net Income, and SNFs
2016–2025

Year	Total Revenue (in millions)	Net Income (in millions)	SNFs
2016	$1,437.6	$32.1	170
2017	$1,598.3	$17.0	181
2018	$1,754.6	$59.1	188
2019	$2,036.5	$92.2	213
2020	$2,402.6	$171.4	219
2021	$2,627.5	$197.7	236
2022	$3,025.5	$224.7	260
2023	$3,729.4	$209.9	286
2024	$4,260.5	$298.5	316
2025	$5,057.8	$344.3	357

Note:
[1] Total Revenue and Net Income for 2016–2019 exclude operations attributable to The Pennant Group, as reported in Ensign's 2020 Form 10-K. Ensign spun off its home health, hospice, and substantially all of its senior living businesses into The Pennant Group on October 1, 2019.

Sources:
[1] Ensign Form 10-K, 2016, p. 7; 2017, p. 8; 2018, p. 8; 2019, p. 7; 2020, pp. 56, 62; 2021, pp. 59, 87; 2022, pp. 68, 98; 2023, pp. 70, 99; 2024, pp. 70, 99; 2025, pp. 71, 101.

In California, as of January 2026, Ensign lists 87 locations on its website, including 80 SNFs, and seven assisted living locations.[49, 50]

Figure 3, below, shows the number of SNF beds that Ensign acquired in California in each year from 2000 to 2025.[51] As shown with the turquoise bars, most of the acquired SNFs were in Southern California, with many

[49] *See* Figure A2 for the list of the seven assisted living facilities. Some of the seven assisted living locations offer independent living, memory care, and/or respite care. *See* "Locations," *The Ensign Group,* available at https://ensigngroup.net/map/.

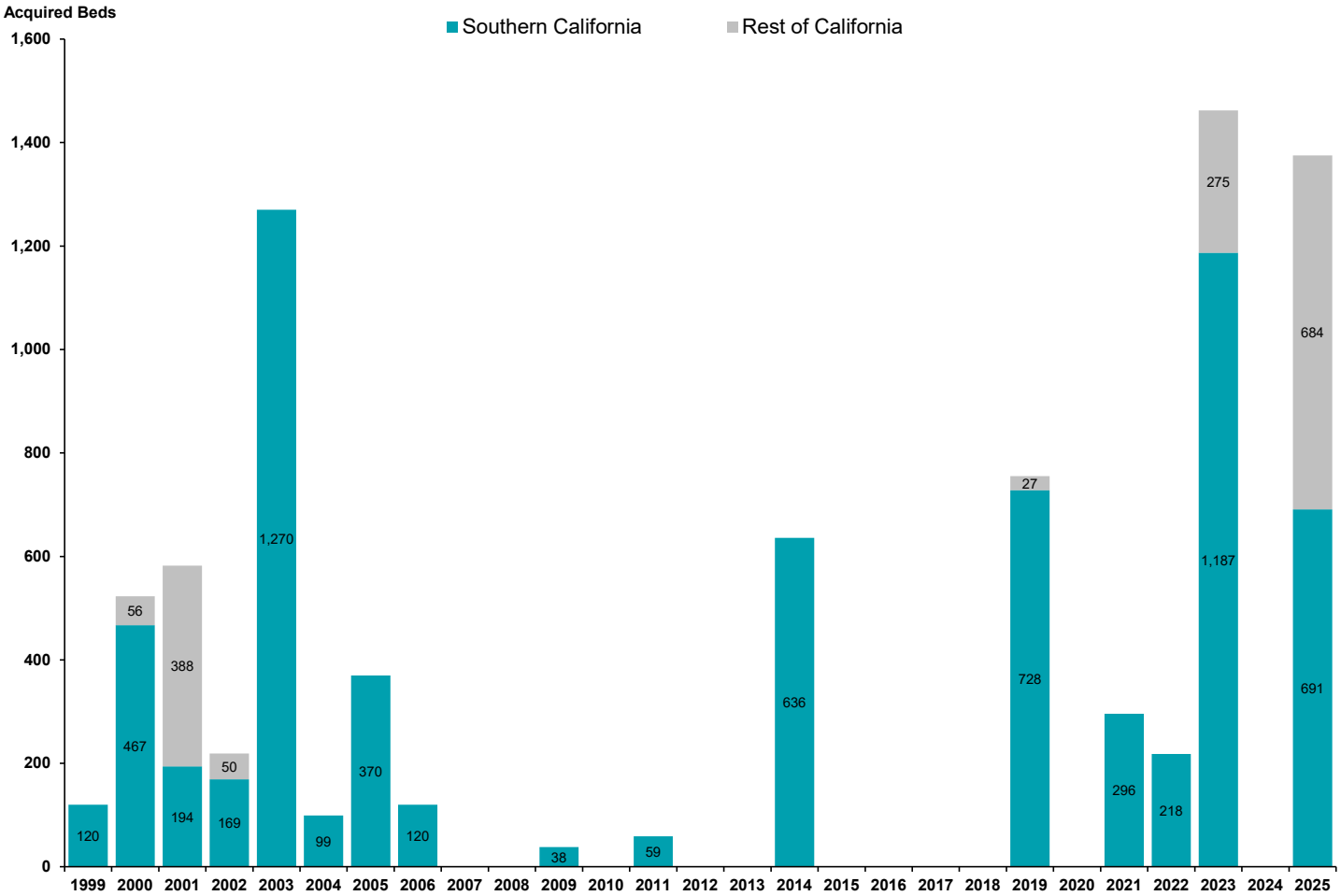
Respite care is "the supervision and care of Chronically Ill Individuals in the home or out of the home while the family or other individuals who normally provide care take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving." Cal. Code Regs. Title 22, § 58033 - Respite Care, California Code of Regulations, *Cornell Law School, Legal Information Institute,* available at www.law.cornell.edu/regulations/california/22-CCR-58033.

[50] Ensign spun off its home health, hospice, and substantially all of its senior living businesses on October 1, 2019. *See* The Pennant Group, Form 8-K, SEC, available at https://www.sec.gov/Archives/edgar/data/1766400/000119312519260914/d812063d8k.htm.

[51] Ensign characterizes its early acquisitions between 2001 and 2005 as follows: "Many of our earliest acquisitions were completed at a time when the skilled nursing industry was undergoing a major restructuring. From 2001 to 2003, we acquired a number of underperforming facilities, as several long-term care providers disposed of troubled facilities from their portfolios. … In 2004 and 2005, we focused on the integration and improvement of our existing operations while limiting our

located in Los Angeles County. Figure A1 in **Appendix A** lists the 80 SNFs that Ensign operates in California, including 22 in Los Angeles County.

Figure 3
Number of SNF Beds Acquired by Ensign in California



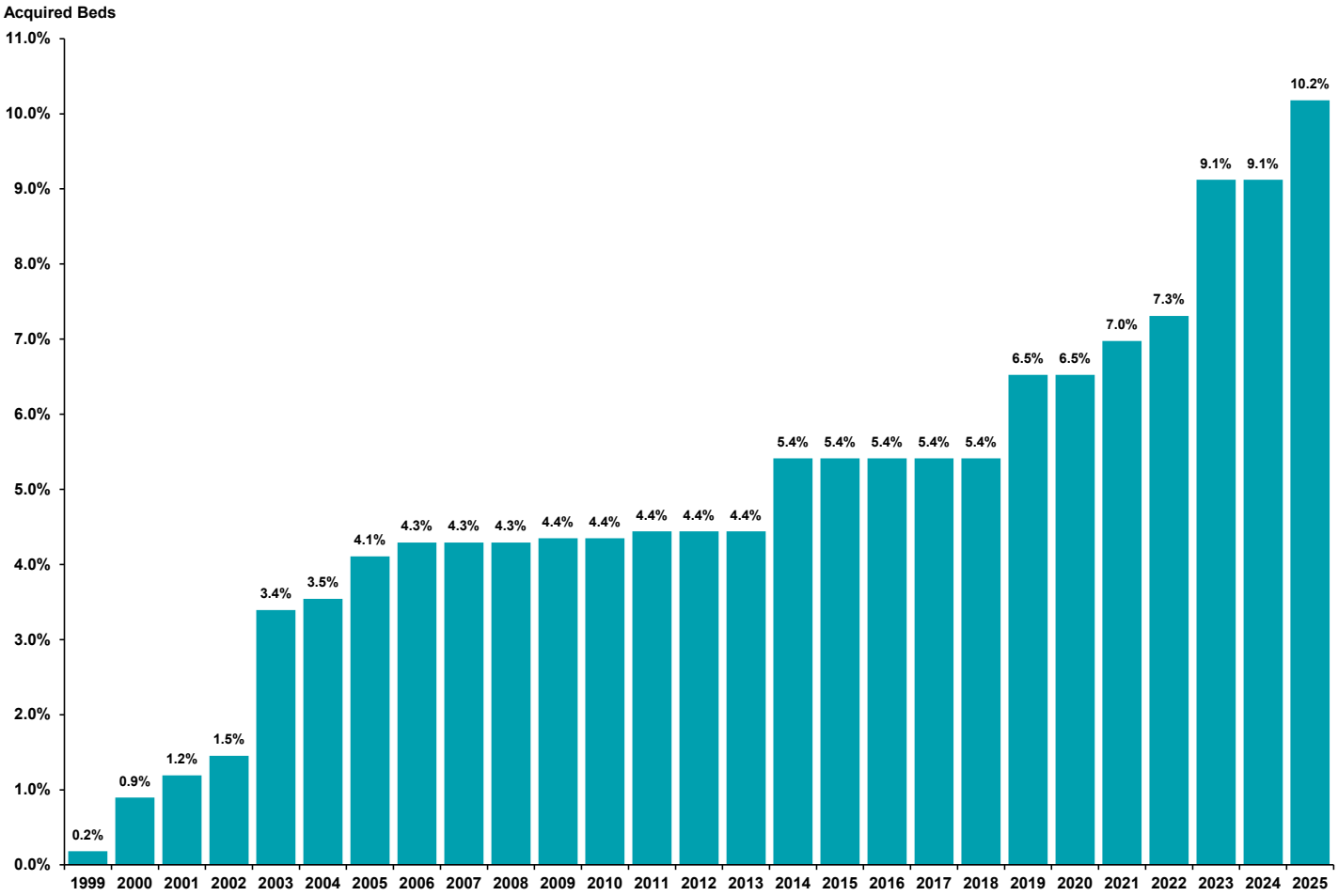
Note:
[1] "Southern California" consists of the following counties: Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura.

Source:
[1] *See* Appendix Figure A1.

As a result of these acquisitions, Ensign operated approximately 10 percent of SNF beds in Southern California as of 2025, as shown in Figure 4 below.

acquisitions to strategically situated properties, acquiring five facilities over that period." Ensign Form 10-K, 2007, p. 2, available at https://www.sec.gov/Archives/edgar/data/1125376/000089256908000267/a38242e10vk.htm.

Figure 4
Ensign Share of SNF Beds in Southern California by Year



Notes:
[1] "Southern California" consists of the following counties: Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura.
[2] Ensign's share in a year is calculated by dividing the number of beds belonging to SNFs Ensign had acquired by that year by the total number of Southern California SNF beds. I use data from 2023 / 2024 for the number of beds in each SNF and the total number of Southern California SNF beds. I include beds in free-standing SNFs and sub-acute and skilled nursing beds in hospital-based SNFs.
[3] For free-standing SNFs, I use the 2024 CMS SNF Cost Report as the primary source for bed counts. For free-standing SNFs with missing bed count information, I supplement the bed count information using the 2024 Medi-Cal SNF Cost Report.

Sources:
[1] *See* Appendix Figure A1.
[2] CMS SNF Cost Report, 2024.
[3] Medi-Cal SNF Cost Report, 2024.
[4] Medi-Cal Hospital Cost Report, FY 2023–2024.

C. The Proposed Acquisition

i. Real Estate and Service Operations

In the proposed acquisition, Providence would sell St. Elizabeth's assets to Toluca Way, a subsidiary of Ensign's REIT, for $4,966,317.[52] The sale price includes "real property, inventory, personal property, intangible property, and other assets related to the operations of St. Elizabeth."[53] [redacted] a consulting firm retained by Providence, assessed the fair market value for St. Elizabeth's real estate alone at [redacted].[54]

Ensign would operate St. Elizabeth through its subsidiary West Star Healthcare LLC ("West Star").[55] West Star would lease the real estate from Toluca Way for $725,616 per year, implying the rental amount is approximately $14,000 per bed.[56, 57] This rent amount is approximately 14.5 percent of the $5 million sale price.[58] [redacted] estimated the property's fair market rent at approximately [redacted] per year.[59]

---

52 As discussed in **Section I,** the proposed acquisition of St. Elizabeth is part of a larger transaction involving seven other Providence facilities located outside of California. The total purchase price of all eight facilities is $90,000,000, of which $4,966,317 is attributable to St. Elizabeth. *See* Purchase and Sale Agreement Disclosure Schedules, in Confidential Materials Supplement to Notice of Proposed Submission and Request for Consent by Providence Health System – Southern California, July 7, 2025 ("Confidential Materials"), p. 12.

53 Examples of intangible assets include warranties, covenants, permits, and regulatory approvals related to St. Elizabeth. The sale excludes certain assets, such as cash, accounts receivable, and computer software and hardware. The sale agreement does not include St. Elizabeth's liabilities as part of the purchase. *See* Purchase and Sale Agreement and Disclosure Schedules in Providence Notice, pp. 8-9, 14.

54 [redacted]

55 Purchase and Sale Agreement and Disclosure Schedules in Providence Notice, pp. 13, 48. Providence Notice, p. 7.

56 "Organizational Chart: Toluca Way Health Holdings LLC," in Providence Health System – Southern California: Response to Second Notice of Deficiency dated December 5, 2025, regarding the sale of St. Elizabeth Care Center, January 23, 2026, p. 6.

57 *See* Response to Fourth Notice of Deficiency dated April 7, 2026, regarding the sale of St. Elizabeth Care Center, April 10, 2026.

58 This implies a capitalization rate (the rate of return earned by the property holder) of approximately 14.5 percent. In contrast, an investor survey conducted by CBRE (a major commercial real estate firm) found that capitalization rates for SNFs ranged from approximately 11.2 to 13.4 percent as of 2024.

See CBRE, "U.S. Senior Housing & Care Investor Survey H2 2024," November 2024, available at https://mktgdocs.cbre.com/2299/0e2432a6-c152-47f8-854a-adc724848444-524430563/U.S._Seniors_Housing_Care_Inve.pdf.

59 [redacted]

St. Elizabeth would also pay 5 percent of its gross revenue to Ensign Services for administrative services (I refer to this fee as "service fee").[60, 61]

Ensign's REIT would also pay fees to Ensign Services, including fees based on revenue generated from the REIT's subsidiaries such as St. Elizabeth.[62]

ii. The Parties' Assessment of the Proposed Acquisition

Ensign and Providence (the "parties") state that the proposed acquisition will improve the quality of care and long-term viability of St. Elizabeth.[63]

Ensign additionally states that it would operate St. Elizabeth in a manner consistent with Providence's mission and values.[64] Specifically, Ensign would not provide assisted suicide services (California End of Life Option) at St. Elizabeth.[65] In addition, Ensign would provide access to chaplaincy services at St. Elizabeth and endeavor to participate in Providence's existing quality improvement collaboratives.[66]

V. Services Provided by Providence and Ensign

The parties both own and operate SNFs. Providence also operates hospitals. In this section, I describe the services provided by SNFs and reimbursement of SNF services. I then briefly describe hospitals and post-acute care providers other than SNFs.

---

60 *See* Response to Fourth Notice of Deficiency dated April 7, 2026, regarding the sale of St. Elizabeth Care Center, April 10, 2026.

61 [redacted]

62 The payment from Ensign's REIT to Ensign Services is in the form of the "Administrative Management Fee" and the "Incentive Fee." The "Administrative Management Fee" is five percent of the REIT's total revenue (including revenue from its subsidiaries), and the "Incentive Fee" is five percent of the REIT's net income, excluding gains (or losses) from sales of real estate, impairment, depreciation, and amortization (capped at one percent of total revenue). *See* "Exhibit 2(B) Management Agreement Between Ensign Services, Inc. and Standard Bearer Healthcare REIT, Inc.," in Response to Third Notice of Deficiency, pp. 21-23, 34.

63 Providence Notice, pp. 2, 774.

64 The OTA states that Providence's mission and values are rooted in "the Roman Catholic moral tradition articulated in such documents as the Ethical and Religious Directives ["ERDs"] for Catholic Health Care Services issued by the United States Conference of Catholic Bishops." *See* Operations Transfer Agreement and Disclosure Schedules in Providence Notice, p. 81.

However, as a secular organization, Ensign purportedly did not agree to operate St. Elizabeth in compliance with the ERDs. Ensign is only required to operate St. Elizabeth in a manner that "[provides] accessible, compassionate, and high-quality care to all, regardless of coverage or ability to pay, in pursuit of improving the health and well-being of the communities served." *See* Response to First Notice of Deficiency, pp. 9-10.

65 *See, e.g.,* "End of Life Option Act," *California Department of Public Health,* available at https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx. *See, also,* Operations Transfer Agreement and Disclosure Schedules in Providence Notice, p. 81.

66 Operations Transfer Agreement and Disclosure Schedules in Providence Notice, pp. 81-82.

A. SNFs

i. Services Provided by SNFs

SNFs provide 24-hour inpatient nursing and supportive care for patients who need ongoing skilled services that cannot be provided in a less intensive setting.[67] Patients are typically admitted to SNFs following hospitalization (post-acute care) or when they require long-term skilled nursing services.[68] SNF services commonly include:

- Skilled nursing services (e.g., wound care, injections, complex medication applications);
- Skilled rehabilitation services (e.g., physical therapy, occupational therapy, and speech-language pathology);
- Ancillary clinical services (e.g., laboratory and radiology services);
- Room and board; and
- Social services.[69]

California's Code of Regulations defines a SNF as:

> *[A] health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. It provides 24-hour inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.*[70]

ii. Nursing Staff in SNFs

Nursing care in SNFs is typically provided by registered nurses ("RNs"), licensed practical nurses ("LPNs") or licensed vocational nurses ("LVNs"), and nursing assistants or nursing aides ("NAs").

RNs, LPNs or LVNs, and NAs have differences in experience and skill levels.

- RNs are licensed healthcare providers with substantial scientific knowledge and technical skills. RNs' day-to-day work includes assessing patients, developing or contributing to care plans, administering

---

67 "State Operations Manual: Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities," *CMS*, February 10, 2023, pp. 18, 20, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07pdf.pdf.

68 *See, e.g.,* "Medicare Benefit Policy Manual: Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance," *CMS*, October 05, 2023, § 10, p. 4, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf; "Medi-Cal and Seniors – Policy at a Glance," *California Health Care Foundation*, April 08, 2025, p. 2, available at https://www.chcf.org/wp-content/uploads/2025/04/MediCalSeniors_PolicyAtAGlance.pdf ("Medi-Cal is the primary payer of nursing home care for seniors. Over 100,000 California seniors receive short- or long-term care in nursing homes each year, and Medi-Cal is the primary payer for 61% of the state's nursing facility residents (see chart on page 1). Medicare pays for up to just 100 days in a nursing facility and only after a qualifying hospitalization. For people without other insurance or the ability to pay out of pocket, Medi-Cal is the only option to pay for long-term stays, which cost an average of $137,000 per year.").

69 *See* "Medicare Benefit Policy Manual: Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance," *CMS*, October 05, 2023, pp. 10, 33, 47, 52, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf.

70 "Skilled Nursing Facility," Cal. Admin. Code Title. 22, § 72103, available at https://govt.westlaw.com/calregs/Document/IB8C471C45B6111EC9451000D3A7C4BC3.

treatments, coordinating care, educating patients and families, and, in some settings, supervising LPNs and NAs.[71]

- LPNs or LVNs are healthcare providers who provide basic nursing and medical care under the supervision of an RN or a physician. LPNs' duties include monitoring vital signs, providing basic patient care and comfort, documenting care, and reporting patients' status and concerns to RNs or physicians.[72]
- NAs provide basic supportive care under the directions of RNs and LPNs. Their duties include bathing, dressing, toileting, repositioning or transferring residents, measuring vital signs, feeding patients, and reporting residents' concerns to nurses.[73]

RNs, LPNs, and NAs also have differences in wages. According to the U.S. Bureau of Labor Statistics' May 2024 Occupational Employment and Wage Statistics, in California, the average hourly wage of an RN is $71.31, LPN is $38.02, and NA is $23.46.[74]

Academic research finds that the nursing staff mix can affect the quality of care in SNFs. For example,

- Using changes in state minimum-staffing laws, Lin (2014) finds that increasing RN hours per resident day significantly reduces inspection deficiencies but increasing NA hours per resident day does not statistically significantly change inspection deficiencies.[75]
- Using 2017–2019 SNF data, Mukamel et al. (2024) find that, when holding other staffing types constant, higher RN staffing is associated with fewer hospitalizations, fewer emergency-room visits, and fewer pressure sores, while higher LPN staffing is associated with fewer hospitalizations. Higher NA staffing is associated with better long-stay activities-of-daily-living outcomes and better short-stay functional outcomes (when keeping staffing of other types of nurses constant).[76]

California Health and Safety Code requires a minimum of 3.5 direct care hours per resident day from RNs, LPNs, and NAs combined. It also requires a minimum of 2.4 hours per resident day from NAs.[77]

---

71 *See* "Registered Nurses," Occupational Outlook Handbook, *U.S. Bureau of Labor Statistics,* available at https://www.bls.gov/ooh/healthcare/registered-nurses.htm; *See also*, "An Explanation of the Scope of RN Practice Including Standardized Procedures," *California Department of Consumer Affairs*, available at https://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf.

72 The U.S. Bureau of Labor Statistics lists LVN and LPN as the same job title. *See* "Licensed Practical and Licensed Vocational Nurses," Occupational Outlook Handbook, *U.S. Bureau of Labor Statistics,* available at https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm.

California uses the title LVN for LPN. *See* "Licensed Vocational Nurses (LVNs)," *California Board of Vocational Nursing and Psychiatric Technicians,* available at https://www.bvnpt.ca.gov/licensees/licensed_vocational_nurses.shtml.

73 *See* "Nursing Assistants and Orderlies," Occupational Outlook Handbook, *U.S. Bureau of Labor Statistics*, available at https://www.bls.gov/ooh/Healthcare/Nursing-assistants.htm.

74 *See* Occupational Employment and Wage Statistics for California, *U.S. Bureau of Labor Statistics*, May 2024, available at https://data.bls.gov/oes/#/area/0600000.

75 *See* Lin, Haizhen, "Revisiting the relationship between nurse staffing and quality of care in nursing homes: An instrumental variables approach," *Journal of Health Economics*, 37:13-24, September 2014.

76 *See* Mukamel, Dana B., et al., "The Relationship between Nursing Home Staffing and Health Outcomes Revisited," *Journal of the American Medical Directors Association*, 25(8), August 2024.

77 *See* California Health and Safety Code Section 1276.65, *California Public Law,* available at https://california.public.law/codes/health_and_safety_code_section_1276.65.

iii. Reimbursement of SNF Services

SNF patients are often indigent and/or elderly. Many are covered by Medi-Cal (health insurance for the low-income) or Medicare (health insurance for the elderly or disabled). Some individuals receive dual coverage from both. Other patients are covered by a commercial plan or pay for SNF services themselves.

SNF reimbursement rates vary by payer. Typically, commercial insurance pays more than Medicare, which in turn pays more than Medi-Cal.[78, 79]

In the remainder of this section, I provide more details on reimbursement by payer.

Medi-Cal

Medi-Cal covers long-term institutional care for eligible beneficiaries who meet both financial and medical necessity criteria. Specifically, Medi-Cal eligibility generally requires income and assets below specific thresholds.[80, 81]

Most Medi-Cal beneficiaries are enrolled in plans operated by private payers (referred to as Medi-Cal managed care), while the remainder are covered by a state-run plan (referred to as Medi-Cal fee-for-service or "Medi-Cal FFS").[82] California Department of Health Care Services ("DHCS") sets Medi-Cal FFS reimbursement rates.[83] Medi-Cal reimburses freestanding SNFs under a facility-specific, cost-based per-diem

78 *See* discussions on commercial payers in this section.

79 "Medicare Payment Policy for Post-Acute Care in Nursing Homes," Schotland, Samuel, et al., *Issue Brief,* Leonard Davis Institute of Health Economics, University of Pennsylvania, September 2023, available at https://ldi.upenn.edu/our-work/research-updates/medicare-payment-policy-for-post-acute-care-in-nursing-homes/, accessed April 17, 2026 ("The shift away from SNFs has important implications for the nursing home industry, which relies on generous Medicare PAC payments for short-stay patients to subsidize their long-term residents, who are primarily covered by Medicaid. Medicare payments are quite lucrative. In 2021, traditional (fee-for-service) Medicare paid a median of $556 per day and $23,797 per stay; according to the Medicare Payment Advisory Commission (MedPAC), nursing homes have an average marginal profit of 26% on these Medicare payments.").

80 *See, e.g.,* "Medi-Cal and Seniors – Policy at a Glance," *California Health Care Foundation*, April 08, 2025, available at https://www.chcf.org/wp-content/uploads/2025/04/MediCalSeniors_PolicyAtAGlance.pdf.

81 *See* "California Medicaid (Medi-Cal) Income & Asset Limits for Nursing Homes & Long Term Care," *American Council on Aging*, March 16, 2026, available at https://www.medicaidplanningassistance.org/medicaid-eligibility-california/.

82 McConville, S., "Counties Are Key Partners in the Medi-Cal Program," *Public Policy Institute of California*, available at https://www.ppic.org/blog/counties-are-key-partners-in-the-medi-cal-program/ ("More than 90% of Medi-Cal enrollees belong to managed care plans.").

83 "Medi-Cal Long-Term Care Reimbursement," *California Department of Health Care Services*, available at https://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/AB1629_WebUpdates/LTC-Rates-PL-26-001-SNF-CY2026.pdf ("The California Department of Health Care Services (DHCS) Fee For Service Rates Development Division establishes Medi-Cal reimbursement rates for the following long-term care (LTC) facilities … [including] Freestanding Skilled Nursing Level B [and] Distinct Part Skilled Nursing Facilities (DP/NF-B).").

methodology.[84] SNFs may negotiate rates with Medi-Cal managed care plans that are higher than Medi-Cal FFS rates or may receive Medi-Cal managed care rates that are the same as Medi-Cal FFS rates.[85]

Cost-based reimbursement can create incentives for facilities to artificially inflate operating costs. One way in which they may do so is by "tunneling" profits to commonly owned entities by paying them above-market prices for services. DHCS employs at least two safeguards to prevent Medi-Cal from paying higher rates to providers engaged in profit tunneling. First, DHCS utilizes a fair rental value system to calculate capital cost reimbursement based on a SNF's age, geographic location, and number of beds.[86] Consequently, a SNF's reported rent, depreciation, and most other capital costs do not affect its Medi-Cal payments.[87] Second, DHCS has caps that limit rates for high-cost SNFs. Specifically, DHCS categorizes allowable expenses into seven cost categories and assigns each SNF to a geographic peer group to determine rate caps for each cost category.[88] These caps on costs do not prevent a SNF or group of SNFs from charging Medi-Cal managed payers a rate that is higher than Medi-Cal FFS, such as when there are bed shortages in a given area or where that SNF or group of SNFs have market power. Nor do they prevent a SNF from reducing costs in ways that hinder the quality and use of services, such as by reducing staffing.

Medicare

Medicare provides health coverage for individuals aged 65 and over and typically covers short-term post-hospital SNF stays. Some Medicare plans are operated by private insurers, which are referred to as Medicare Advantage plans.

SNFs are reimbursed through Medicare Part A, which makes payments on a per-diem basis. Medicare calculates SNF reimbursement rates in two steps. The first step is to use national data to calculate a "base payment rate," separately for urban and rural areas. The second step is to adjust the base payment rate for the patient's acuity and the SNF's local labor costs.[89]

---

84 *See, e.g.,* the file "CY 2026 FSSA Rate Study," in "Freestanding Skilled Nursing Facilities and Subacute Units," *California DHCS*, available at https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/.

85 *See* "Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care," *California Department of Health Care Services*, September 16, 2024, p. 9, available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-009.pdf, which discusses how Medi-Cal Managed Care plans are required to pay SNFs at least the FFS rate.

86 The fair rental value system uses construction costs and U.S. treasury bond yields to calculate fair rental value. *See* "Methods and Standards for Establishing Facility-Specific Reimbursement Rates for Freestanding Skilled Nursing Facilities Level-B and Subacute Care Units of Freestanding Skilled Nursing Facilities," *California Department of Health Care Services*, p. 15, available at https://www.dhcs.ca.gov/SPA/Documents/Supplement-4-to-Attach-4-19-D.pdf.

87 *See* "Skilled Nursing Facilities," *California State Auditor,* May 01, 2018, p. 11, available at https://information.auditor.ca.gov/pdfs/reports/2017-109.pdf.

88 *See* "Skilled Nursing Facilities," *California State Auditor,* May 01, 2018, p. 11, available at https://information.auditor.ca.gov/pdfs/reports/2017-109.pdf.

89 "Skilled Nursing Facility Prospective Payment System," *CMS,* available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#SNF, accessed March 3, 2026 ("We determine SNF payments by adjusting base payment rates for geographic differences in labor costs and case-mix, and we calculate separate base rates for urban and rural areas. … We base the standardized per-diem rates on national data from urban and rural areas. Case-mix and wage adjustments apply to these per-diem rates.")

Medicare Advantage plans typically negotiate payment rates with SNFs,[90] although in my experience, these rates are often tied explicitly or implicitly to the rates paid by Part A of traditional Medicare (e.g., a Medicare Advantage plan could contract with a SNF at a rate of 105 percent of the Medicare Part A rate). Facilities are more likely to negotiate higher rates with Medicare Advantage plans in areas with bed shortages or in areas in which a SNF or group of SNFs have market power.

I evaluate whether SNFs have an incentive to inflate their costs to increase Medicare reimbursement rates, which is an issue different than using market power to increase rates or reduce costs by reducing staffing. I conclude any such incentive is likely minimal for Medicare Part A as individual SNFs' costs have a negligible effect on the base payment rates for Medicare Part A. This is because the CMS base payment rates are calculated by averaging costs across many SNFs, rather than based on the costs of a single SNF.

Commercial insurance

Rates paid by commercial payers are typically negotiated with the SNF and may exceed Medicare and Medicaid rates.[91]

Private pay

Private-pay rates for individuals without insurance are set by the SNF.[92]

B. Hospitals and Other Post-Acute Care Providers

SNFs sit within a broader ecosystem of healthcare providers. Patients typically receive SNF care after an acute healthcare episode, most often following discharge from a hospital.[93] Hospitals therefore serve as an important source of patient referrals for SNFs, even when hospitals and SNFs are not commonly owned. Most SNFs operate independently of hospitals, but some hospitals and SNFs are co-owned. In those cases, the hospital-SNF relationship may affect referral patterns from the hospital to the SNF.

SNFs treat post-acute care patients who cannot be treated in a less intensive setting. Less intensive settings include outpatient rehabilitation, home health care, or assisted living facilities. SNFs therefore serve as an important source of patient referrals to other post-acute providers that provide less intensive care.

---

90 "Chapter 11, The Medicare Advantage Program: Status Report," *Report to the Congress: Medicare Payment Policy,* March 2025, p. 11, available at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf ("MA plans typically have flexibility to use alternative payment models [and] negotiate [payment rates] with individual providers.").

91 Hulver, S. et al., "5 Key Facts About Medicaid and Hospitals," *KFF*, March 5, 2025, available at https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-hospitals/ ("In an effort to increase access for Medicaid enrollees, Medicaid managed care rules finalized in 2024 permit states to pay hospitals and nursing facilities at the average commercial payment rate (ACR) when using directed payments, which is substantially higher than the Medicare payment ceiling used for Medicaid FFS supplemental payments.").

92 *See, e.g.,* "§ 149.610 Requirements for provision of good faith estimates of expected charges for uninsured (or self-pay) individuals," Code of Federal Regulations, *National Archives,* available at https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610 ("***Expected charge*** means, for an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual" (emphasis in original)).

93 For example, Medicare generally requires beneficiaries to be formally admitted to a hospital as an inpatient for at least three consecutive midnights to qualify for Medicare Part A coverage at a SNF. "Skilled Nursing Facility 3-Day Rule Billing," *CMS,* May 2025, available at https://www.cms.gov/files/document/skilled-nursing-facility-3-day-rule-billing.pdf

VI. SNF Payer Mix, Per Diems, and Managed Care Prices

A. SNF Payer Mix

In this section, I study the share of patients by payer type (the SNF "payer mix") of St. Elizabeth and Ensign, and how Ensign SNFs' share of Medi-Cal patient days compares with third-party SNFs close to them. Because the reimbursement that SNFs receive may differ by the type of payer through which the patient receives their insurance, payer mix is relevant for understanding a SNF's financial situation.

Payer mix is also relevant to SNF competition. A SNF that selectively admits more Medicare and fewer Medi-Cal patients restricts the supply of SNF care for Medi-Cal patients and thus reduces competition among SNFs serving this population.

Figure 5, below, shows payer mix for the parties' SNFs. Approximately 36 percent of St. Elizabeth's patients are insured by a Medi-Cal plan and 41 percent by Medicare.[94] In comparison, approximately 60 percent of Ensign's patients are insured by Medi-Cal and 32 percent by Medicare.

Figure 5
Share of Patient Days by Payer
St. Elizabeth, Other Providence SNFs, Ensign SNFs, and California SNFs
2023–2024

	Number of SNFs	Medicare (incl. MA)	Medi-Cal (incl. managed care)	Commercial	Self-Pay & Other
St. Elizabeth	1	41%	36%	1%	22%
Other Providence SNFs	3	64%	29%	7%	0%
Holy Cross Medical Center	*1*	*60%*	*40%*	*0%*	*0%*
Little Company of Mary Medical Center - San Pedro	*1*	*53%*	*40%*	*7%*	*0%*
Little Company of Mary Medical Center - Torrance	*1*	*86%*	*1%*	*13%*	*0%*
Ensign SNFs	80	32%	60%	1%	6%
California SNFs	**1,163**	**23%**	**65%**	**4%**	**8%**

Notes:
[1] For Ensign SNFs, see Appendix Figure A1.
[2] SNFs in this table consist of both free-standing SNFs and hospital-based SNFs. Payer mix for free-standing SNFs is from 2024 Medi-Cal SNF Cost Reports. Payer mix for hospital-based SNFs is from FY 2023–2024 Medi-Cal Hospital Cost Reports
[3] Percentages are calculated using total annualized patient days.
[4] "Self-Pay & Other" includes patients whose primary payer is the patient or the patient's family, charity care, the Veterans Administration, and workers' compensation. Twenty percent of St. Elizabeth's patient days are self-pay.

Sources:
[1] Medi-Cal SNF Cost Reports, 2024.
[2] Medi-Cal Hospital Cost Reports, FY 2023–2024.
[3] CMS SNF Enrollments, January 2026.
[4] CMS SNF Ownership, January 2026.
[5] *See* Appendix Figure A1.

Figure 6, below, shows payer mix for SNFs within 10 miles of St. Elizabeth. Approximately 70 percent of patients in third-party SNFs in this area are insured by Medi-Cal. In contrast, approximately 61 percent of patients of the two Ensign SNFs in this area are insured by Medi-Cal.

[94] "Medi-Cal and Seniors – Policy at a Glance," *California Health Care Foundation*, April 8, 2025, available at https://www.chcf.org/resource/medi-cal-seniors-policy-at-a-glance/, accessed February 23, 2026.

Figure 6
Share of Patient Days by Payer
St. Elizabeth, Other Providence SNF, Ensign SNFs, and Other SNFs
SNFs Within 10 Miles of St. Elizabeth
2023–2024

	Number of SNFs	Medicare (incl. MA)	Medi-Cal (incl. managed care)	Commercial	Self-Pay & Other
St. Elizabeth	1	41%	36%	1%	22%
Other Providence SNF	1	60%	40%	0%	0%
Ensign SNFs	2	37%	61%	1%	2%
Other SNFs	101	17%	70%	4%	9%
All SNFs	**105**	**17%**	**69%**	**4%**	**9%**

Notes:
[1] The "Other Providence SNF" is part of a Providence hospital, Holy Cross Medical Center.
[2] For Ensign SNFs, see Appendix Figure A1.
[3] "Other SNFs" consists of SNFs that are not part of Ensign or Providence.
[4] SNFs in this table consist of both free-standing SNFs and hospital-based SNFs. Payer mix for free-standing SNFs is from 2024 Medi-Cal SNF Cost Reports. Payer mix for hospital-based SNFs is from FY 2023–2024 Medi-Cal Hospital Cost Reports
[5] Percentages are calculated using total annualized patient days.
[6] "Self-Pay & Other" includes patients whose primary payer is the patient or the patient's family, charity care, the Veterans Administration, and workers' compensation. Twenty percent of St. Elizabeth's patient days are self-pay.

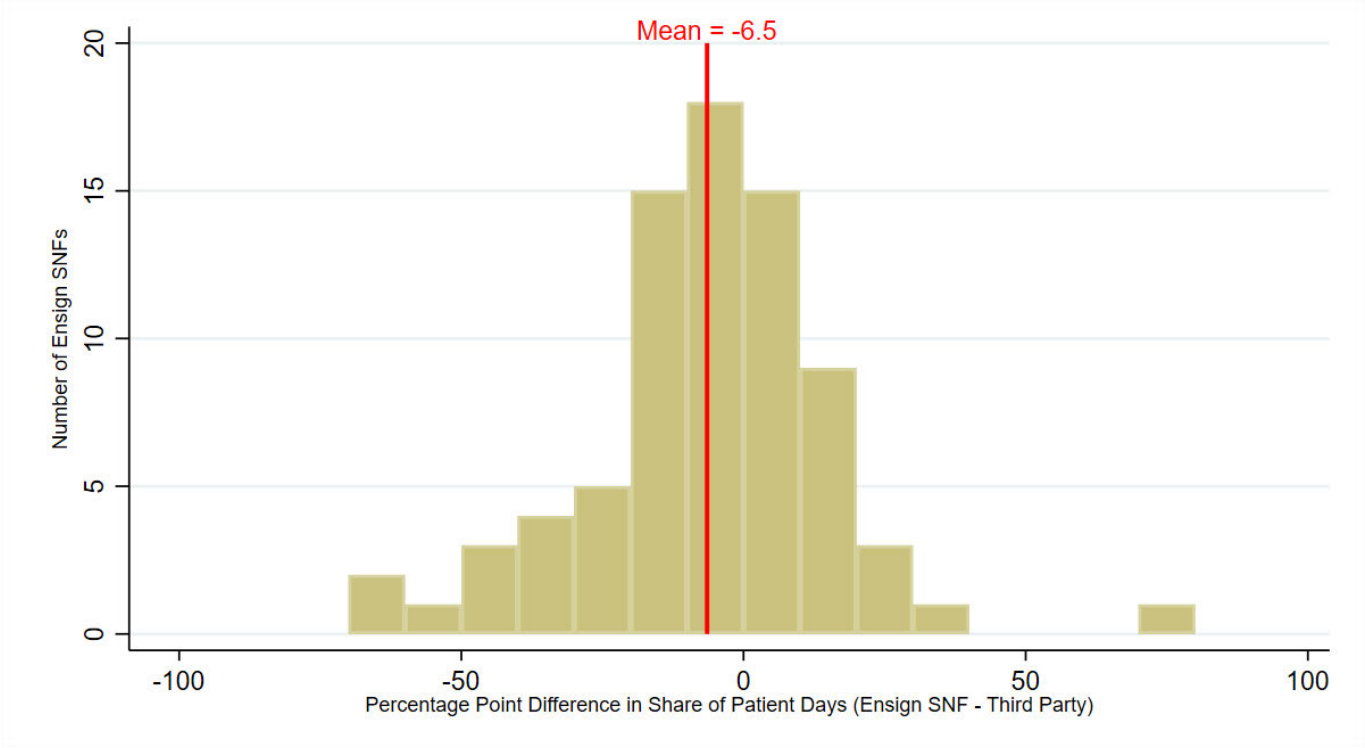
Sources:
[1] Medi-Cal SNF Cost Reports, 2024.
[2] Medi-Cal Hospital Cost Reports, FY 2023–2024.
[3] CMS SNF Enrollments, January 2026.
[4] CMS SNF Ownership, January 2026.
[5] *See* Appendix Figure A1.

Figure 7 shows the distribution of the difference between the share of Medi-Cal patient days at each Ensign free-standing SNF and the average share of Medi-Cal patient days at nearby free-standing third-party SNFs located within 10 miles.[95] Approximately 62 percent of Ensign SNFs have a lower Medi-Cal share than nearby third-party SNFs, and the Medi-Cal share at Ensign SNFs is, on average, approximately 6.5 percentage points lower than at neighboring third-party facilities.[96]

[95] All but one of Ensign's 80 California SNFs are free-standing.

[96] I find that the 6.5 percentage point difference is statistically significant at five percent level.

Figure 7
Difference in Share of Medi-Cal Patient Days
Between Ensign and Nearby Third-Party SNFs



Notes:
[1] Each data point used to plot this histogram is an area with 10-mile radius centered around an Ensign SNF. I dropped two Ensign SNFs with no third-party SNFs within 10 miles of their locations from the calculations, which leaves 77 Ensign SNFs.
[2] The red vertical line is the average value of percentage point difference in share of patient days between Ensign and the nearby third-party SNFs.
[3] I only include free-standing SNFs in this calculation.
[4] For each SNF, the share of Medi-Cal patient days is calculated by dividing annualized Medi-Cal patient days to annualized total patient days.

Sources:
[1] Medi-Cal SNF Cost Reports, 2024.
[2] CMS SNF Enrollments, January 2026.
[3] CMS SNF Ownership, January 2026.

B. SNF Per Diems and Managed Care Prices

In this section, I compare per diems for St. Elizabeth, other Providence SNFs, Ensign SNFs, and third-party SNFs located within 10 miles of St. Elizabeth. I calculate per diems separately for Medicare Advantage, Medicare FFS, Medi-Cal managed care, and Medi-Cal FFS.

I also calculate Medicare Advantage/managed care prices as Medicare Advantage/managed care per diems divided by the corresponding FFS per diem. This approach adjusts for cost differences across facilities

reflected in FFS prices, including patient acuity, labor costs, and geographic location.[97] To the extent that coding intensity and treatment intensity are also reflected in FFS per diems and are similar between managed care and FFS patients, this approach also adjusts for those differences.

Figure 8 presents Medi-Cal per diems. I find that St. Elizabeth received an average Medi-Cal managed care per diem of $244 and an average Medi-Cal FFS per diem of $391, meaning that Medi-Cal managed care paid approximately 62 percent of Medi-Cal FFS per diem. In contrast, Ensign's Medi-Cal managed care per diem is 93 percent of its Medi-Cal FFS per diem, whereas nearby third-party SNF's Medi-Cal managed care per diem is 91 percent of their Medi-Cal FFS per diem. This analysis indicates that Ensign's SNFs generally receive higher Medi-Cal managed care per diems, relative to Medi-Cal FFS per diems, than St. Elizabeth and other third-party SNFs.

Figure 8
Average Medi-Cal Per Diems
St. Elizabeth, Other Providence SNF, Ensign, and Third-Party SNFs
SNFs Within 10 Miles of St. Elizabeth

Facility	Average Medi-Cal Managed Care Per Diem [A]	Average Medi-Cal FFS Per Diem [B]	Average Managed Care Per Diem as Percent of FFS Per Diem [C]
St. Elizabeth	$244	$391	62%
Other Providence SNF	$1,123	$959	117%
Ensign	$232	$250	93%
Third-Party SNFs	$314	$344	91%

Notes:
[1] Column [A] is calculated using Medi-Cal claims data.
[2] Column [B] is based on administratively-set "regular" per diems published by California DHCS. For hospital-based SNFs, I use the regular per diems for non-ventilator dependent patients.
[3] Ensign has two SNFs within 10 miles of St. Elizabeth. I drop one of the two SNFs, Lake Balboa Care Center, from the calculations, because it has very low levels of Medi-Cal patient days in the data. As such, the per diems for Ensign are for the other Ensign SNF in this area, Panorama Gardens.
[4] The "Other Providence SNF" is part of Holy Cross Medical Center, a Providence hospital.

Sources:
[1] Medi-Cal claims data, 2024.
[2] California DHCS SNF rate files for calendar year 2024.

Figure 9 presents Medicare per diems. I find that St. Elizabeth received an average Medicare Advantage per diem of $712 and an average Medicare FFS per diem of $518, meaning that Medicare Advantage paid

[97] For Medicare FFS rate setting, *see* "Skilled Nursing Facility Prospective Payment System," *CMS,* available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#SNF, accessed March 3, 2026 ("We determine SNF payments by adjusting base payment rates for geographic differences in labor costs and case-mix, and we calculate separate base rates for urban and rural areas. … We base the standardized per-diem rates on national data from urban and rural areas. Case-mix and wage adjustments apply to these per-diem rates.").

For Medi-Cal FFS rate setting, *see* the file "CY 2026 FSSA Rate Study," in "Freestanding Skilled Nursing Facilities and Subacute Units," *California DHCS*, available at https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/.

approximately 137 percent of Medicare FFS per diem. In contrast, Ensign's Medicare Advantage per diem is 115 percent of its Medicare FFS per diem, whereas nearby third-party SNFs' Medicare Advantage per diem is 102 percent of their Medicare FFS per diem. This analysis indicates that Ensign's SNFs generally receive higher Medicare Advantage per diems, relative to Medicare FFS per diems, than third-party SNFs, but lower than St. Elizabeth. Also, for each group of facilities in Figure 8, compared with Figure 7, its Medicare Advantage per diem is higher than its Medi-Cal managed care per diem. For each group, its Medicare FFS per diem is also higher than its Medi-Cal FFS per diem, except for third-party SNFs, whose average Medicare FFS per diem is similar to average Medi-Cal FFS per diem. As such, SNFs have more financial incentive to treat Medicare patients than Medi-Cal patients.

Figure 9
Average Medicare Advantage Per Diems
St. Elizabeth, Ensign, and Third-Party SNFs
SNFs Within 10 Miles of St. Elizabeth

Facility	Average Medicare Advantage Per Diem [A]	Average Medicare FFS Per Diem [B]	Average Medicare Advantage Per Diem as Percent of FFS Per Diem [C] = [A]/[B]
St. Elizabeth	$712	$518	137%
Ensign	$492	$428	115%
Third-Party SNFs	$347	$342	102%

Notes:
[1] Medicare claims data for the other Providence SNF within 10 miles of St. Elizabeth appear noisy, and I excluded that SNF from this table.
[2] Column [C] may not exactly equal to [A] / [B] due to rounding.

Source:
[1] Medicare claims data, 2023.

VII. Competitive Landscape

Both Providence and Ensign operate SNFs in Los Angeles County. Figure 10 below shows locations of St. Elizabeth, other Providence SNFs, Ensign SNFs, and third-party SNFs in this area. The map also shows nearby Providence hospitals in Southern California. There are:

- 102 SNFs within 10 miles of St. Elizabeth, 2 of which are part of Ensign and 1 of which is part of Providence;
- 16 SNFs within 5 miles of St. Elizabeth, none of which are part of Ensign; and
- Two other Providence SNFs in Los Angeles County, both of which are further than 20 miles from St. Elizabeth.

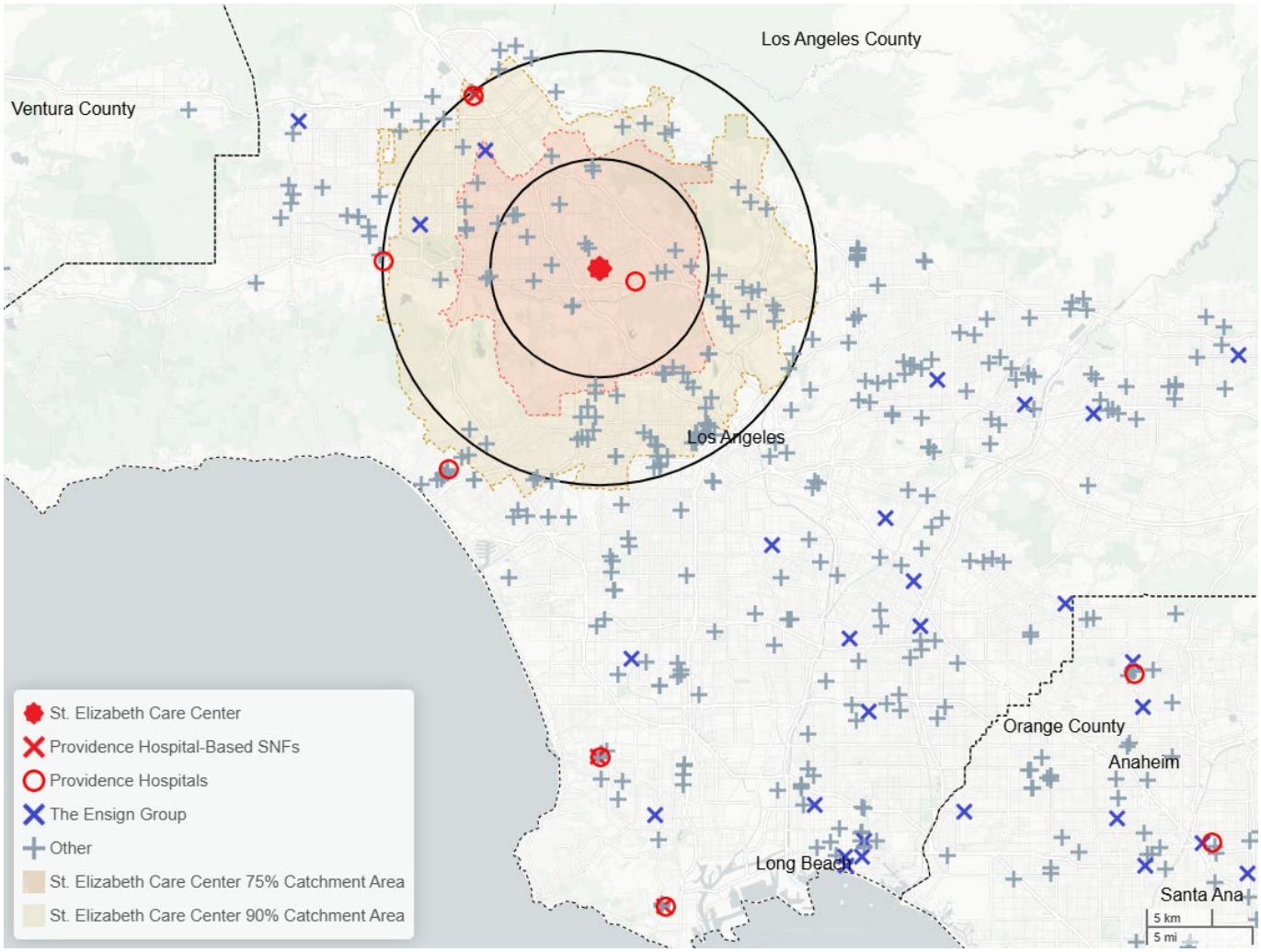
To evaluate the SNF competitive landscape for this acquisition, I looked at St. Elizabeth's patient travel patterns, which are informative of these patients' choice set regarding SNF care.[98] Patients generally want to receive care close to home, therefore SNFs close to where St. Elizabeth's patients reside are close competitors to St. Elizabeth. Also, patient travel patterns reflect the distance patients are willing to go for care, therefore SNFs within certain distances that St. Elizabeth's patients are willing to travel can be considered competitors of St. Elizabeth. Looking at patient travel patterns is a common method for defining a healthcare market.[99]

Based on Medi-Cal claims submitted by St. Elizabeth in 2024, more than 75 percent of St. Elizabeth's SNF patients reside in zip codes within 5.6 miles of St. Elizabeth, and approximately 90 percent reside in zip codes within 9.7 miles of St. Elizabeth. The red shaded area below shows the set of patient zip codes closest to St. Elizabeth that cover 75 percent of St. Elizabeth's SNF patients. The orange shaded area below shows the set of patient zip codes closest to St. Elizabeth that cover 90 percent of St. Elizabeth's SNF patients.

98 Determining patient choice set is core to market definitions. *See, e.g.,* §4.3 Market Definition, 2023 Merger Guidelines, U.S. Department of Justice and the Federal Trade Commission ("The Agencies sometimes define geographic markets as regions encompassing a group of supplier locations. When they do, the geographic market's scope is determined by customers' willingness to switch between suppliers.").

99 For example, OCAG used patient travel patterns to define relevant geographic market in a previous antitrust matter. *See, e.g.,* OCAG's Complaint to challenge Providence's proposed acquisition of several SNFs, September 21, 2021, available at https://www.courthousenews.com/wp-content/uploads/2021/09/california-providence-complaint.pdf, accessed March 1, 2026 ("The relevant geographic market for the provision of Skilled Nursing Facility services is defined by the distance patients are willing and/or able to travel to receive Skilled Nursing Facility services, and is thus local in nature. Because Skilled Nursing Facility patients often wish to receive visits from family or friends, these patients are typically unwilling to reside in facilities located far from their communities.").

Figure 10
SNFs around St. Elizabeth
5-Mile and 10-Mile Radius Centered on St. Elizabeth



Sources:
[1] CMS SNF Enrollments, January 2026.
[2] CMS SNF Ownership, January 2026.
[3] *See* Figure 1 and Appendix Figure A1.

Figure 11, below, shows the discharge shares of SNFs within 5 miles and 10 miles of St. Elizabeth. Ensign has two SNFs within 10 miles of St. Elizabeth, which account for approximately 3.0 percent of all SNF discharges in that area. St. Elizabeth accounts for approximately 0.6 percent of discharges among SNFs within 10 miles of St. Elizabeth. Among the three other Providence SNFs, the only one within approximately 10 miles of St. Elizabeth is the SNF located at Providence Holy Cross Medical Center, which accounts for approximately 2.2 percent of discharges among SNFs within 10 miles of St. Elizabeth. However, as shown in Figure 4, Ensign has a share of approximately 10 percent as of 2025 when looking at the broader Southern California region.[100]

[100] In addition, Ensign's SNFs account for approximately 8.5 percent of discharges among SNFs in Los Angeles County.

Figure 11
Shares of Discharges for SNFs Within 5 Miles and 10 Miles of St. Elizabeth

	Within 5 Miles		Within 10 Miles	
	Count of SNFs	Share of Discharges	Count of SNFs	Share of Discharges
Ensign	0	0.0%	2	3.0%
Other Providence SNF	0	0.0%	1	2.2%
St. Elizabeth	1	3.4%	1	0.6%
Other	15	96.6%	98	94.3%
Total	**16**	**100.0%**	**102**	**100.0%**

Notes:
[1] The number of discharges is from the 2023-2024 CMS SNF Cost Report data. Some California SNFs in that data are closed or stopped providing skilled nursing services as of now. These facilities are excluded from the share calculations.
[2] The "Other Providence SNF" is part of a Providence hospital, Holy Cross Medical Center.
[3] "Other" consists of SNFs that are not part of Ensign or Providence.
[4] Average annual discharges are calculated as the average reported discharges across all associated SNFs per 365-day period across the 2022-2024 CMS SNF Cost Report for free-standing SNFs and from the 2023–2024 Medi-Cal Hospital Cost Report for hospital-based SNFs.

Sources:
[1] CMS SNF Cost Report, 2022–2024.
[2] Medi-Cal Hospital Cost Report, FY 2023–2024.
[3] CMS SNF Enrollments, January 2026.
[4] CMS SNF Ownership, January 2026.

VIII. Analysis of Effect of Proposed Acquisition

In this section, I evaluate the potential effects of the proposed acquisition on competition and quality of care. As described in more detail below, I find limited evidence that the proposed acquisition is likely to lessen competition in the short term. However, the longer-term effects may be different from the short-term effects.

In **Section VIII.A**, I analyze to what extent the acquisition would increase horizontal market power and concentration.

In **Section VIII.B**, I analyze the effects of Ensign's prior acquisitions on quality, patient access, and per diems. Evidence from those acquisitions is informative about this acquisition's likely effect.[101]

In **Section VIII.C**, I examine the specific arrangement in the proposed acquisition where one entity would operate St. Elizabeth and pay rents and service fees to a related party under common ownership. I consider potential effects of this arrangement on SNF reimbursements and SNF operations by reviewing relevant economic literature and how SNFs are reimbursed in California.

In **Section VIII.D**, I discuss non-horizontal effects of the proposed acquisition. For example, the acquisition could affect competition through cross-geography or cross-service mechanisms, which I describe in more detail below.

[101] A reason for why the proposed acquisition may potentially affect these outcomes at St. Elizabeth is because the proposed acquisition would change St. Elizabeth's ownership model and mission, converting the facility from a religious nonprofit to a for-profit operator.

A. Change in Horizontal Market Power and Market Concentration

In this section, I assess the potential effect of the proposed acquisition on market power and market concentration. I perform these analyses for SNF services. I find that St. Elizabeth and Ensign are not close competitors in the SNF marketplace, and the proposed acquisition does not significantly increase the parties' market power or market concentration within the horizontal market.

Despite these findings, there is a risk that if Ensign continues to acquire SNFs in this market, the cumulative market concentration may eventually become much higher, and Ensign may be able to eventually achieve considerable market power in the future. In a highly concentrated market, a SNF operator with SNFs that Medi-Cal managed care or Medicare Advantage plans consider to be must-haves could exercise market power in negotiations with these plans to secure reimbursement rates above those paid under the Medi-Cal or Medicare FFS program. This risk of price increases is even more relevant if network adequacy requirements compel plans to contract with certain facilities.[102]

Indeed, [redacted] there are situations where Medi-Cal managed care plans pay higher rates than Medi-Cal FFS.[103]

In **Section VIII.A.i**, I calculate the diversion ratios between St. Elizabeth and Ensign.[104] The diversion ratio from St. Elizabeth to Ensign is the share of St. Elizabeth's patients who would go to Ensign's SNF(s) should St. Elizabeth close.[105] Higher diversion ratios indicate closer competition between the parties and more potential for the proposed acquisition to lessen competition.

In **Section VIII.A.ii**, I define the relevant market for the proposed acquisition.

In **Section VIII.A.iii**, I assess whether the proposed acquisition significantly increases concentration in this market under the thresholds established in the federal antitrust authorities' Merger Guidelines.

---

[102] Based on population density, the California DHCS requires timely access to SNFs to Medi-Cal managed care enrollees. *See* "Medicaid Managed Care Final Rule: Network Adequacy Standards (2018)," DHCS, p. 8, available at https://www.dhcs.ca.gov/wp-content/uploads/2025/10/FinalRuleNAStandards3-26-18.pdf. Similarly, a Medicare Advantage plans that contract with SNFs must have a SNF network that meets maximum time and distance standards. *See* "422.116 Network adequacy," *Code of Federal Regulations,* available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116. In general, all health care service plans in California are evaluated for network adequacy including a requirement that they contract with a sufficient number of SNFs. *See* "APL 25-019, Network Adequacy Standards and Methodology for RY 2026", *California Department of Managed Health Care*, p. 4, available at https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL25-019-AmendmentstoRule1300_67_21300_67_1_31300_51andNetworkAdequacyRequirementsforRY2026%2812_12_2025%29.pdf. Such standards align with my previous discussion that generally patients want to receive care close to home and my analysis of patient travel patterns.

[103] [redacted]

[104] *See* Ravel, Devesh, et al., "A Semiparametric Discrete Choice Model: An Application to Hospital Mergers," *Economic Inquiry,* 55(4): 1919-1944, October 2017.

[105] The diversion ratio from the target to the acquirer also represents the share of the target's patients (out of all of the target's patients who would leave the target) who would substitute to the acquirer if the target loses patients by lowering the quality of care that it provided.

i. Diversion Ratios between St. Elizabeth and Ensign

I calculate diversion ratios between St. Elizabeth and Ensign facilities using patient discharges in the Medi-Cal claims data from 2024, the latest year of claims data available to me.[106, 107] The diversion ratio calculation considers patient age, gender, and patient zip code.[108, 109] As shown in Figure 12 below, I find that the diversion ratios are low between St. Elizabeth and Ensign's SNFs, indicating that they are not close horizontal competitors.

Figure 12
Diversion Ratios between St. Elizabeth and Ensign SNFs
Based on 2024 Medi-Cal Claims

From St. Elizabeth to Ensign	3.66%
From Ensign to St. Elizabeth	0.02%

Source: Medi-Cal claims data, 2024.

ii. Market Definition

Antitrust markets include two dimensions: the product market and the geographic market. I use all SNF services as the product market. Both St. Elizabeth and Ensign offer SNF services.

To evaluate the geographic market appropriate for the proposed acquisition, I consider diversions from St. Elizabeth to other facilities. Based on this evidence, I use SNFs within 10 miles of St. Elizabeth as the geographic market.

In Figure 13 below, I show diversions from St. Elizabeth to other SNFs. Approximately 69 percent of St. Elizabeth's patients would choose SNFs within 10 miles of St. Elizabeth, which is likely sufficient for this to be a well-defined antitrust market.[110] Approximately 89 percent of St. Elizabeth's patients would choose SNFs within 15 miles of St. Elizabeth.

[106] Devesh Raval, et al., A Semiparametric Discrete Choice Model: An Application to Hospital Mergers, *Economic Inquiry*, 55(4): 1919-1944, October 2017.

[107] A technical description of the claims data processing steps is in **Appendix C**.

[108] **Appendix D** has a technical description of the approach I use to calculate diversion ratios.

[109] As an extreme illustrative example, if two facilities are located next to each other, but treat patients residing in completely different zip codes, the two facilities would have zero diversion between them. The two facilities would not be competing against each other since they are not competing for the same group of patients.

[110] This follows from the logic of the hypothetical monopolist test. A hypothetical monopolist of SNFs within 10 miles of St. Elizabeth likely would impose a small but significant and non-transitory increase in price ("SSNIP") or worsening of terms ("SSNIPT"). This is because a hypothetical monopolist would be able to threaten a Medi-Cal or Medicare managed care insurer with the loss of access to St. Elizabeth and the second choice of 69 percent of St. Elizabeth's patients. (Diversions represent second choices and 69 percent of diversions would be to other SNFs controlled by the hypothetical monopolist.) Such an insurer would likely prefer to accept a SSNIP at St. Elizabeth than lose access to the preferred SNFs treating so many of St. Elizabeth's patients.

Figure 13
Diversions from St. Elizabeth to Other SNFs
Based on 2024 Medi-Cal Claims

As-the-Crow-Flies Distance (Miles)	Total Diversion to SNFs within This Distance
5	35%
10	69%
15	89%
20	92%
25	94%

Source: Medi-Cal claims data, 2024.

iii. Change in Market Concentration

It is an empirical question of whether the proposed acquisition would increase the market concentration in this area. The proposed acquisition would result in St. Elizabeth switching from one system with SNFs within 10 miles to another system with SNFs within 10 miles.

Figure 14 below calculates the Herfindahl-Hirschman Index ("HHI") and changes in HHI for services provided by SNFs located within 10 (and 15) miles of St. Elizabeth due to Ensign's past acquisitions and the proposed acquisition. Absent Ensign's acquisitions (i.e., unwinding Ensign's past acquisitions), the SNF market within 10 miles of St. Elizabeth would have an HHI of approximately 483, which is not concentrated under the federal Merger Guidelines.[111] Under the current ownership structure (i.e., accounting for Ensign's past acquisitions), this market has an HHI of approximately 487, which is again not concentrated. The proposed acquisition would raise the HHI to 488 (an increase of approximately 0.9 HHI points). Neither Ensign's acquisition of St. Elizabeth nor Ensign's full series of acquisitions trigger the structural presumption in the federal Merger Guidelines.[112] Expanding the geographic market to include SNFs within 15 miles of St. Elizabeth, neither Ensign's acquisition of St. Elizabeth nor Ensign's full series of acquisitions trigger the structural presumption in the federal Merger Guidelines.

These results do not establish that the acquisition raises no competitive concerns. Rather, they indicate that the acquisition by itself would not materially increase the concentration in the area surrounding St. Elizabeth. This analysis is limited to concentration among SNFs near St. Elizabeth and does not assess whether Ensign's broader acquisition strategy may increase concentration in other geographic areas. Nor does it assess whether Ensign's size across its holds might give it market power. Any such assessments would require separate, market-specific analyses.

111 "Herfindahl-Hirschman Index," *Antitrust Division, U.S. Department of Justice*, January 17, 2024, available at https://www.justice.gov/atr/herfindahl-hirschman-index ("The agencies generally consider markets in which the HHI is between 1,000 and 1,800 points to be moderately concentrated, and consider markets in which the HHI is in excess of 1,800 points to be highly concentrated. *See* U.S. Department of Justice & FTC, *Merger Guidelines* § 2.1 (2023).").

112 *See* "Guideline 1: Mergers Raise a Presumption of Illegality When They Significantly Increase Concentration in a Highly Concentrated Market," *Antitrust Division, U.S. Department of Justice*, available at https://www.justice.gov/atr/merger-guidelines/applying-merger-guidelines/guideline-1.

Figure 14
Change in SNF Market HHI Due to Ensign Acquisitions
Based on Shares of Discharges
SNFs Within 10 Miles and 15 Miles of St. Elizabeth

		HHI	
		Within 10 Miles	Within 15 Miles
[A]	Absent Ensign's Acquisition of Its Current In-Market Facilities	483	343
[B]	Current	487	344
[C]	Current + Proposed Acquisition of St. Elizabeth Care Center	488	345
[D]	*Change in HHI from [A] to [B]*	*4.2*	*1.3*
[E]	*Change in HHI from [B] to [C]*	*0.9*	*0.3*

Notes:
[1] HHI is the sum of the squared system shares of SNF discharges, multiplied by 10,000. I use the annualized discharge numbers underlying Figure 11 above for this HHI calculation.
[2] A "system" is defined using the "Affiliation Entity Name" in CMS Medicare Enrollment data, Ensign's website, and Medi-Cal Cost Reports.
[3] Row [A] is calculated by re-assigning Ensign's shares to the previous owners of its two facilities in this market. Lake Balboa Care Center was a standalone facility before Ensign's acquisition in November 2022. Panorama Gardens was part of a system called Beverly Health & Rehab SVCs before Ensign's acquisition in 2000. Beverly Health & Rehab SVCs no longer exists. For the purpose of this HHI calculation, I assume Panorama Gardens was a standalone facility before Ensign's acquisition. The owners prior to Ensign's acquisition are from ownership information in Medi-Cal Cost Reports and CMS SNF Ownership data.
[4] Some California SNFs in the CMS SNF Cost Report (2022–2024) do not appear in the CMS Enrollment data as of January 2026. Some of these SNFs are closed or stopped providing skilled nursing services as of now. These facilities are excluded from the calculations of market HHI.
[5] Numbers in rows [D] and [E] may not align exactly with those calculated from rows [A] to [C] due to rounding.

Sources:
[1] CMS SNF Cost Report, 2022–2024.
[2] Medi-Cal Hospital Cost Reports, FY 2023–2024.
[3] CMS SNF Enrollments, January 2026.
[4] CMS SNF Ownership, January 2026.
[5] Lake Balboa Care Center Medi-Cal Cost Report, December 31, 2022.
[6] Panorama Gardens Nursing and Rehabilitation Center Medi-Cal Cost Report, August 31, 2000.

B. Analysis of Ensign's Past Acquisitions

I analyze the effect of 28 Ensign SNF acquisitions in California between 2019 and 2023.[113]

First, I compare St. Elizabeth to SNFs that Ensign has historically acquired. Whether Ensign's acquisition of St. Elizabeth is likely to have effects similar to its prior acquisitions may depend, in part, on how similar St. Elizabeth is to those previously acquired facilities. For example, the effects of acquiring a low-quality SNF may differ from those of acquiring a high-quality SNF. Accordingly, the extent to which Ensign's prior

[113] *See* Appendix Figure A1 for the list of Ensign facilities with their acquisition dates. These 28 SNFs include 17 acquired from Sabra in February 2023. I excluded Valley of the Moon Post Acute, which Ensign started managing in July 2019, because it is a hospital-based SNF and is not in CMS SNF Cost Report data. *See* "The Ensign Group Closes on Expansion in California," *The Ensign Group*, February 1, 2023, available at https://s203.q4cdn.com/190017989/files/doc_news/2023/02/18866.pdf.

acquisition targets resemble St. Elizabeth may help determine how informative those acquisitions are for assessing the likely effects of the proposed acquisition.

Second, I evaluate whether care quality and patient accessibility of SNFs acquired by Ensign changed after prior acquisitions.

Third, I examine whether Medicare per diems changed after Ensign's past acquisitions and evaluate whether changes appear to be driven by prices or quantity or coding.[114]

I use a difference-in-differences ("DID") approach to evaluate the effect of Ensign's acquisitions between 2019 and 2023. The DID approach is commonly used by economists to evaluate the impacts of policies or organizational changes. The specific DID approach I use for this analysis compares the difference in outcome of the acquired facilities before and after the year (or month) of their acquisitions with the difference in the average outcome of a set of benchmark facilities before and after the same year (or month). The benchmark is SNFs in California counties with minimal Ensign presence.[115]

I find that St. Elizabeth is comparable to Ensign SNFs acquired between 2019 and 2023 on health outcome metrics. However, it currently serves, on average, lower acuity patients, has lower percentages of Medi-Cal patients, and has lower levels of RN staffing compared to Ensign SNFs (*see* **Section VIII.B.i** below). I also examine how these Ensign SNFs' performance changed following their acquisition by Ensign. I find no statistically significant change in health outcomes or patient acuity levels, but some evidence of Ensign substituting RN hours and LPN hours to NA hours (*see* **Section VIII.B.ii** below).

I also find no statistically significant change in Medicare Advantage or Medicare FFS per diems following these Ensign acquisitions (*see* **Section VIII.B.iii** below).

i. Ensign's Past Acquisitions versus St. Elizabeth

Figure 15 below compares St. Elizabeth with Ensign SNFs in California that were acquired between 2019 and 2023. I find that St. Elizabeth is of lower overall quality than these Ensign SNFs according to CMS's five-star rating system,[116] but the health outcome metrics of St. Elizabeth's patients are generally comparable with Ensign SNFs' patients. St. Elizabeth also appears to treat lower acuity patients. On staffing, St. Elizabeth appears to have a unique staffing model of very low levels of RNs and high levels of NA compared to Ensign SNFs, with overall staffing levels slightly higher than that of Ensign SNFs. St. Elizabeth also treats a higher percentage of Medicare patients and a lower percentage of Medi-Cal patients compared to Ensign SNFs.

[114] I study the effect of Ensign's past acquisitions on Medicare per diems. I do not have sufficient historical data to study the effect of the Ensign's past acquisitions on Medi-Cal managed care per diems.

[115] Specifically, these are counties with no more than one Ensign SNF.

[116] The five-star rating system evaluates each SNF based on health inspection outcomes, staffing, and health outcome metrics. *See, e.g.,* "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide," *CMS*, April 2026, available at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.

Figure 15
Comparison of St. Elizabeth with SNFs Acquired by Ensign between 2019 and 2023

	Metric	St. Elizabeth [A]	Ensign Average [B]	Difference [C] = [A]−[B]
	CMS overall five-star rating (higher is better)			
[1]	Overall five-star rating	2	3.3	-1.3
	Health outcome metrics (lower is better)			
[2]	Adjusted rate of unplanned re-hospitalization within 30 days of SNF admission	21.8%	22.5%	-0.7%
[3]	Adjusted rate of emergency room visit within 30 days of SNF admission	8.9%	10.1%	-1.2%
[4]	Adjusted number of unplanned hospitalizations per 1,000 long-stay resident days	2.5	2.2	0.3
[5]	Adjusted number of emergency room visits per 1,000 long-stay resident days	1.1	1.4	-0.2
	Nursing care staffing (hours per patient day)			
[6]	All employed nursing staff	4.6	4.3	0.4
[7]	Employed RNs	0.2	0.4	-0.2
[8]	Employed LPNs	1.3	1.2	0.0
[9]	Employed NAs	3.2	2.7	0.5
	Patient volume and payer mix			
[10]	Percent of Medi-Cal patient days	35.7%	55.7%	-20.0%
[11]	Percent of Medicare patient days	41.3%	37.0%	4.3%
[12]	Percent of commercial patient days	1.4%	1.3%	0.1%
[13]	Percent of self-pay & other patient days	21.6%	6.0%	15.6%
	Patient acuity/characteristics			
[14]	“Expected” percentage of patients with unplanned re-hospitalization within 30 days of SNF admission	19.1%	25.6%	-6.5%
[15]	“Expected” percentage of patients with emergency room visits within 30 days of SNF admission	9.7%	11.9%	-2.1%
[16]	“Expected” number of unplanned hospitalizations per 1,000 long-stay resident days	1.8	2.6	-0.8
[17]	“Expected” number of emergency room visits per 1,000 long-stay resident days	1.5	1.8	-0.4
[18]	Average length of stay (days)	87.9	88.1	-0.2

Notes:
[1] Approximately twenty percent of St. Elizabeth’s patients are self-pay.
[2] The “expected” value metrics in the patient acuity panel measure the patient health outcomes that would be expected if the SNF’s patients were treated by a SNF of “average” quality. Consequently, the “expected” value metrics are SNF patient acuity metrics, and lower values indicate lower acuity patients. “SNF Medicare Compare” in **Appendix F** has details of these metrics.
[3] Column [B] and [C] may not sum up to [A] due to rounding.

Sources:
[1] CMS five-star rating: CMS SNF Medicare Compare, May 2026.
[2] Health outcome metrics and patient acuity: data associated with March 2026 CMS SNF Medicare Compare, which reports metric values measured between July 1, 2024 and June 30, 2025.
[3] Nursing care staffing and patient length of stay: CMS CMS SNF Cost Report, 2024.
[4] Patient volume and payer mix: 2024 Medi-Cal SNF Cost Reports and Medi-Cal Hospital Cost Reports for FY 2023–2024.

ii. Care Quality and Patient Access

For changes in care quality, I analyze metrics on health outcomes, staffing levels, and staffing compositions. These metrics are components of CMS's five-star quality rating system.

For changes in patient accessibility, I analyze metrics on patient volume, payer mix, and patient acuity. These metrics are from CMS SNF Cost Reports and CMS SNF Medicare Compare data.

Both care quality and accessibility are relevant for analyzing SNF competition. Care quality is a key dimension of competition among SNFs because Medicare and Medi-Cal FFS rates are set by government agencies. A SNF that is perceived to have higher care quality could in theory attract more patients, therefore organically increasing its market power and its ability to negotiate higher rates with managed care and commercial plans.

SNF accessibility is also directly relevant for analyzing SNF competition. A SNF with lower overall accessibility restricts the supply of SNF care in its local market and thus reduces competition in that market. A SNF that selectively admits only sicker or less sick patients out of profitability concerns restricts the supply of SNF care to specific groups of patients with certain levels of acuity and thus reduces competition among SNFs supplying care to these patients.

My findings on the effect of these acquisitions are the following:

- **Health outcome metrics:** I find no statistically significant change among the health outcome metrics I analyze.
- **Staffing:** I find substitution from RN hours and LPN hours to NA hours following these acquisitions, with no statistically significant overall change in total nursing hours per patient day. As described in **Section V.A.ii** of my report, research suggests that reducing the number of RN hours may result in a decline in quality. While my analysis does not identify any deterioration in health outcomes due to Ensign's prior acquisitions, it remains possible that changes in staffing composition could have longer-term effects on quality of care that are not reflected in the available data.
- **Patient volume and payer mix:** I find a significant increase in the total patient days and total Medicare patient days immediately following these acquisitions.[117] Specifically, I find that, on average, the SNFs acquired by Ensign had approximately 10 percent more total patient days after the acquisitions. In other words, Ensign facilities on average, have fewer empty beds post-acquisition. On the other hand, I find that, on average, these SNFs had approximately 40 percent more Medicare patient days after the acquisitions, and this increase was driven by an increase in traditional Medicare patient days. Based on the payer mix of California SNFs, more than 80% of non-Medicare patients are covered by Medi-Cal.[118] Therefore, Ensign has potentially substituted some Medi-Cal patients with higher-paying Medicare patients.
- **Length of stay**: I find a statistically significant increase in length of stay of approximately 40 percent following Ensign's past acquisitions. Because total patient days increased by only about 10 percent over the same period, this result means that the total number of unique patients treated declined following the acquisitions.

[117] Medicare patient days consist of FFS and Medicare Advantage patient days and also days for dual-covered patients with Medi-Cal coverage.

[118] *See* Figure 5.

- **Patient acuity:** I find no statistically significant change in patient acuity following the Ensign acquisitions.

Appendix B of my report shows trends in the pre- and post-acquisition periods for these metrics.[119] A technical discussion on the data sources, data processing considerations, and regression specifications is in **Appendix C, F,** and **E.**

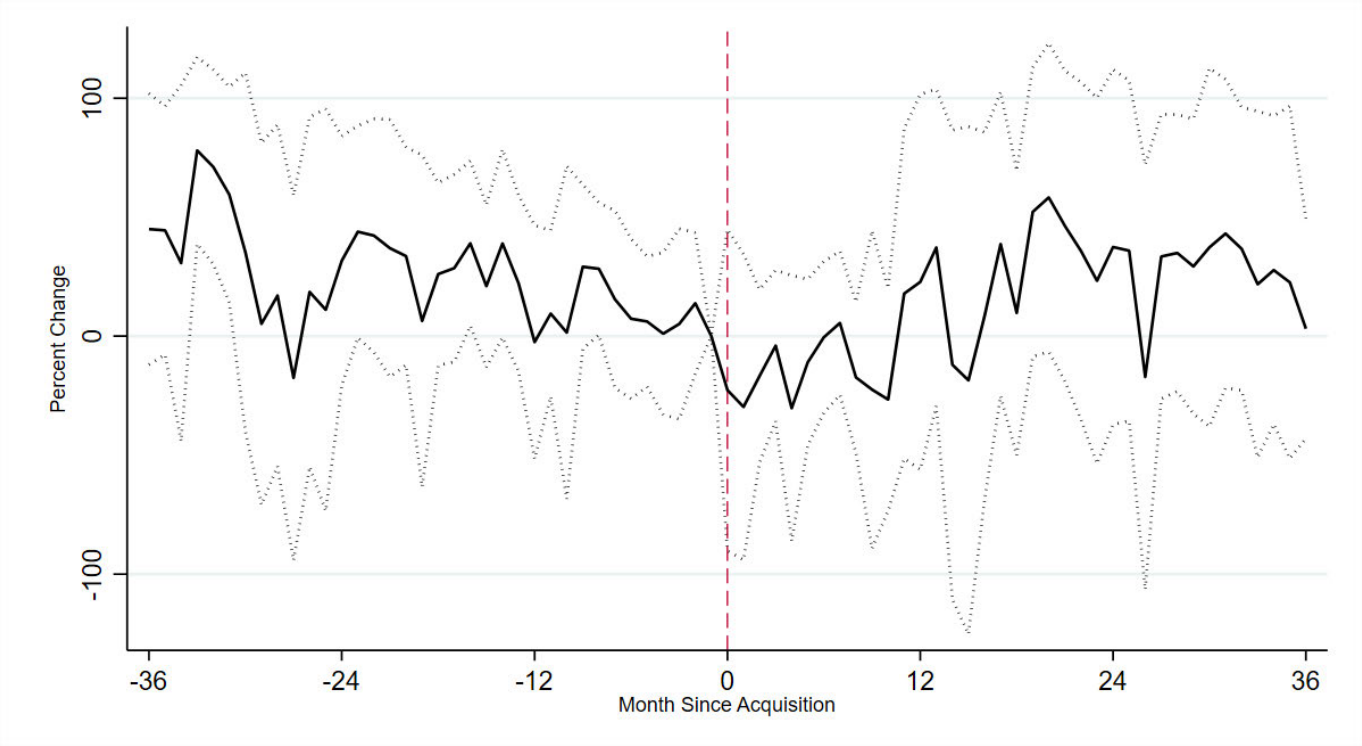
iii. Medicare FFS and Medicare Advantage Per Diems

I begin by evaluating how per diems changed post-acquisition for Medicare Advantage and Medicare FFS.

Figure 16 below shows how Ensign's Medicare Advantage per diem changed following the Ensign acquisitions. I find no statistically significant change in Medicare Advantage per diems following the acquisitions.

[119] I report percent changes of each metric in the Appendix figures.

Figure 16
Changes in Medicare Advantage Per Diem
SNFs Acquired by Ensign between 2019 and 2023

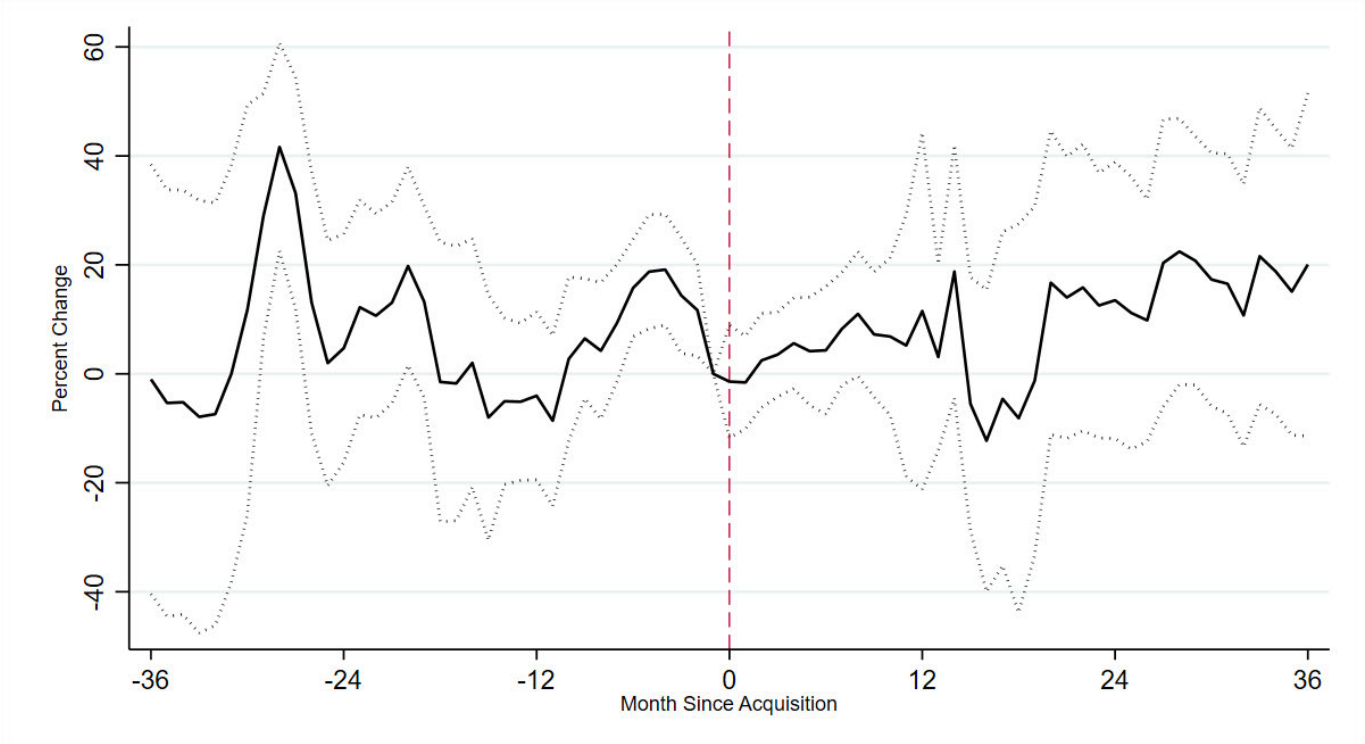


Notes:
[1] Dashed vertical line indicates the month when the acquisitions happened.
[2] Analysis includes facility fixed effects and month fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: Medicare claims data, 2018–2023.

Figure 17 below shows how Ensign's Medicare FFS per diems changed following the Ensign acquisitions. I find no statistically significant change in Medicare FFS per diems following the acquisitions.

Figure 17
Changes in Medicare FFS Per Diem
SNFs Acquired by Ensign between 2019 and 2023

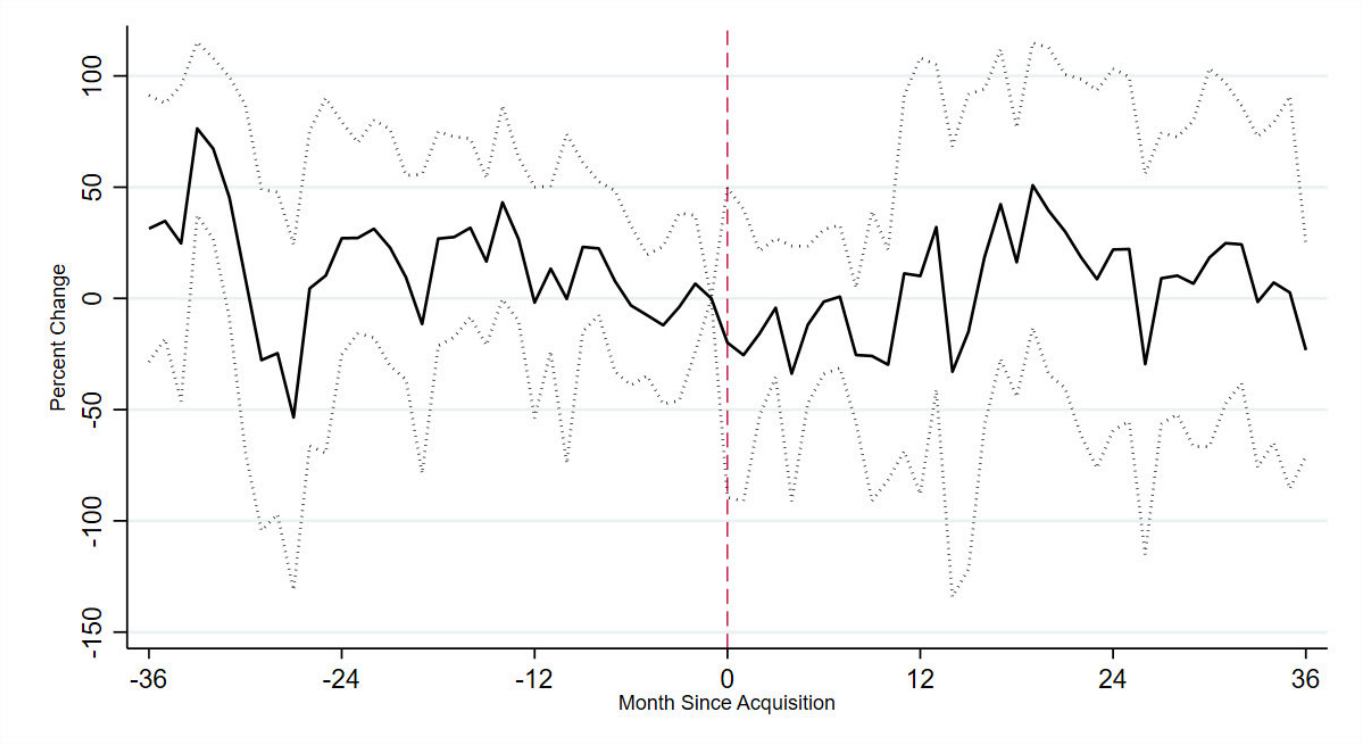


Notes:
[1] Dashed vertical line indicates the month when the acquisitions happened.
[2] Analysis includes facility fixed effects and month fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: Medicare claims data, 2018–2023.

Figure 18 below shows how Ensign SNFs' Medicare Advantage per diem relative to Medicare FFS per diem changed following the Ensign acquisitions. As explained above, this ratio is a measure of the rates paid by Medicare Advantage plans. I do not find any statistically significant change in Medicare Advantage rates in the three years following these acquisitions.

Figure 18
Changes in Medicare Advantage Per Diem Relative to Medicare FFS Per Diem
SNFs Acquired by Ensign between 2019 and 2023



Notes:
[1] Dashed vertical line indicates the month when the acquisitions happened.
[2] The figure shows the percent change in relative per diem. As a hypothetical example, if the Medicare Advantage per diem relative to the Medicare FFS per diem was 1.2, and the percent change was 10 percent, then the relative per diem became 1.32 after the change.
[3] Analysis includes facility fixed effects and month fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: Medicare claims data, 2018–2023.

C. Analysis of the Proposed Transaction Structure

The proposed acquisition involves the SNF operator, West Star, paying rent to an entity under common ownership, Toluca Way, which is a subsidiary of Ensign's REIT.[120] In addition, St. Elizabeth would pay fees to Ensign Services for administrative services. The transfer of value through transactions among affiliated entities is commonly referred to as "profit tunneling." In this section, I analyze whether these arrangements could adversely affect St. Elizabeth, which may raise competitive concerns, such as higher prices, lower quality, restrictions on patient access, or an increased risk that St. Elizabeth does not remain a going concern.

These types of related-party payments raise at least three concerns: (1) they may be inflated so that the parent company obtains higher payments without benefiting a SNF's quality of care, (2) they may signify that the owner intends to use fewer resources to hire additional staff or invest in capital improvements to improve

[120] Ensign's REIT would also pay management fees to Ensign Services. *See* **Section IV.C** above.

quality of care, and (3) if St. Elizabeth were to cease operating as a going concern, the state or another public entity could be left responsible for ongoing lease obligations, even if the rent exceeds fair market value.[121] I find there is the greatest risk from the third concern.

i. SNF Related-Party Payments

As an initial matter, economists find that related-party payments are prevalent among SNFs and are often at above market rates. For example, one study finds that 77 percent of free-standing nongovernment SNFs in the United States made payments to related parties. A federal government agency conducted an audit of 14 SNFs and found that seven reported related party payments that were above market value, totaling $1.7 million in inflated costs.[122] In addition, a study of Illinois SNFs identified significant related party markups, including profit margins of 36 percent on real estate services, 42 percent on management services, and 38 percent on ancillary services rendered by related parties.[123]

These studies likely understate the prevalence and magnitude of inflated related-party payments because SNFs are not required to substantiate these payments.[124] Economists have found that this lack of oversight contributes to misreporting in the Medicare Cost Reports.[125] A federal government agency also found that some SNFs were noncompliant with related-party payment and disallowance reporting requirements.[126]

For the proposed acquisition, West Star would pay an annual rent amount of $725,616, which is approximately 14.5 percent of the $5 million sale price, to Ensign's REIT. An investor survey by a commercial real estate firm found that SNFs typically pay an annual rent of approximately 11.2 to 13.4 percent of their value as of 2024.[127] This suggests West Star's annual rent is above typical market levels. And, Providence's consulting firm, [redacted], estimated the property's fair market rent at approximately $[redacted] per year.[128] As such, the lease arrangement appears to pose a potential risk of tunneling profits from St. Elizabeth to affiliated entities.

---

121 *See*, *e.g.,* Sherman, Ted, et al., "Inside the 'multibillion-dollar game' to funnel cash from nursing homes to sister companies," *NJ.com*, April 30, 2025, available at https://www.nj.com/news/2025/04/inside-the-multibillion-dollar-game-to-funnel-cash-from-nursing-homes-to-sister-companies.html. *See, also,* discussions in **Section VIII.C.ii**.

122 *See* "Some Selected Skilled Nursing Facilities Did Not Comply with Medicare Requirements for Reporting Related-Party Costs," *Department of Health and Human Services Office of Inspector General*, December 2024, p. 2, 11-12, available at https://oig.hhs.gov/documents/audit/10131/A-07-21-02836.pdf.

123 *See* Gandhi, Ashvin, and Andrew Olenski, "Tunneling and Hidden Profits in Health Care," *National Bureau of Economic Research Working Paper*, September 2025, p. 24.

124 *See* Harrington, et al., "United States' Nursing Home Finances: Spending, Profitability, and Capital Structure," *International Journal of Social Determinants of Health and Health Services,* 54(2), 2024, p. 138.

125 *See* Gandhi, Ashvin, and Andrew Olenski, "Tunneling and Hidden Profits in Health Care," *National Bureau of Economic Research Working Paper*, September 2025, p. 4.

126 *See* "Some Selected Skilled Nursing Facilities Did Not Comply with Medicare Requirements for Reporting Related-Party Costs," *Department of Health and Human Services Office of Inspector General*, December 2024, p. 2, available at https://oig.hhs.gov/documents/audit/10131/A-07-21-02836.pdf.

127 *See* CBRE, "U.S. Senior Housing & Care Investor Survey H2 2024," November 2024, available at https://mktgdocs.cbre.com/2299/0e2432a6-c152-47f8-854a-adc724848444-524430563/U.S._Seniors_Housing_Care_Inve.pdf.

128 *See* **Section IV.C** above.

In addition, West Star would pay service fees representing five percent of St. Elizabeth's gross revenue to Ensign Services. While a five-percent service fee appears to be industry standard based on materials produced by the parties, SNFs generally operate on relatively low margins, and the cumulative effect of management fees and other charges paid to affiliated entities may therefore have a meaningful impact on the facility's financial performance.[129]

Finally, Ensign's REIT, which is collecting rent from West Star, would also pay fees to Ensign Services that would be between five and six percent of the REIT's total revenue.[130] This means that West Star would be effectively transferring more than five percent of St. Elizabeth's gross revenue to Ensign Services, increasing the potential concerns of the impact of related-party payments on St. Elizabeth's financial stability.

ii. Analysis of Potential Competitive Concerns

I next consider whether profit-tunneling, either through above-market rent or service fees, could raise competitive concerns. I find that profit tunneling is unlikely to meaningfully change a SNF's Medicare or Medi-Cal reimbursement rates, which are largely determined through administratively set payment systems or negotiations with managed care plans.[131] Nevertheless, SNFs may still have incentives to inflate payments to affiliated entities. These incentives include shielding assets from malpractice liabilities and lowering tax burden.[132, 133] By directing revenue from the operating entity (which bears clinical and malpractice risk) to affiliated real estate (or management) entities, owners can potentially reduce the amount of assets exposed to legal judgments. In addition, related-party payments could be used to shift income to affiliates in more favorable tax positions. Such actions may maximize the operator's profit while adversely impacting the quality of care.

---

129 [redacted]

A long-term care industry publication also states that the 5 percent management fee is standard. *See* Marselas. Kimberly, "Why COVID may kill the management fee and change LTC deal-making for good," *McKnights Long-Term Care News*, November 2, 2021, available at https://www.mcknights.com/news/why-covid-may-kill-the-management-fee-and-change-ltc-deal-making-for-good.

130 The payment from Ensign's REIT to Ensign Services is in the form of the "Administrative Management Fee" and the "Incentive Fee." The "Administrative Management Fee" is five percent of the REIT's total revenue (including revenue from its subsidiaries), and the "Incentive Fee" is five percent of the REIT's net income, excluding gains (or losses) from sales of real estate, impairment, depreciation, and amortization (capped at one percent of total revenue). *See* "Exhibit 2(B) Management Agreement Between Ensign Services, Inc. and Standard Bearer Healthcare REIT, Inc.," in Response to Third Notice of Deficiency, pp. 21-23, 34.

131 Specifically, as discussed in **Section V.A.iii** above, traditional Medicare (i.e. non-Medicare Advantage plans) does not reimburse individual SNFs based on their individual operating expenses, and traditional Medi-Cal (non-managed care) has multiple safeguards against profit tunneling.

132 *See* Gandhi, Ashvin, and Andrew Olenski, "Tunneling and Hidden Profits in Health Care," *National Bureau of Economic Research Working Paper*, September 2025, pp. 1-4.

133 *See e.g.,* "How large businesses use partnerships to create tax deductions out of thin air: An explainer on related party basis shifting," *The Tax Law Center at NYU Law*, available at https://www.law.nyu.edu/sites/default/files/Related%20Party%20Basis%20Shifting%20%E2%80%93%20An%20Explainer.pdf.

Specific Concerns with Above-Market Rent

Above-market rent may increase the likelihood that Ensign will prioritize patients covered by higher-reimbursed Medicare and reduce access to Medi-Cal patients post-acquisition.

In addition, above-market rent may increase the risk that St. Elizabeth may not remain a going concern. As one well-known example, in 2016, Steward Health Care entered a sale-leaseback arrangement of all its hospital buildings and land to Medical Properties Trust,[134] which burdened the system with significant rent payments. Steward Health Care subsequently declared bankruptcy in 2024. An analysis of federal and state records found that the number of quality deficiencies per Steward Health Care hospital in 2024 was approximately 3.5 times the national average.[135] The collapse of Steward Health Care also put financial burdens on the Massachusetts state government, which provided significant financial assistance to the hospitals to prevent closure.[136]

There is additional evidence that sale-leasebacks can place financial strain on SNFs. For example, HCR ManorCare, once the nation's second largest nursing home chain, filed for bankruptcy in 2018 after falling behind on $446 million in rent owed to Quality Care Properties Inc. HCR ManorCare previously sold its property and facilities to Quality Care Properties in 2011 for $6.1 billion and leased them back. According to its bankruptcy filing, HCR ManorCare's revenues were insufficient to cover its monthly rent obligations since 2012, one year after the sale-leaseback.[137]

Specific Concerns with Service Fee

The service fee, which is currently set to five percent of St. Elizabeth's gross revenue, raises several potential issues.

First, the fee could contribute to financial strain at St. Elizabeth, which could lead the facility to defer investments in quality, staffing, or maintenance, or threaten its ability to remain a going concern.

Second, nothing prevents Ensign from increasing the fee in the future. As a result, even if the current five percent fee does not create financial strain, Ensign could later set a fee that does create strain.

---

134 A sale-leaseback arrangement is when a health care facility sells its real estate to another entity and at the same time leases it from that entity. The sale-leaseback arrangement is similar to the related-party payment at issue in the proposed transaction in that the healthcare facility would potentially be subject to higher-than-market-rate rent amounts.

135 *See* Brangham, William, et al., "Investigation reveals how investors made millions as Steward Health Care system collapsed," *PBS News*, September 12, 2024, available at https://www.pbs.org/newshour/show/investigation-reveals-how-investors-made-millions-as-steward-health-care-system-collapsed; Goldstein, Amy, "Lessons from the collapse of Steward Health Care," *Brookings*, October 2, 2025, available at https://www.brookings.edu/articles/lessons-from-the-collapse-of-steward-health-care.

136 *See, e.g.,* "Steward Hospitals Bought (and Closed)," Massachusetts Health & Hospital Association, September 3, 2024, available at https://www.mhalink.org/mondayreport/steward-hospitals-bought-and-closed/, ("[S]ix of the [Steward Health Care] hospitals [in Massachusetts] were sold and the remaining two were closed. … Steward's agreement with the purchasers is contingent on Steward receiving $42 million from the state to continue operations at the hospitals in September.").

137 *See* "A private equity firm purchased a major nursing home chain. What happened next?" *Advisory Board*, February 08, 2024, available at https://www.advisory.com/daily-briefing/2018/11/28/nursinghome; Rucinski, Tracy, "HCR ManorCare files for bankruptcy with $7.1 billion in debt," *Reuters*, March 05, 2018, available at https://www.reuters.com/article/world/hcr-manorcare-files-for-bankruptcy-with-71-billion-in-debt-idUSKBN1GH2BT.

Third, because the fee is based on revenue, it gives Ensign an incentive to increase St. Elizabeth's revenues. Although not necessarily problematic, this may increase the likelihood that Ensign prioritizes higher-reimbursed Medicare patients and reduces access for Medi-Cal patients post-acquisition.

Finally, the service fee and above-market rent, taken together, may increase the likelihood of financial strain at St. Elizabeth.

D. Non-Horizontal Effects of the Proposed Acquisition

The acquisition could also affect competition through non-horizontal means.

In particular, Ensign operates in a number of geographies. This means that the merger could lead to higher prices for cross-geography reasons.

Furthermore, Providence operates across a number of services, including general acute care hospitals and SNFs. This co-ownership could have affected competition when St. Elizabeth was part of Providence. And therefore, St. Elizabeth leaving Providence could independently affect competition.

In the remainder of this section, I first describe the economic mechanisms through which a cross-geography merger can increase prices. I then analyze whether these mechanisms apply to this acquisition. Finally, I describe the cross-service mechanisms through which this acquisition could affect competition.

i. Cross-Geography Economic Mechanisms

Ensign's acquisition of St. Elizabeth could raise concerns about increased prices arising from either increased market power or an increased exercise of existing market power.

Cross-geography mergers can increase the market power of the merged entity even when the merging providers do not compete directly for the same patients in a local market. The acquisition may nonetheless change negotiations between the provider and insurers.

Change in Market Power

A precondition for most economic mechanisms through which cross-geography mergers can increase prices is that the merged entity negotiates jointly with an insurer across multiple geographies post-acquisition.[138,139]

Joint negotiations can increase market power where the loss of the merged entity from an insurer's network in one geography increases the loss in profits that the insurer would suffer from losing the merged entity in

[138] Cross-geography mergers can also increase prices by increasing multi-market contact between competitors, which can soften competition. The proposed transaction does not meaningfully affect multi-market contact for Ensign because St. Elizabeth operates in a geography in which Ensign already operates. The proposed transaction could, however, increase the multi-market contact associated with St. Elizabeth by making it part of Ensign's broader network of facilities.

Giving St. Elizabeth the same degree of multi-market contact as Ensign would be more likely to increase prices if Ensign's prices were higher than St. Elizabeth's. Ensign's greater multi-market contact is one possible reason Ensign might have a stronger negotiating position, and therefore higher prices, than St. Elizabeth. The transaction could allow Ensign to apply its existing negotiating position to St. Elizabeth. But if, holding factors other than negotiating position constant, St. Elizabeth's prices are already comparable to or higher than Ensign's, then it would be less likely that Ensign has a stronger position to apply at St. Elizabeth post transaction.

[139] *See, e.g.,* Schmitt, Matt, "Multimarket Contract in the Hospital Industry," *American Economic Journal: Economic Policy,* 2018, pp. 361-387.

another geography.[140] Put differently, the question is whether the insurer's harm from excluding both facilities is greater than the sum of the harms from excluding each facility separately. This may occur where the insurer has customers who care about the provider network across multiple geographies. For example, an employer with employees in two geographies may be willing to tolerate a provider-network gap in one area but not gaps in both areas. In that circumstance, the merged entity may become more valuable to the insurer than the two providers were separately because excluding the combined system would create a broader network deficiency and a larger loss of profits. Cross-market mergers can also affect competition where insurers' prices to customers are linked across markets. If an insurer cannot easily adjust premiums separately by geography, then the loss of a provider in one geography may affect the insurer's profitability or product attractiveness in other geographies. That linkage can make the combined provider more important to the insurer than either provider would be separately.

Joint negotiations can also increase market power if the merged entity can use negotiations in one geography to disadvantage rivals in another. For example, the merged entity might condition negotiations in one geography on an insurer agreeing to contract terms that limit the incentive or ability of competitors to compete in another geography. The merged entity might also condition negotiations in one geography on an insurer steering patients away from rival facilities in another market (i.e., foreclosure of rival facilities). Those terms could deny rivals the volume or scale needed to compete effectively. In that case, the concern is that the acquisition may reduce the competitive constraint imposed by rival providers, which would allow the merged entity to exercise additional market power, such as by raising negotiated prices.

A condition that increases the risk that a cross-market merger will increase market power is that the merged entity has sufficient market power to impose all-or-nothing negotiation on insurers. If the merged entity attempts to negotiate on an all-or-nothing basis with insurers but lacks market power when doing so, then the insurer can simply say no. In that circumstance, the merged entity lacks sufficient market power for a cross-market merger to cause harm.

The strength of a cross-geography theory therefore depends on several acquisition-specific factors:

- whether the merged entity has a history or ability to engage in all-or-nothing negotiations;
- whether the facilities serve common customers; and
- whether insurers' prices are linked across geographies.

Change in Exercise of Market Power

An acquisition, including a cross-market acquisition, can also increase prices by increasing the degree to which the parties leverage existing market power to obtain higher prices. This can occur if the acquirer is a stronger negotiator than the target or if the acquirer's mission is more focused on earning profit than the target.

The current available evidence is generally inconsistent with this concern. If Ensign were particularly able to leverage existing market power, then, all else equal, its past acquisitions would be more likely to have resulted in price increases, and its prices would be more likely to exceed St. Elizabeth's. Neither is true.

[140] This discussion is based on Dafny, Ho, and Lee (2019) and Vistnes and Sarafidis (2013). *See* Dafny, Leemore, et al., "The price effects of cross-market mergers: theory and evidence from the hospital industry," *RAND Journal of Economics*, 50(2), 2019. *See also*, Vistnes, Gregory and Yianis Sarafidis, "Cross-Market Hospital Mergers: A Holistic Approach," *Antitrust Law Journal*, 79(1), 2013.

ii. Cross-Geography Analysis

Based on the factors described in the prior section, I find that there is not an immediate risk that the current acquisition substantially increases prices because of cross-geography concerns. While the risk of "future all or nothing" contracting is present with Ensign as an operator of SNFs in multiple geographies, that risk with respect to St. Elizabeth specifically as one of many SNFs in its local environment appears lessened. As discussed below, I reach this conclusion for several reasons and therefore do not recommend a specific condition at this time based on the below.

First, Ensign's Medicare Advantage or Medi-Cal managed care prices are not consistently higher than St. Elizabeth's. This suggests that if St. Elizabeth was to adopt Ensign's prices, prices would not consistently increase (*see* **Section VI.B**).

Second, Ensign's past acquisitions have not increased its Medicare Advantage prices (*see* **Section VIII.B**).

Third, I find no evidence that Ensign currently engages in all-or-nothing contracting, [redacted].[141] Cross-geography acquisitions are unlikely to lead to increases in market power if Ensign does not engage in cross-geography contracting.

However, there could be concerns that Ensign's continued growth could ultimately lead to higher prices because of cross-geography concerns. Specifically, Ensign already operates approximately 10 percent of the SNF beds in Southern California and has steadily acquired additional facilities in California,[142] including facilities in geographic areas with more limited SNF alternatives.[143] In addition, there are situations where Medi-Cal managed care plans pay higher rates than Medi-Cal FFS.

It also appears that Ensign's affiliated SNFs enter into management or centralized services contracts with Ensign Services. Such agreements include terms that would facilitate Ensign Services' ability to coordinate contracts with payers across multiple Ensign affiliates.[144] This raises the specific risk that Ensign Services will negotiate centralized payer contracts on behalf of Ensign SNFs including St. Elizabeth at higher per-diem rates than the rates in existing contracts.

Hence, Ensign could engage in all-or-nothing contracting in the future and might even be today with other payers.[145] Similarly, Ensign's continued growth could increase its importance to managed care payers,

---

141 [redacted]

142 [redacted]

143 For example, there are two Ensign SNFs in areas with no third-party (i.e., non-Ensign and non-Providence) SNFs within 10 miles of their locations. *See* notes in Figure 7.

144 *See* Response to Third Notice of Deficiency, pp. 2-3 ("[The Ensign Group] is the sole owner of [Ensign Services]. … [Ensign Services] serves as 'the Service Center,' which provides management and administrative services to [the Ensign Group]'s affiliates."), 56-58 ("[Ensign Services] [a]ssists Facility staff with negotiating and entering agreements with Accountable Care Organizations, Managed Care Organizations and health care insurers for the purpose of establishing revenue generating provider agreements.").

145 There are Medi-Cal managed care and Medicare Advantage payers that operate in multiple geographies in California, including in areas where Ensign operates facilities. *See, e.g.,* "Health Plan Dashboard," *California Department of Managed*

including Medi-Cal managed care and Medicare Advantage payers, which face federal and state network requirements that may create incentives to contract with SNF providers. [146] Also, Ensign's footprint outside of California could continue to grow without triggering additional merger reviews within California, which could increase Ensign's cross-market market power and increase the risk of price increases because of cross-geography concerns. However, the impact of such a risk on St. Elizabeth appears lessened based on my prior discussion of its role in its local market.

iii. Cross-Service Effects of the Acquisition

The proposed acquisition would see St. Elizabeth leaving the Providence Health System and joining Ensign. Because Providence offers both acute care and post-acute care services, the acquisition could eliminate certain cross-service effects that resulted from St. Elizabeth being part of Providence.

[redacted] [147] Providence's ownership of St. Elizabeth therefore could have been placing upward pressure on prices. Eliminating Providence's ownership of St. Elizabeth reduces the risk of increased rates at St. Elizabeth following the proposed acquisition.

The proposed acquisition may also promote more competition among SNFs for patients from the nearby Providence Saint Joseph Medical Center. Based on the Medicare and commercial claims data, St. Elizabeth has historically overwhelmingly received its patients from Providence hospitals, especially Providence Saint Joseph Medical Center. St. Elizabeth is now competing to get more patients from other hospitals. However,

Care, available at https://wpso.dmhc.ca.gov/dashboard/Marketplace.aspx. *See, also*, "Medi-Cal Managed Care Plans by County," *DHCS,* available at https://www.dhcs.ca.gov/wp-content/uploads/2025/10/MCP-County-Table-2023-2024.pdf.

146 California DHCS requires timely access to SNFs to Medi-Cal managed care enrollees. *See* "Medicaid Managed Care Final Rule: Network Adequacy Standards (2018)," *DHCS*, p. 8, available at https://www.dhcs.ca.gov/wp-content/uploads/2025/10/FinalRuleNAStandards3-26-18.pdf. Similarly, a Medicare Advantage plans that contract with SNFs must have a SNF network that meets maximum time and distance standards. *See* "422.116 Network adequacy," *Code of Federal Regulations,* available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116. In general, all health care service plans in California are evaluated for network adequacy including a requirement that they contract with a sufficient number of SNFs. *See* "APL 25-019, Network Adequacy Standards and Methodology for RY 2026", *California Department of Managed Health Care*, p. 4, available at https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL25-019-AmendmentstoRule1300_67_21300_67_1_31300_51andNetworkAdequacyRequirementsforRY2026%2812_12_2025%29.pdf. Such standards align with my previous discussion that generally patients want to receive care close to home and my analysis of patient travel patterns.

147 [redacted]

the proposed acquisition would eliminate any efficiencies that result from St. Elizabeth being integrated in the same system as Providence hospitals.[148]

IX. Assessment of Potential Conditions for Approving the Acquisition

The acquisition of a nonprofit provider by a for-profit entity raises competition-related concerns in the longer-term even if the transaction is not deemed to be sufficiently problematic for competition in the short term. As a nonprofit, Providence's assets should be put to public use. Once Providence's assets are transferred to a for-profit, no such obligation would exist. It is therefore important to evaluate whether a change in mission could result in changes to access to care.

Should the transaction be approved, the OCAG may want to impose conditions to minimize the longer-term risk of anti-competitive behavior that may result in reduced access or higher prices. The proposed conditions might include the following:

- **Require St. Elizabeth to continue to provide access to Medi-Cal patients**

  Because St. Elizabeth and Ensign SNFs serve lower shares of Medi-Cal patients than other SNFs in the area around St. Elizabeth, OCAG may want to consider conditions to mitigate the risk that Ensign reduces access for Medi-Cal patients post-transaction. For example, OCAG could require St. Elizabeth to maintain a patient mix that resembles the patient mix of the broader community or its historical average patient mix.[149] In conjunction with, or as an alternative to, such a condition, OCAG may want to monitor St. Elizabeth's shares of Medi-Cal patients post-acquisition by comparing it with the shares of Medi-Cal patients receiving SNF care in the surrounding community.[150]

- **Implement safeguards on rental agreement**

  The transaction imposes above-market rent obligations on St. Elizabeth. Specifically, the proposed acquisition requires St. Elizabeth to pay annual rent of $725,616 to a related party. As described previously in **Section VIII.C**, Providence's consulting firm, [redacted], estimated the property's fair market rent at approximately [redacted] per year. In addition, the proposed rent is higher relative to the property's value than is typical for SNFs.

  As I discussed in **Section VIII.C**, above-market rent can harm local SNF competition and the state in several ways. Therefore, OCAG may want to consider implementing safeguards to mitigate these risks. For example, it could require an independent third-party assessment of fair market rent for the property to be adopted in the lease agreement.

---

148 *See, e.g.,* Konetzka, R. Tamara, et al., "The effect of integration of hospitals and post-acute care providers on Medicare payment and patient outcomes," *Journal of Health Economics*, 2018, pp.244-258 ("Theoretically, vertical integration can serve to achieve efficiencies by facilitating coordination of care, addressing incomplete contracting problems, and otherwise reducing transaction costs."). Using a dataset that includes all Medicare-reimbursed hospitalizations and post-acute care use in the U.S. between 2005 and 2013, the paper finds that vertical integration between hospitals and SNFs increases Medicare payments and reduces rehospitalization rates.

149 I found that 69 percent of SNF patients in St. Elizabeth's market (SNFs within 10 miles) were insured by Medi-Cal. *See* Figure 6.

150 As there is not up-to-date publicly available data on patient mix, St. Elizabeth may need to provide periodic reports of its census data so that OCAG could conduct this monitoring.

In addition, OCAG could prohibit Ensign from encumbering St. Elizabeth with debt, or other liabilities, to the point of placing the short-term or long-term financial viability at substantial risk of closing and/or reducing staffing levels.

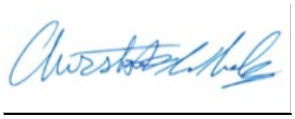
As part of such conditions, OCAG could monitor St. Elizabeth and affiliated entities for heightened risk of insolvency, such as through a periodic review of financial statements or revenue- and utilization-related metrics. Such measures would help reduce the likelihood of financial distress and the state's exposure in the event of financial distress.

- **Implement safeguards on service agreement**

The proposed acquisition requires St. Elizabeth to pay Ensign Services a service fee equal to five percent of its gross revenue. There is the risk that a service fee, particularly in combination with above-market rental rates, may reduce St. Elizabeth's ability to make needed investments or continue as a going concern.

OCAG may want to consider safeguards to mitigate these risks, including (i) limiting Ensign's ability to increase the service fee or impose additional affiliated-party fees without prior approval and (ii) monitoring St. Elizabeth and affiliated entities for heightened risk of insolvency.

Christopher Whaley, Ph.D.



Date:

July 10, 2026

X. Appendix

A. Ensign Facilities in California

Figure A1
Ensign SNFs

SNF Facility	County	Number of SNF Beds	Acquisition Date
Danville Post Acute Rehabilitation	Contra Costa	49	February 1, 2023
Pacific Gardens Nursing and Rehabilitation Center	Fresno	180	August 1, 2025
Alamitos Belmont Health and Rehabilitation	Los Angeles	94	February 1, 2023
Arbor Glen Care Center	Los Angeles	95	February 1, 2001
Atlantic Memorial Healthcare Center	Los Angeles	97	July 1, 2002
Broadway by the Sea	Los Angeles	95	February 1, 2023
Brookfield Healthcare Center	Los Angeles	70	June 1, 2003
Camino Healthcare	Los Angeles	99	January 1, 2021
Chatsworth Park Health Care Center	Los Angeles	128	February 1, 2023
Claremont Care Center	Los Angeles	99	October 1, 2003
Downey Post Acute	Los Angeles	98	March 1, 2019
Edgewater Skilled Nursing Center	Los Angeles	81	February 1, 2023
Garden View Post Acute Rehabilitation	Los Angeles	97	February 1, 2023
Huntington Park Nursing Center	Los Angeles	99	August 1, 2025
Lake Balboa Care Center	Los Angeles	50	February 1, 2023
Lomita Post Acute Care Center	Los Angeles	68	February 1, 2023
Mission Care Center	Los Angeles	58	May 6, 2005
Panorama Gardens Nursing and Rehabilitation Center	Los Angeles	145	September 1, 2000
Madera Post Acute Center (fka Ramona Nursing and R	Los Angeles	148	February 1, 2023
Rose Villa Healthcare Center	Los Angeles	53	June 1, 2003
Shoreline Healthcare Center	Los Angeles	72	July 1, 2002
Southland Care Center & Southland Living	Los Angeles	120	December 16, 1999
The Orchard Post Acute Care	Los Angeles	162	July 1, 2000
Whittier Hills Healthcare Center	Los Angeles	160	July 1, 2000
Northbrook Healthcare Center	Mendocino	62	November 15, 2001
Ukiah Post Acute	Mendocino	50	January 1, 2002
Alamitos West Health and Rehabilitation	Orange	150	April 1, 2025
Beachside Nursing Center	Orange	59	February 1, 2023
Coventry Court Health Center	Orange	95	February 1, 2023
Mainplace Post Acute	Orange	163	May 1, 2019
New Orange Hills	Orange	143	February 1, 2023
Pacific Haven Subacute and Healthcare Center	Orange	99	April 1, 2025
Palm Terrace Healthcare and Rehabilitation Center	Orange	99	November 1, 2004
Sea Cliff Healthcare Center	Orange	182	September 1, 2003
St. Catherine Healthcare	Orange	98	January 1, 2021
St. Elizabeth Healthcare Center	Orange	59	May 1, 2019
The Hills Post Acute	Orange	172	May 1, 2019

SNF Facility (continued)	County	Number of SNF Beds	Acquisition Date
Victoria Healthcare and Rehabilitation Center	Orange	79	July 1, 2003
Desert Mountain Care Center	Riverside	99	February 1, 2022
Palm Terrace Care Center	Riverside	70	February 1, 2023
Premier Care Center for Palm Springs	Riverside	99	November 15, 2001
The Grove Care and Wellness	Riverside	38	January 16, 2009
Arrowhead Springs Healthcare	San Bernardino	119	February 1, 2022
Brookside Healthcare Center	San Bernardino	97	August 2, 2003
Grand Terrace Health Care Center	San Bernardino	59	February 1, 2023
Upland Rehabilitation and Care Center	San Bernardino	198	August 6, 2005
Arroyo Vista Nursing Center	San Diego	53	October 1, 2003
Carmel Mountain Rehabilitation and Healthcare Center	San Diego	120	March 1, 2006
Golden Hill Post Acute	San Diego	99	January 1, 2021
Grossmont Post Acute Care	San Diego	86	December 1, 2014
Lemon Grove Care and Rehabilitation Center	San Diego	158	June 1, 2003
Magnolia Post Acute Care	San Diego	99	December 1, 2014
Mission Hills Post Acute Care	San Diego	75	December 1, 2014
Palomar Vista Healthcare Center	San Diego	74	July 1, 2003
Parkside Health and Wellness Center	San Diego	52	December 1, 2014
Somerset Post Acute Care	San Diego	47	December 1, 2014
South Bay Post Acute Care	San Diego	98	December 1, 2014
The Cove at La Jolla	San Diego	59	December 1, 2014
The Springs at Pacific Regent	San Diego	59	October 1, 2011
Victoria Post Acute Care	San Diego	120	December 1, 2014
Vista Knoll Specialized Care Facility	San Diego	119	October 1, 2003
Arbor Rehabilitation & Nursing Center	San Joaquin	149	August 1, 2025
Fairmont Rehabilitation Hospital	San Joaquin	59	February 1, 2023
Pacifica Nursing and Rehabilitation Center	San Mateo	68	February 1, 2023
Channel Islands Post Acute	Santa Barbara	156	November 1, 2019
Buena Vista Care Center	Santa Barbara	150	August 1, 2025
Villa Maria Post Acute	Santa Barbara	80	May 1, 2019
Fairfield Post Acute Rehabilitation	Solano	99	February 1, 2023
Broadway Villa Post Acute	Sonoma	140	November 16, 2001
Cloverdale Healthcare Center	Sonoma	70	November 15, 2001
Park View Post Acute	Sonoma	116	April 1, 2001
Summerfield Healthcare Center	Sonoma	56	July 1, 2000
Valley of the Moon Post Acute	Sonoma	27	July 1, 2019
Turlock Nursing and Rehabilitation Center	Stanislaus	144	August 1, 2025
Vintage Faire Nursing & Rehabilitation Center	Stanislaus	99	August 1, 2025
Camarillo Healthcare Center	Ventura	114	August 20, 2005
Glenwood Care Center	Ventura	99	November 1, 2003
Shoreline Care Center	Ventura	193	August 1, 2025
Victoria Care Center	Ventura	187	November 1, 2003
Courtyard Health Care Center	Yolo	112	August 1, 2025

Notes:
[1] The list of Ensign locations is compiled from the facilities listed on Ensign's website and SNFs listed as part of "The Ensign Group" according to the "Affiliation Entity Name" field in CMS SNF Enrollments and Ownership data. Ensign already lists Providence St. Elizabeth on its website under a new name, Toluca Lake Transitional Care. I excluded this facility from the Ensign list.
[2] County and SNF Beds are from CMS SNF Cost Reports, 2022-2024.
[3] Valley of the Moon number of SNF beds is from Sonoma Valley Hospital's Annual Utilization Report, 2025, available at https://reports.siera.hcai.ca.gov/.

Sources:
[1] Ensign's June 30, 2026 Response to AG Supplemental Request for the proposed acquisition of St Elizabeth.
[2] CMS SNF Enrollments, January 2026.
[3] CMS SNF Cost Report, 2023–2024.
[4] Sonoma Valley Hospital, Annual Utilization Report, 2025, available at https://reports.siera.hcai.ca.gov/.

Figure A2
Ensign Assisted Living Facilities in California

Facility	City	Zip Code
Arbor Place Residential Care Community	Lodi	95240
Katella Senior Living Community	Los Alamitos	90720
Lexington Assisted Living	Ventura	93003
Sea Cliff Assisted Living	Huntington Beach	92648
The Grove Assisted & Independent Living	Riverside	92501
Turlock Residential	Turlock	95382
Vintage Faire Residential	Modesto	95356

Source:
[1] "Locations," *The Ensign Group,* available at https://ensigngroup.net/map/.

B. Figures for Analysis of Ensign's Past Acquisitions

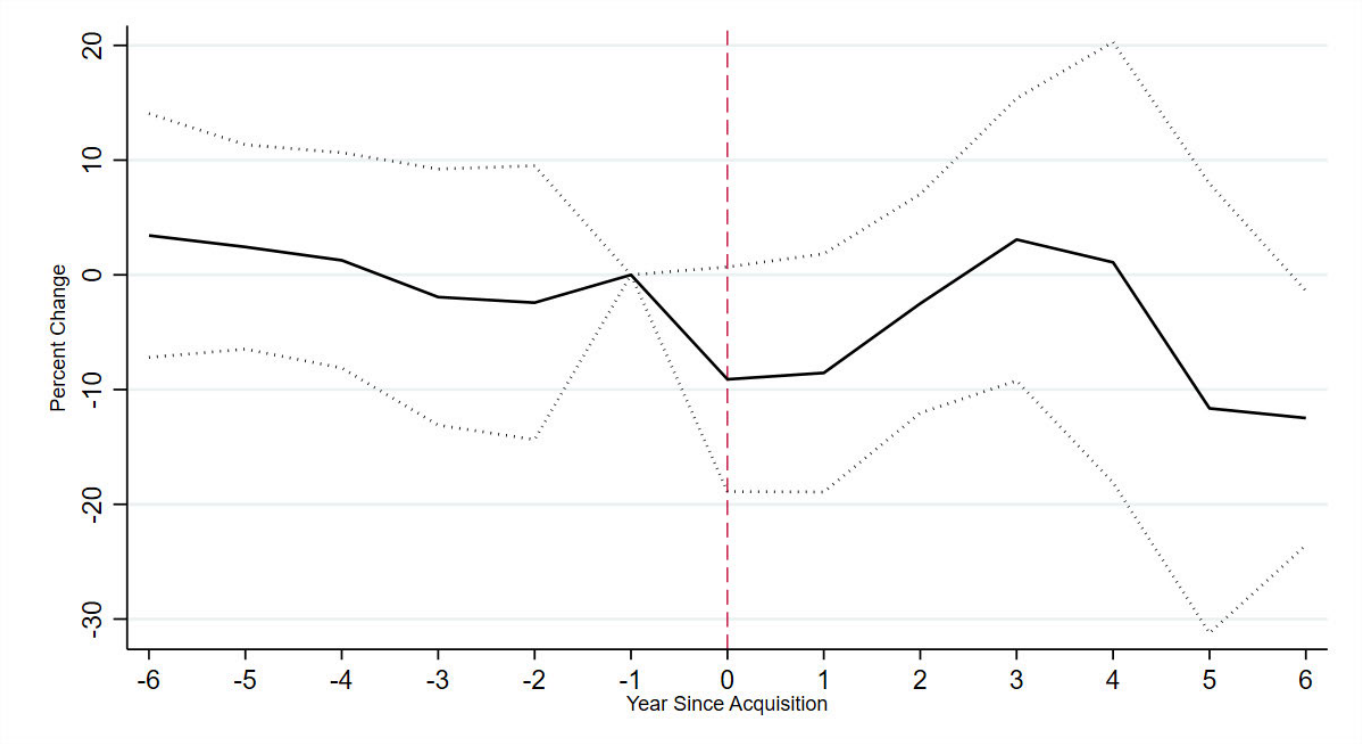
i. Health Outcome Metrics

To study the effects of the Ensign acquisitions on quality of care, I look at four claims-based health outcome metrics from the CMS SNF Medicare Compare data:

1. Percentage of residents admitted from a hospital who were re-hospitalized for an unplanned inpatient stay or observation stay within 30 days of the start of a SNF admission.
2. Percentage of residents admitted from a hospital who had an outpatient emergency department visit within 30 days of the start of a SNF admission.
3. Number of unplanned hospitalizations among long-stay residents per 1,000 long-stay resident days.
4. Number of outpatient emergency department visits among long-stay residents per 1,000 long-stay resident days.

Figures below show the estimated effects of Ensign's 2019–2023 acquisitions on the acquired SNFs using these four metrics.

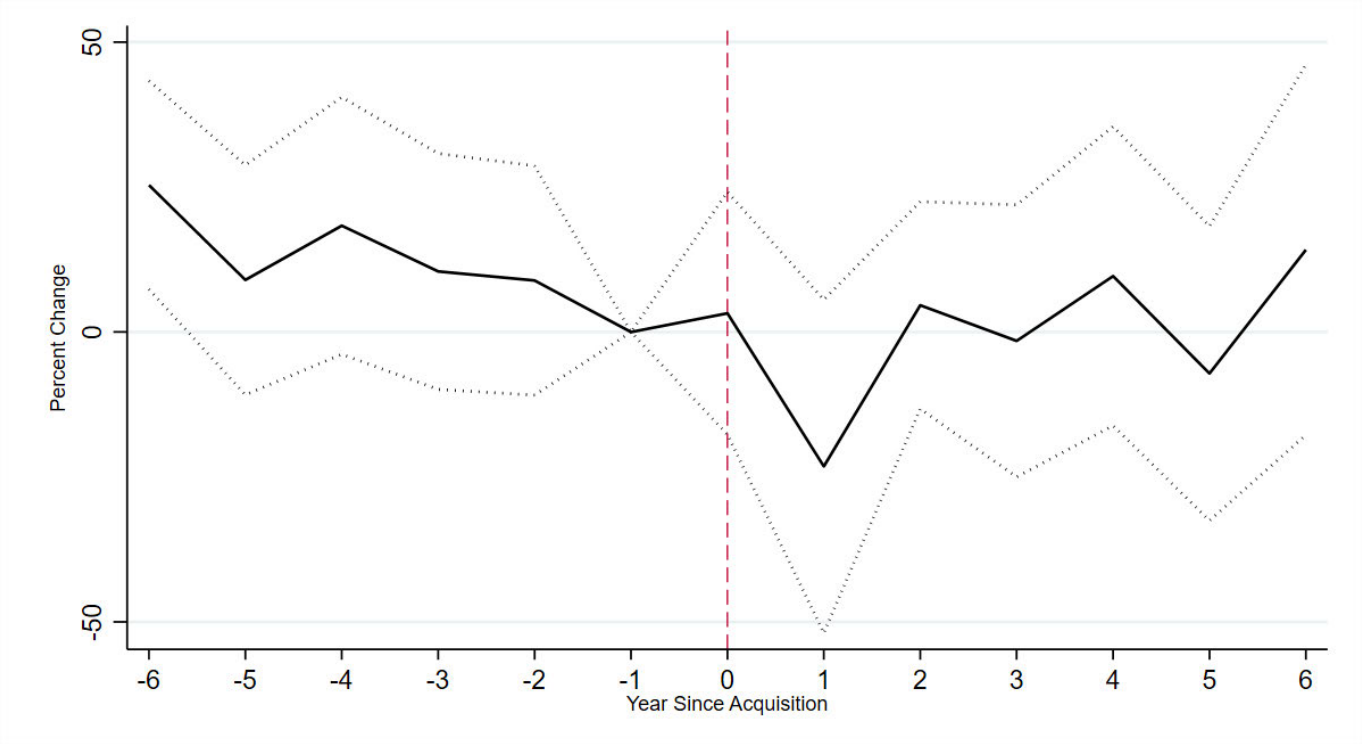
Figure B1
Ensign Acquisitions
Percentage of Patients with Unplanned Re-Hospitalization Within 30 Days of SNF Admission
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS SNF Medicare Compare, 2015–2025.

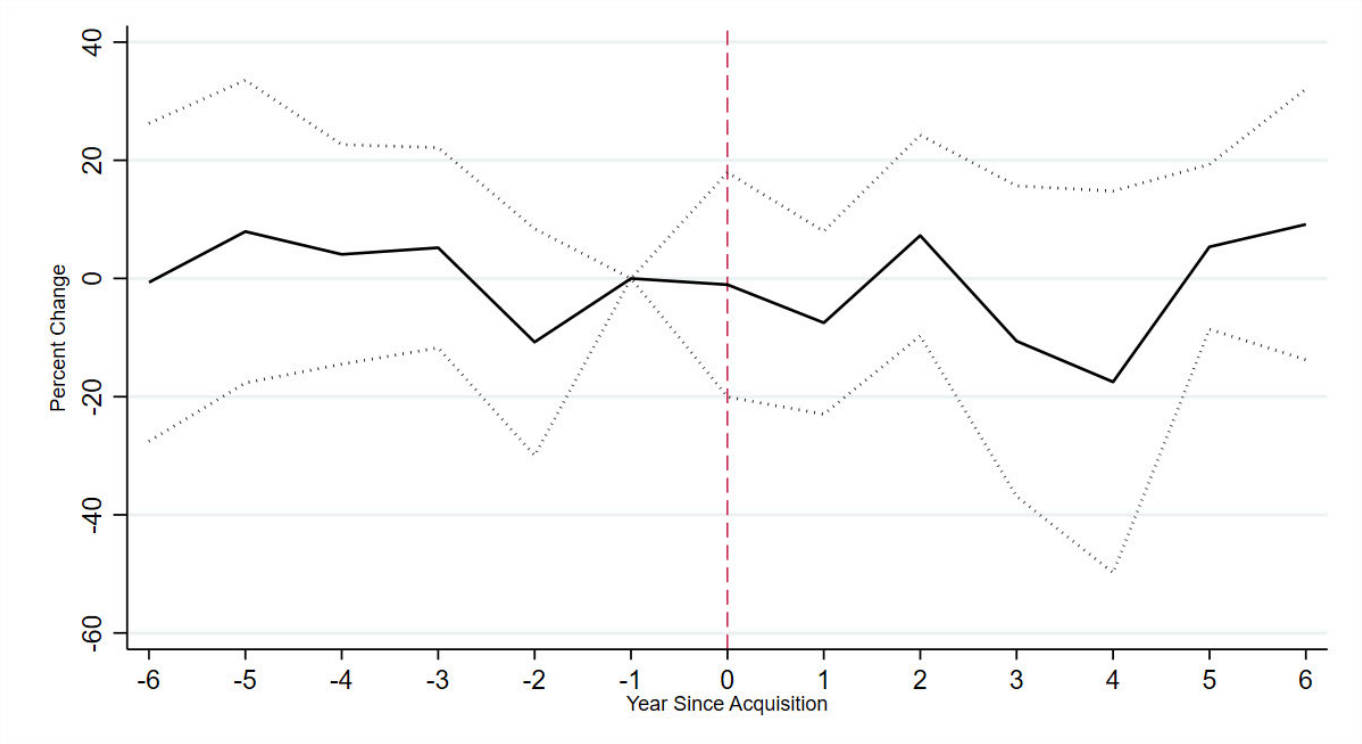
Figure B2
Ensign Acquisitions
Percentage of Patients with Emergency Room Visits Within 30 Days of SNF Admission
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The immediate period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

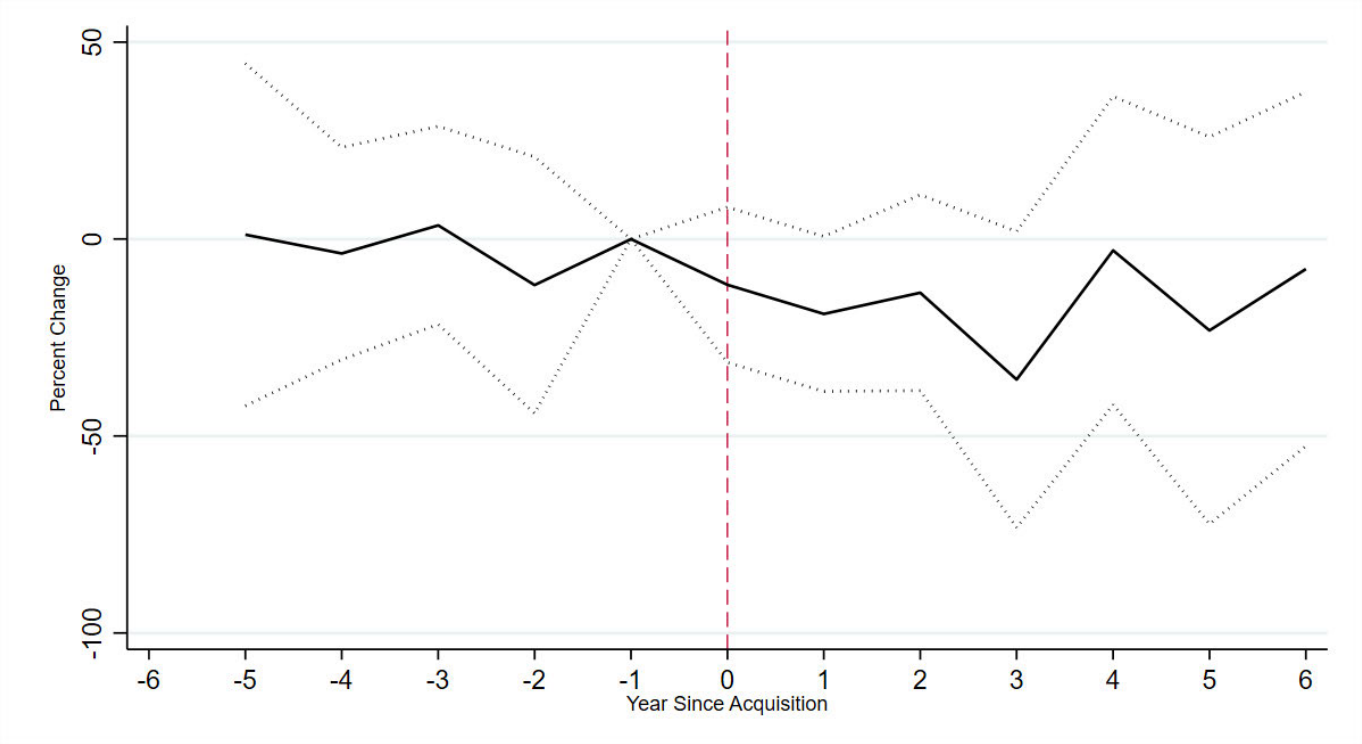
Figure B3
Ensign Acquisitions
Number of Unplanned Hospitalizations per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

Figure B4
Ensign Acquisitions
Number of Emergency Room Visits per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

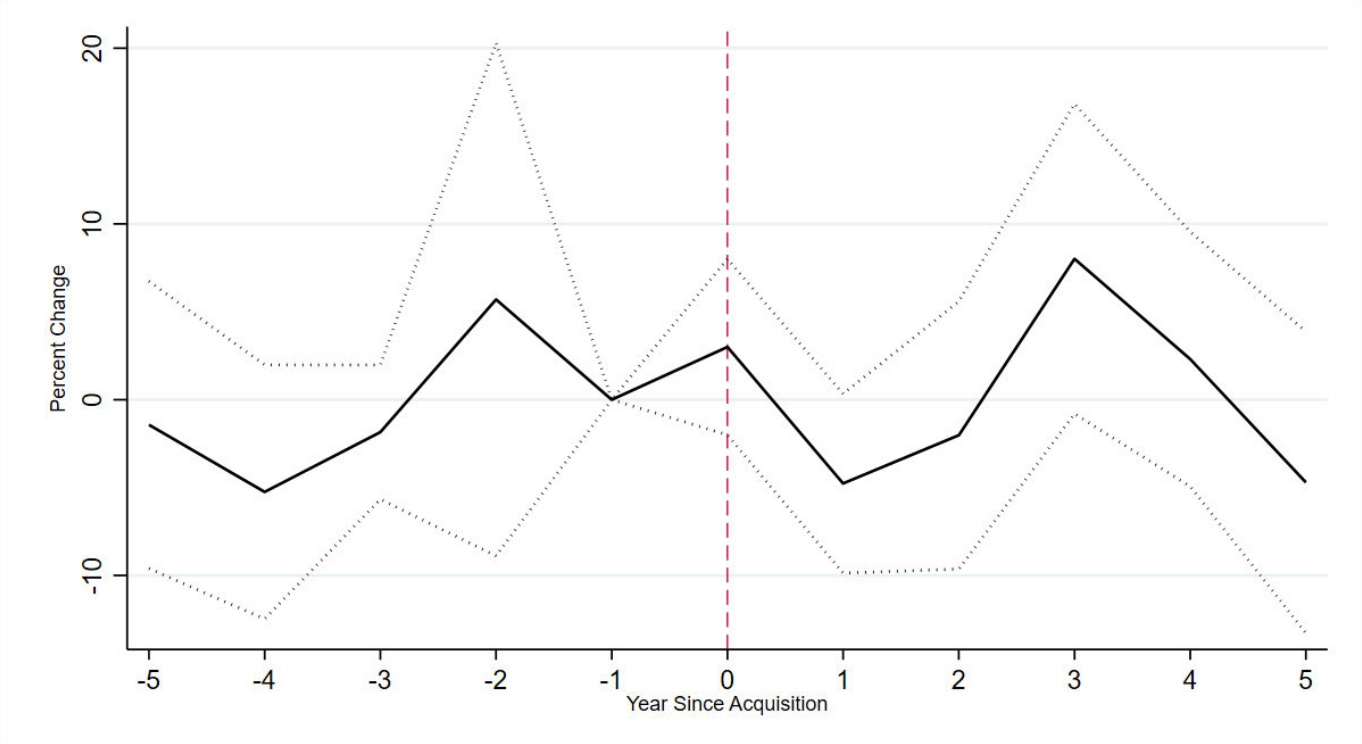
ii. Nursing Care Staffing

I examine whether the Ensign acquisitions between 2019 and 2023 affected the level of nursing care provided to patients on a per patient day basis for the acquired facilities. I also examine whether these acquisitions affected the composition of nursing staff, namely, the composition of RNs, LPNs, and NAs.

I use the CMS SNF Cost Report for the analyses on nursing staff. Specifically, in Figures below, I show the estimated effects of the Ensign acquisitions on total nursing hours per patient day of the following:

1. All employed nursing staff (RNs, LPNs, and NAs combined),
2. Employed RNs,
3. Employed LPNs, and
4. Employed NAs.

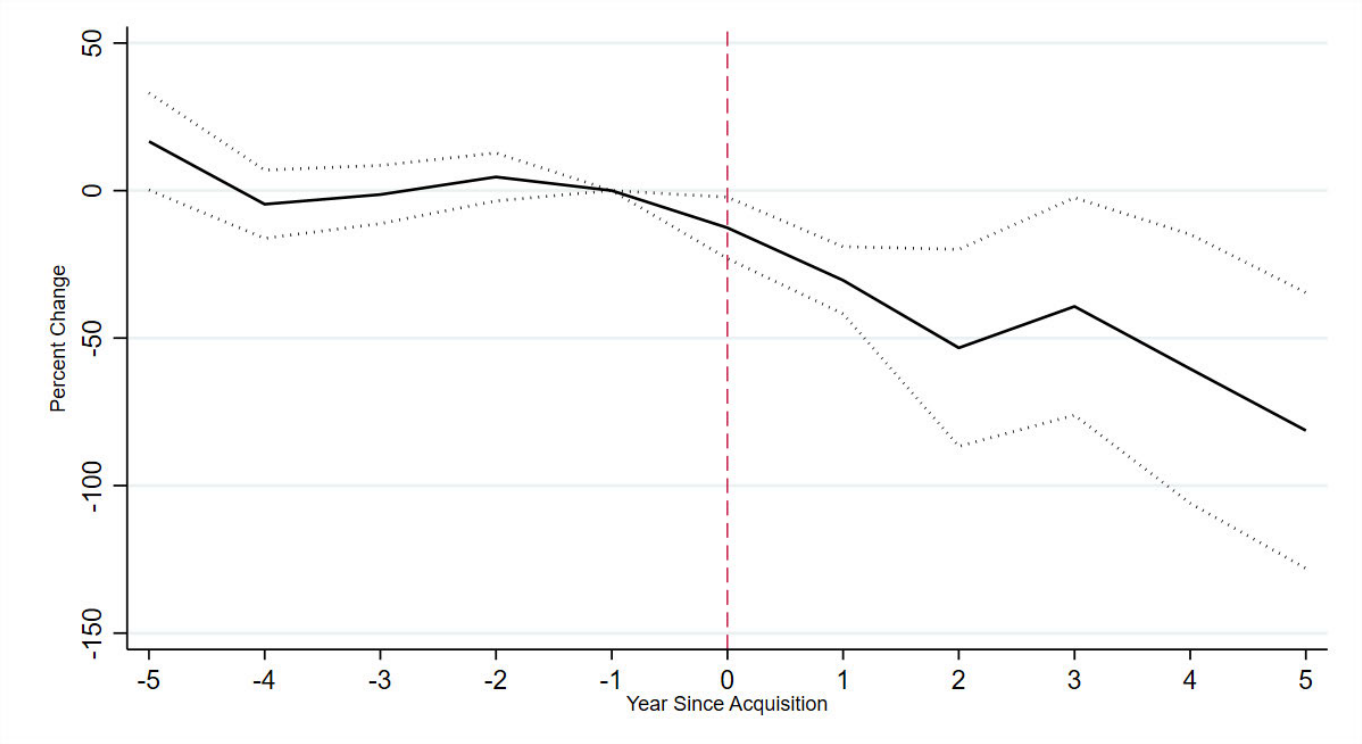
Figure B5
Ensign Acquisitions
Total Nursing Hours per Patient Day of Employed Nursing Staff



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS SNF Cost Report, 2015–2024.

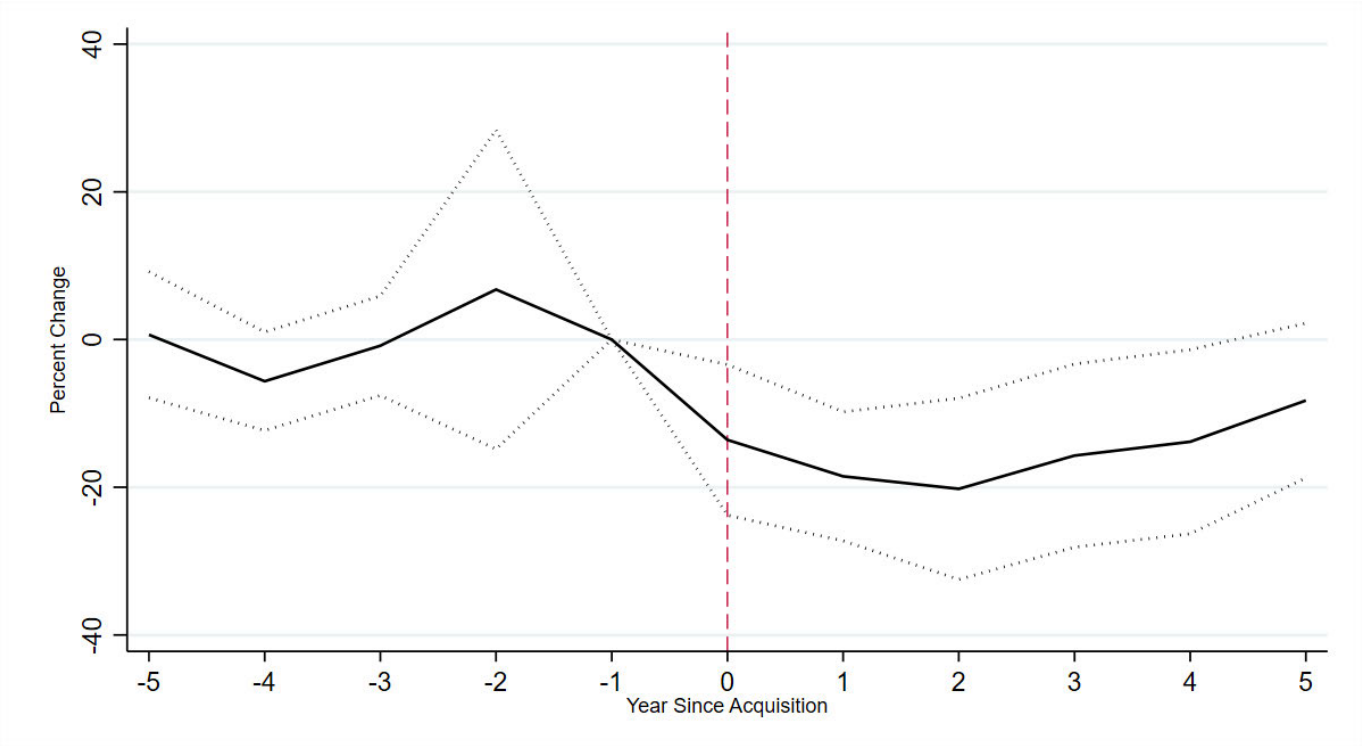
Figure B6
Ensign Acquisitions
Total Nursing Hours per Patient Day of Employed RNs



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS SNF Cost Report, 2015–2024.

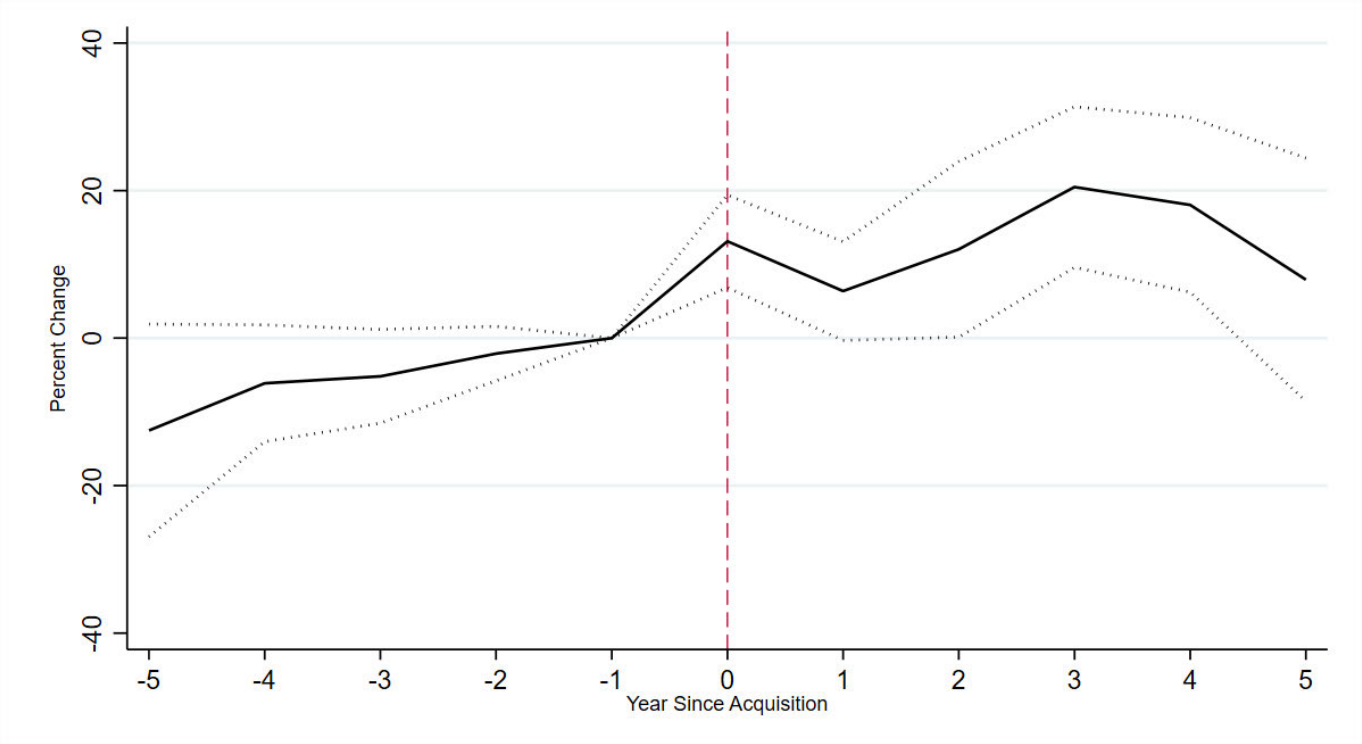
Figure B7
Ensign Acquisitions
Total Nursing Hours per Patient Day of Employed LPNs



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS SNF Cost Report, 2015–2024.

Figure B8
Ensign Acquisitions
Total Nursing Hours per Patient Day of Employed NAs

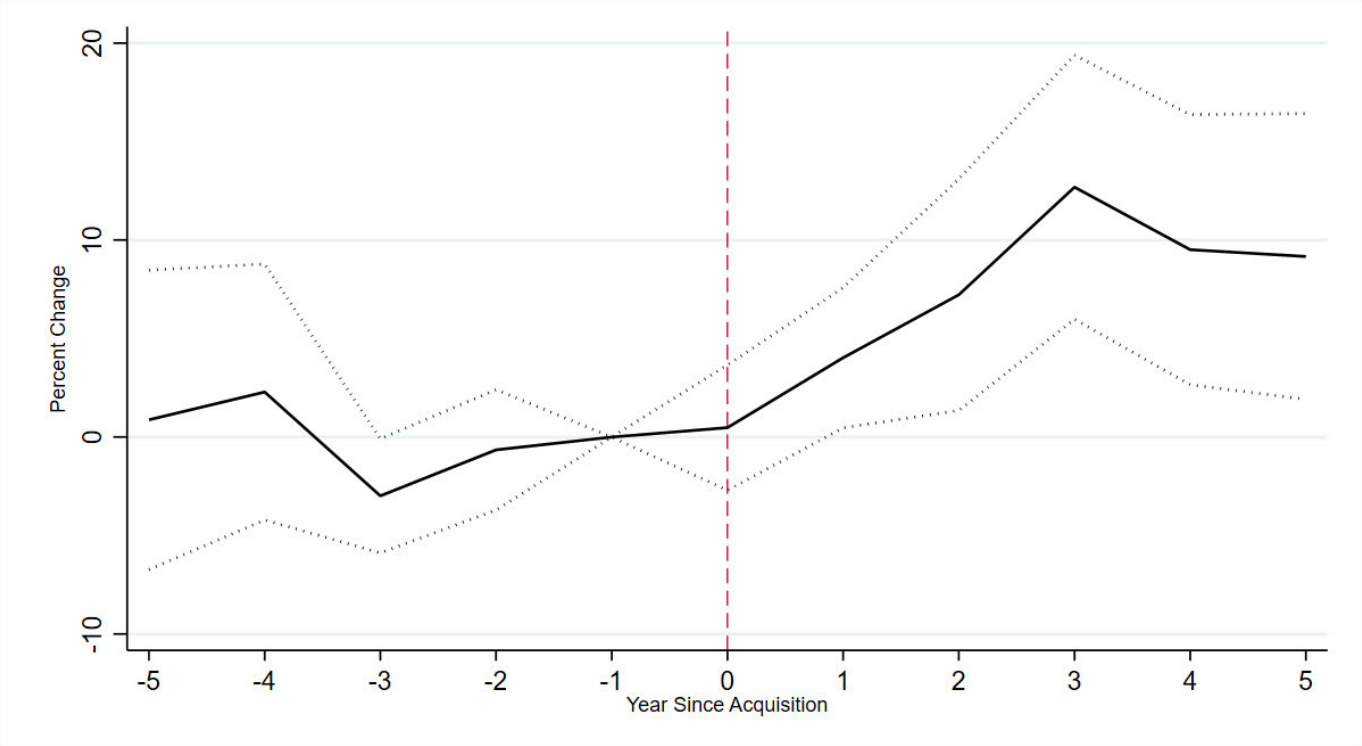


Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS SNF Cost Report, 2015–2024.

iii. Patient Volume and Payer Mix

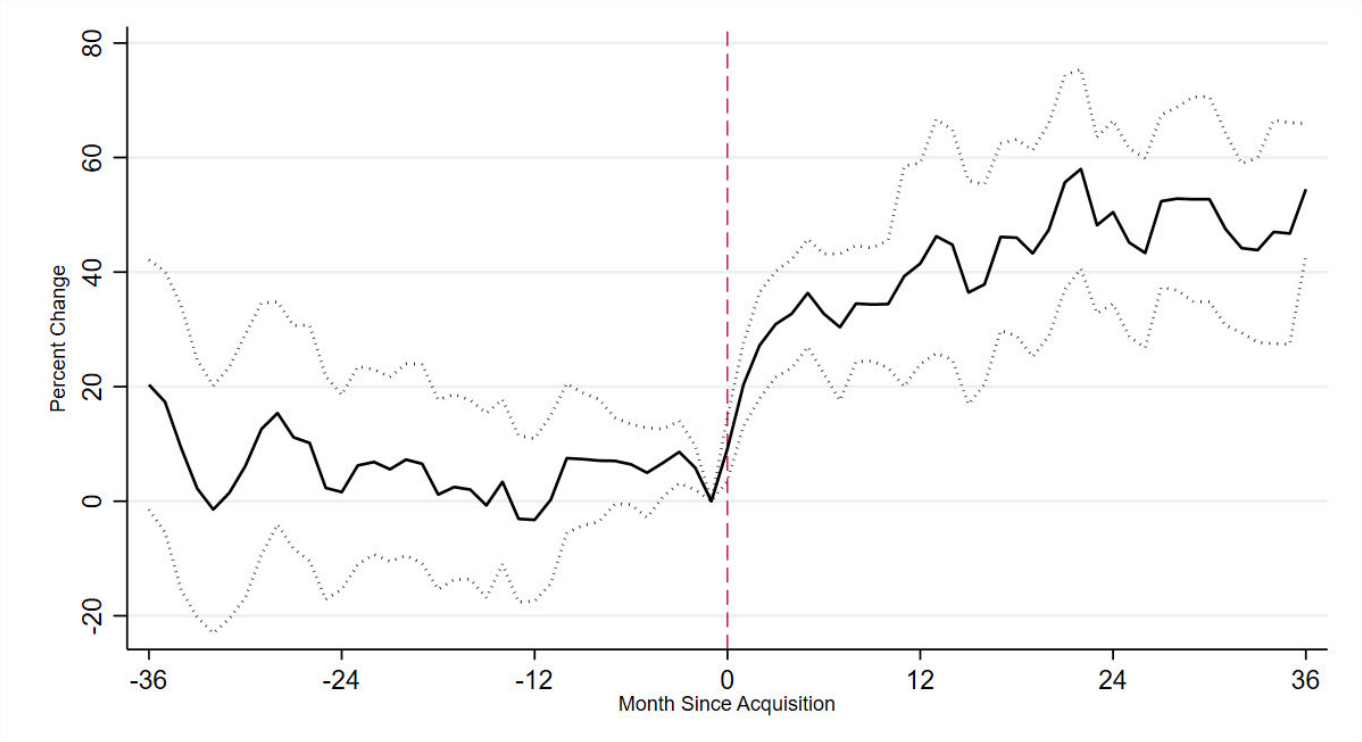
Figure B9
Ensign Acquisitions
Total Patient Days



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS SNF Cost Report, 2015–2024.

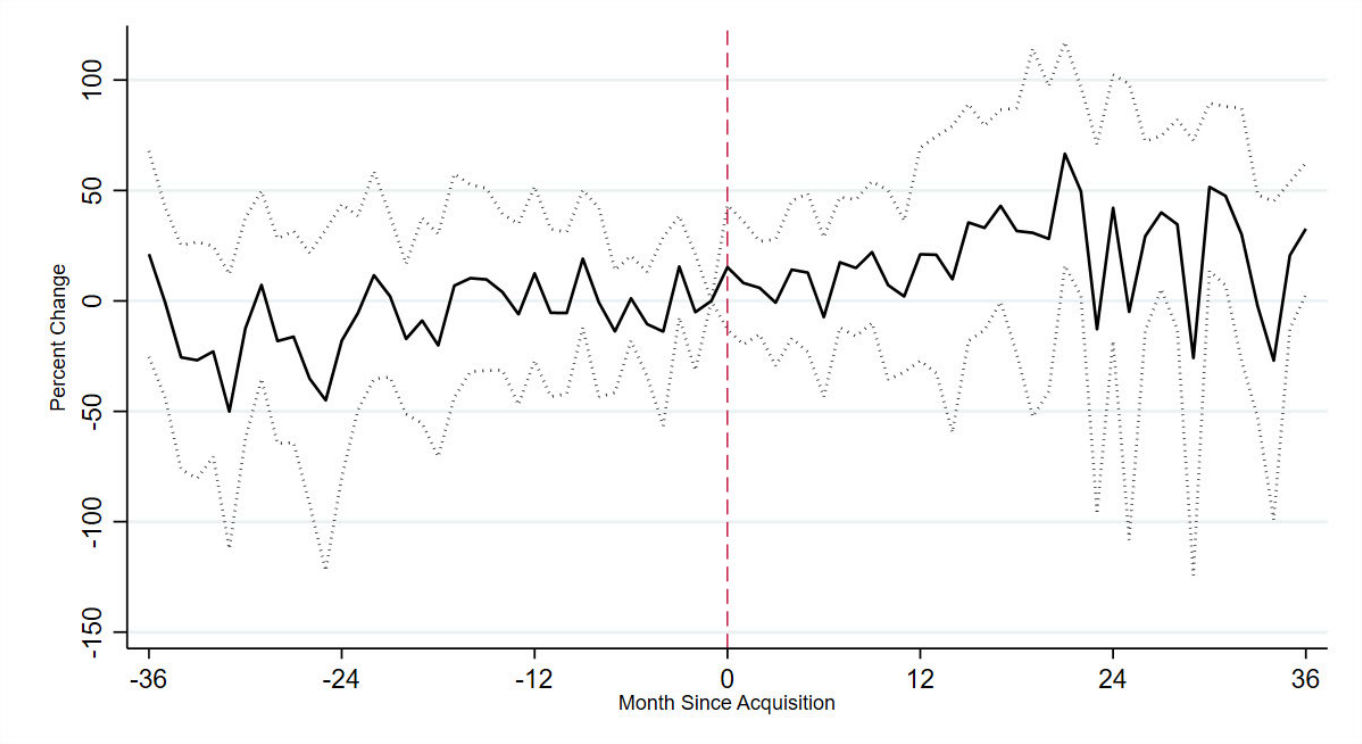
Figure B10
Ensign Acquisitions
Total Medicare Patient Days



Notes:
[1] Dashed vertical line indicates the month when the acquisitions happened.
[2] Analysis includes facility fixed effects and month fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: Medicare claims data, 2018–2023.

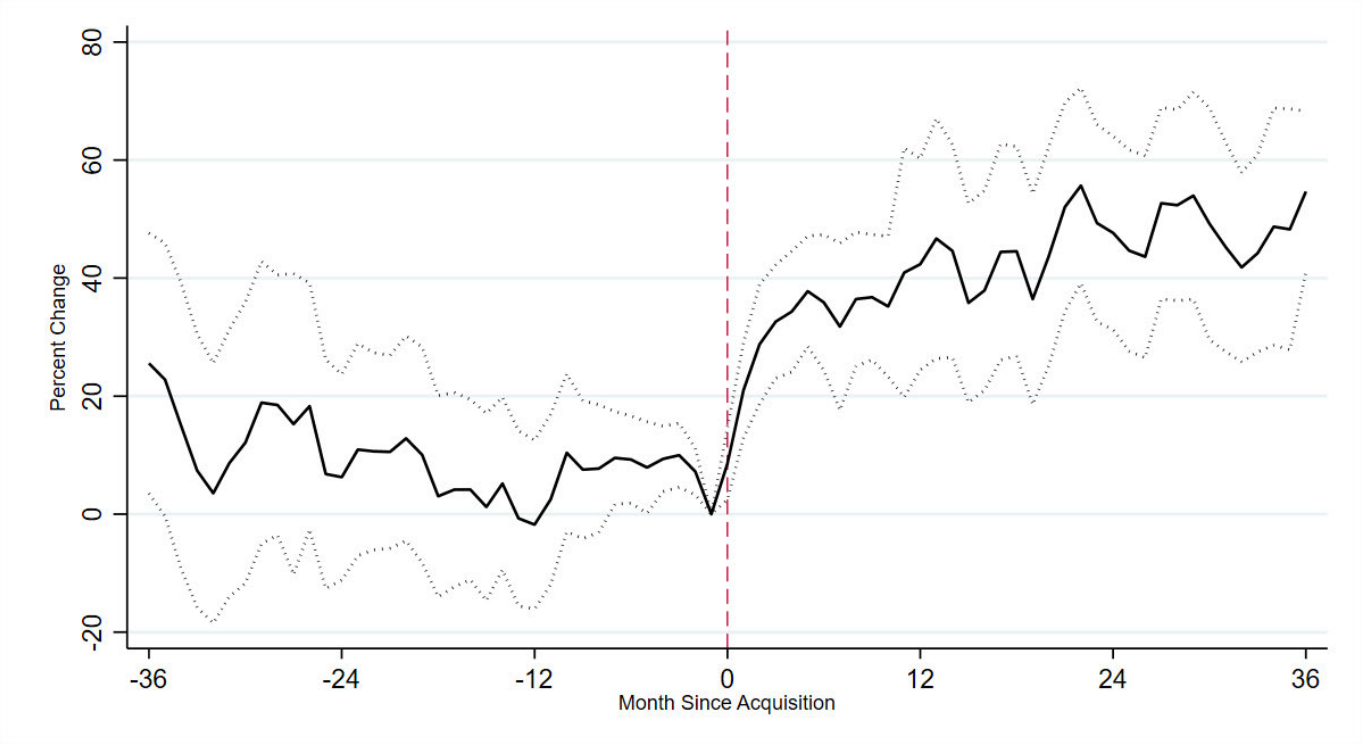
Figure B11
Ensign Acquisitions
Medicare Advantage Patient Days



Notes:
[1] Dashed vertical line indicates the month when the acquisitions happened.
[2] Analysis includes facility fixed effects and month fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: Medicare claims data, 2018–2023.

Figure B12
Ensign Acquisitions
Medicare FFS Patient Days



Notes:
[1] Dashed vertical line indicates the month when the acquisitions happened.
[2] Analysis includes facility fixed effects and month fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: Medicare claims data, 2018–2023.

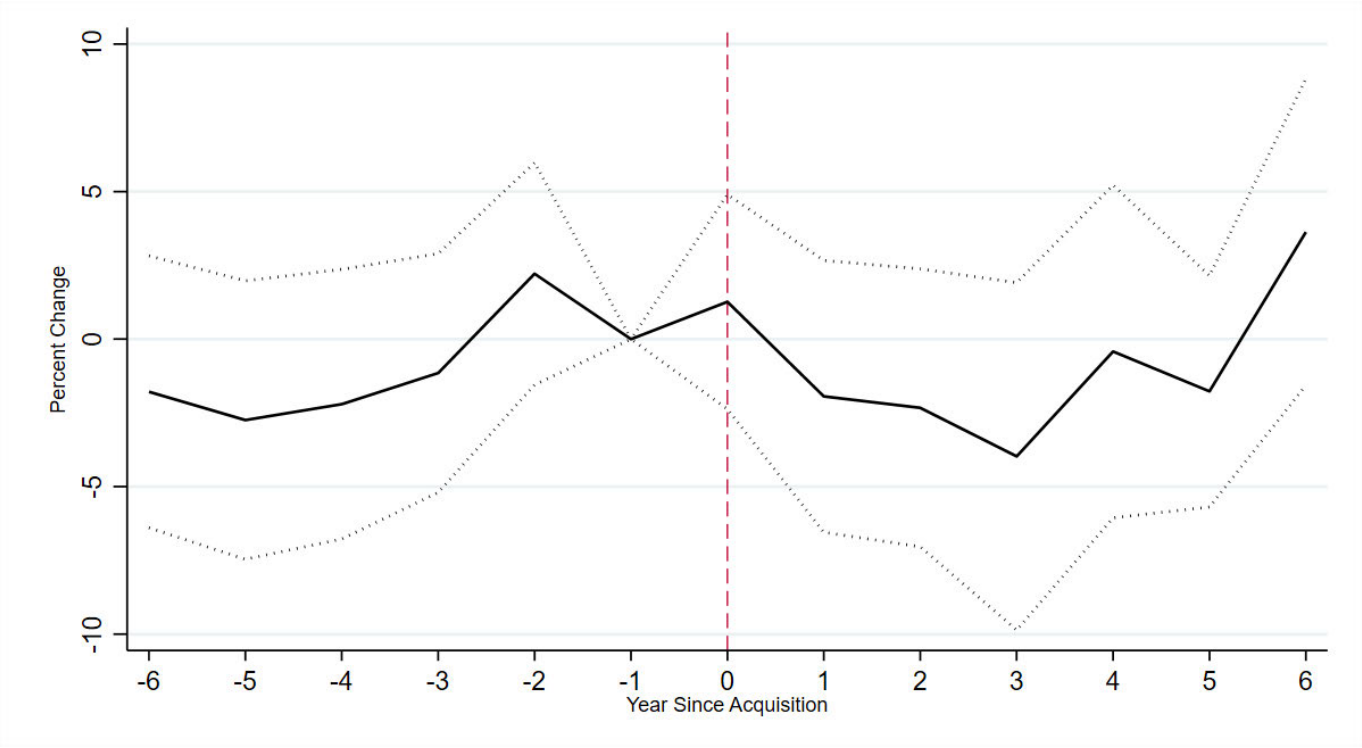
iv. Patient Acuity

I study the effect of the 2019-2023 Ensign acquisitions on the acuity of admitted patients to examine whether the acquisitions led to selective admissions of sicker or less sick patients.

For each of the four health outcome metrics I studied above, CMS reports the “expected value” version of the metric. The “expected value” measures patient health outcomes if the SNF’s patients were treated by a SNF with “average” quality. Consequently, I use these “expected values” as four additional patient acuity metrics.

Figures below show the estimated effects of Ensign’s 2019-2023 acquisitions on the acquired SNFs.

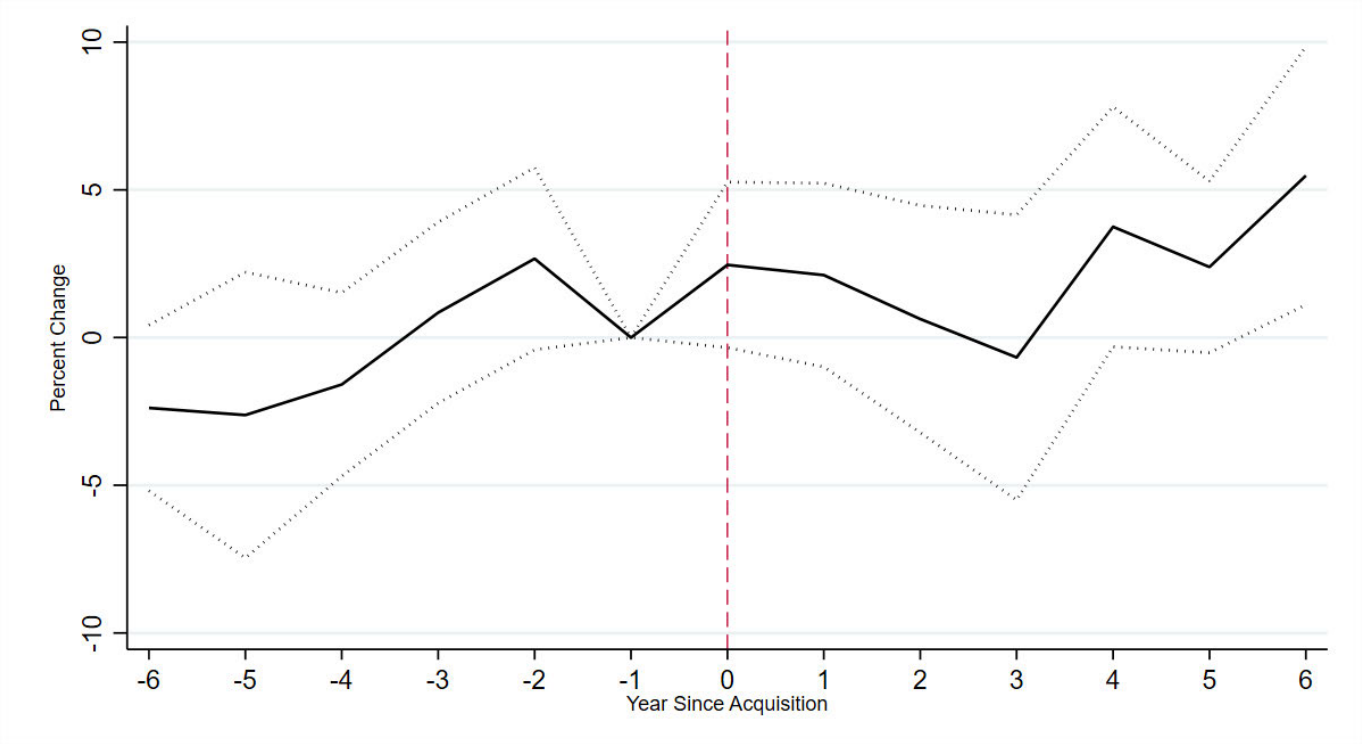
Figure B13
Ensign Acquisitions
"Expected" Percentage of Patients with Unplanned Re-Hospitalization Within 30 Days of SNF Admission
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

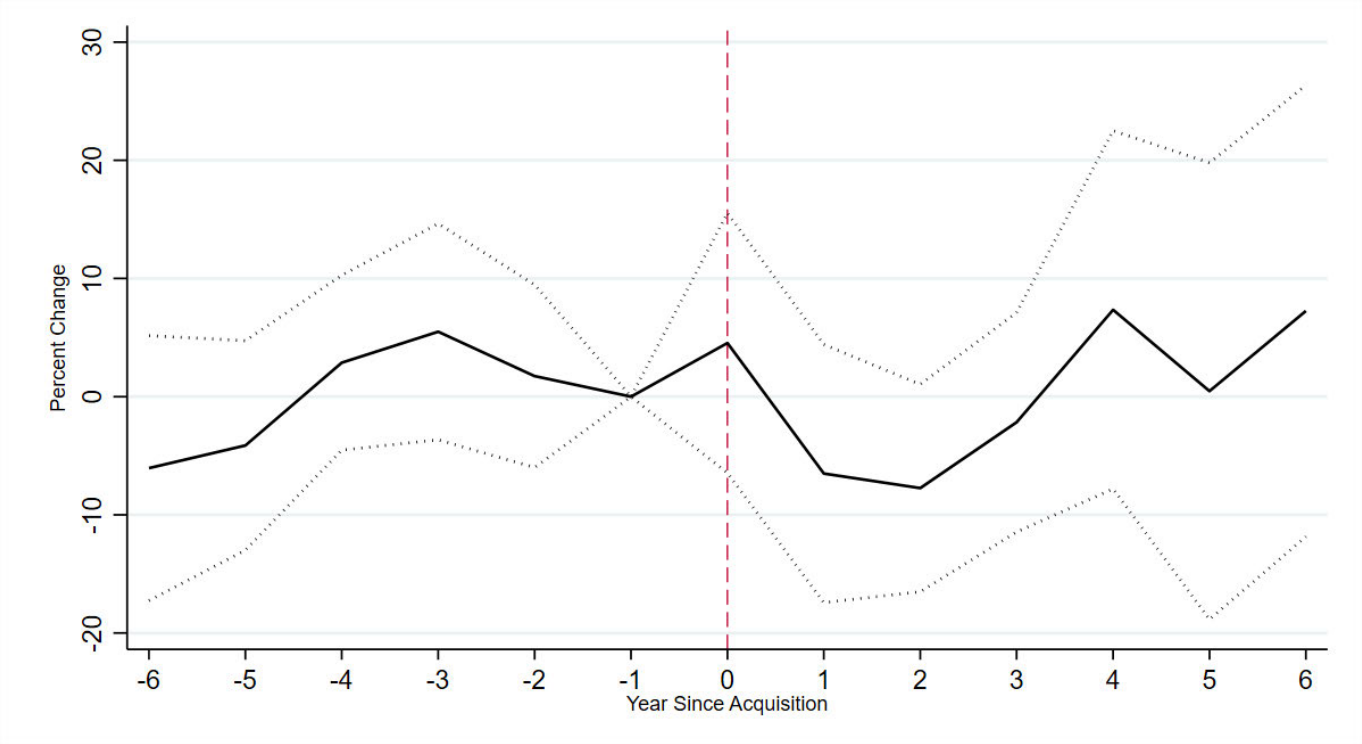
Figure B14
Ensign Acquisitions
"Expected" Percentage of Patients with Emergency Room Visits Within 30 Days of SNF Admission
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

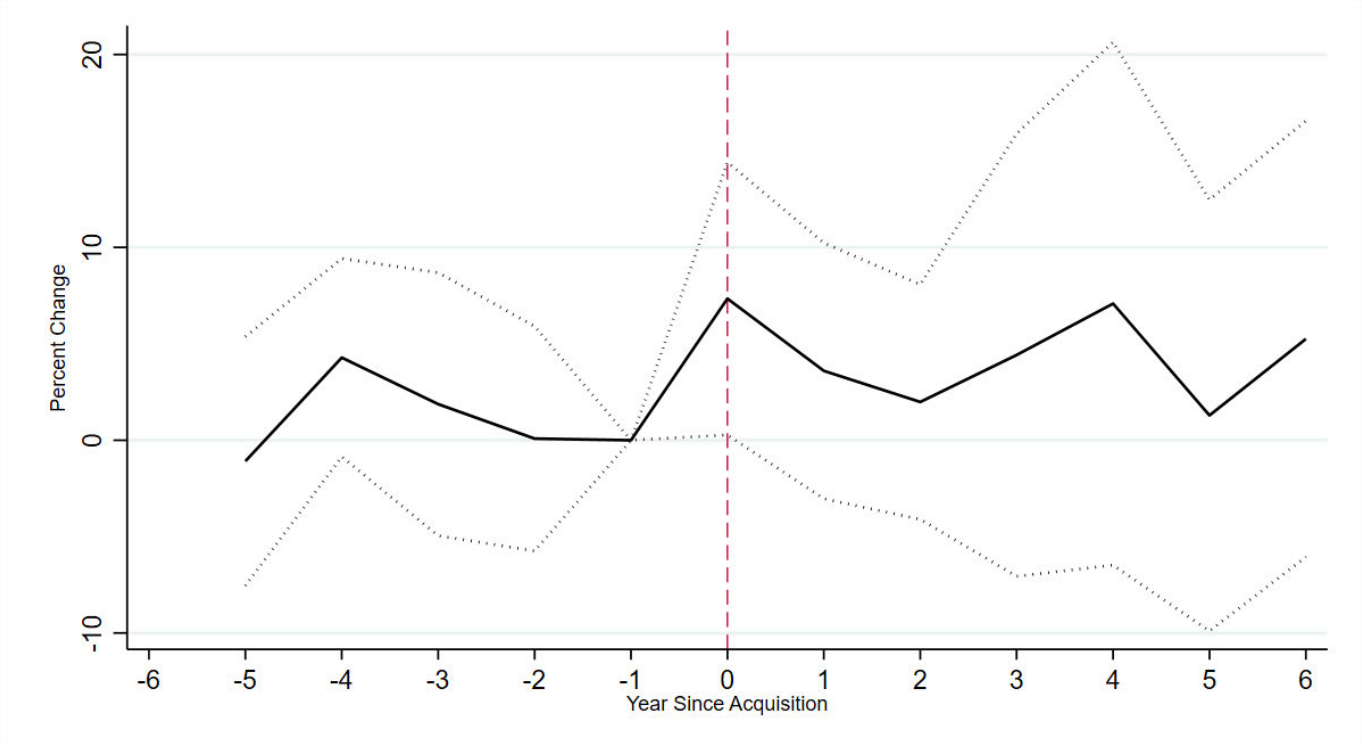
Figure B15
Ensign Acquisitions
"Expected" Number of Unplanned Hospitalizations per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

Figure B16
Ensign Acquisitions
"Expected" Number of Emergency Room Visits per 1,000 Long-Stay Resident Days
Lower Percentage Is Better

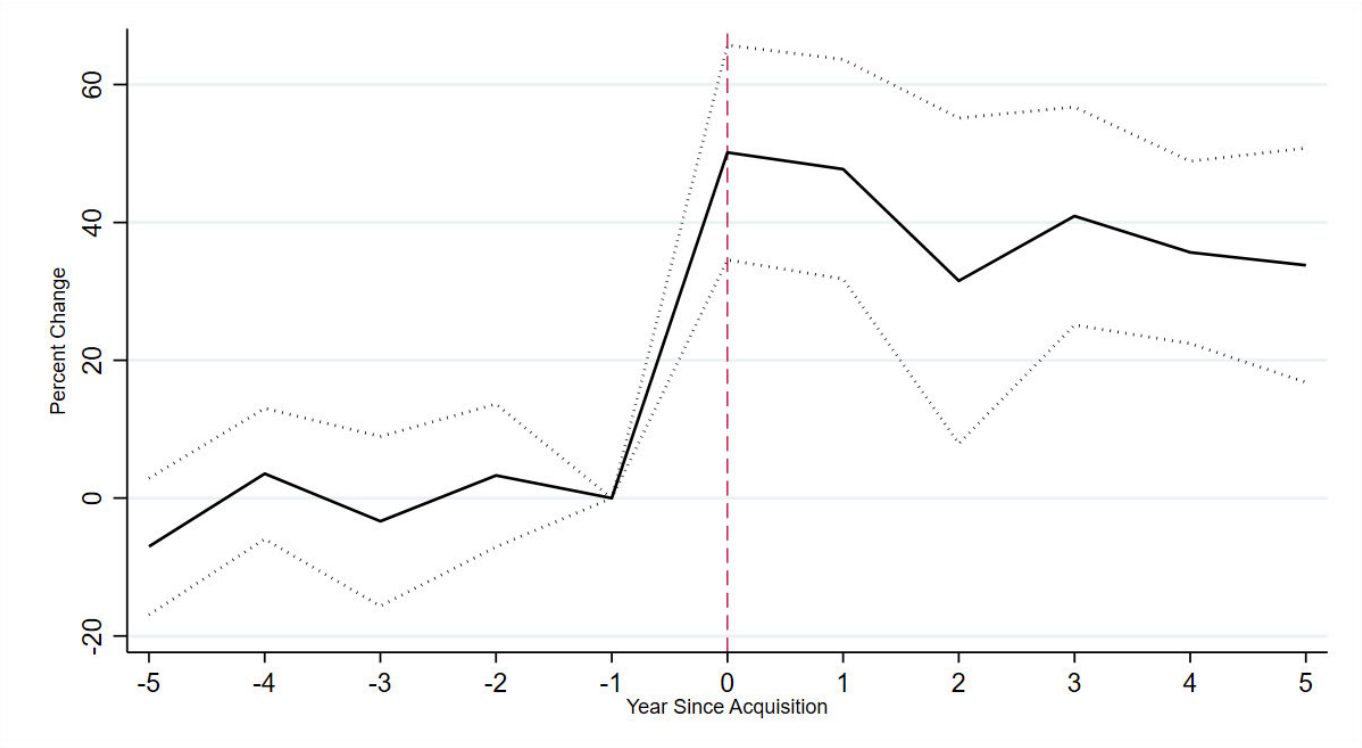


Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. The period before the acquisition is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2015–2025.

v. Length of Stay

Figure B17
Ensign Acquisitions
Average Length of Stay



Notes:
[1] Dashed vertical line indicates the year when the acquisitions happened.
[2] Analysis includes facility fixed effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. The period before the acquisition is used as the benchmark period.
[3] The average length of stay at period "-1" among Ensign SNFs was approximately 68 days. As such, a 40 percent increase in length of stay is approximately a 27-day increase in length of stay.

Source: CMS SNF Cost Report, 2015–2024.

C. Claims Data

i. Medi-Cal Claims Data

I received data from DHCS containing Medi-Cal claims submitted by California SNFs for services rendered from 2018 to 2024. The data include both Medi-Cal FFS and Medi-Cal managed care claims and are at the claim line level.[151]

I focus on the data for 2024 since it is the latest year available to me. I filter the 2024 data to inpatient claims submitted by long-term care facilities with a place of service of SNF.[152] I then aggregate the data from the line level to the claim level. I exclude 66 claims with conflicting claim-level information across claim lines (e.g. more than one patient zip code or more than one provider address within one claim).

For the diversion analysis using Medi-Cal claims data, I further aggregate the 2024 claim-level data to unique patient-facility pairs.[153] I exclude 2,384 pairs with missing patient gender, patient zip code, or patient county. The table below shows the number of unique patient-facility pairs, number of unique patients, and number of facilities for 2024 in the prepared dataset used to calculate diversions.

Number of unique patient-facility pairs [A]	**Number of Unique Patients [B]**	**Number of Facilities [C]**
181,447 patient-facility pairs	164,238 patients	1,158 SNFs

For the per diem analysis in **Section VI.B** using Medi-Cal claims data, I use the 2024 claim-level dataset to calculate the number of patient days and total insurer paid amount for each SNF in each month, separately for Medi-Cal managed care and Medi-Cal FFS.[154] Specifically, I first summarize claims into distinct inpatient

[151] In addition, the data include claims for individuals with dual coverage from Medi-Cal and Medicare.

[152] Specifically, I filter to claims with "Claim Type Code Desc (C1r)" = "Inpatient," "POS Code w Desc (C3d)" = "3 Nursing Facility, Level A/B," and "FI Provider Type Code Desc (C1r)" = "LONG TERM CARE FACILITY" or "RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)."

[153] I define a unique facility as the combination of its National Provider Identifier ("NPI") and address.

[154] The allowed amount information is not available in the Medi-Cal claims data, which is why I use Medi-Cal paid amount. Allowed amount includes both insurer payment and patient cost sharing.

stays based on member ID, unique SNF ID, service start date, and discharge date on the claim.[155, 156] I then allocate the total insurer paid amount for each stay to each month based on the number of days the stay falls in that month. I drop from the 2024 claim-level dataset claims with conflicting patient or provider information reported in different claim lines and claims with Medicare involvement.[157] These sampling restrictions drop approximately 13 percent of claims. After summarizing claims to unique inpatient stays, I further drop approximately nine percent of stays with zero Medi-Cal payments.[158] Finally, after allocating unique stays to service months, I drop less than 0.1 percent of service days that fall outside of calendar year 2024. The table below shows the number of unique SNFs, average number of Medi-Cal patient days per SNF, and average Medi-Cal revenue per SNF in the final prepared dataset for the per diem analysis.[159]

Number of Unique SNFs [A]	Average Medi-Cal Patient Days per SNF in 2024 [B]	Average Medi-Cal Revenue per SNF in 2024 [C]
1,100	17,681	$5.9 million

ii. Medicare Claims Data

I was approved access by HCAI to traditional Medicare, Medicare Advantage, and commercial claims data for medical services rendered for California residents from 2018 to 2023.[160] I use the HCAI claims data for the Medicare per diem analysis in **Section VI.B** and the analysis on whether Medicare per diem changed following Ensign's prior acquisitions in **Section VIII.B.iii**. For both analyses, I use the Medicare claims to calculate the number of patient days and total allowed amount for each SNF in each month from 2018 to 2023, separately for Medicare Advantage and Medicare FFS.

---

155 The unique SNF ID is a time-invariant ID for a SNF that I constructed. The existing SNF ID in the claims data is NPI, which can and often change after an acquisition. In addition, one SNF can concurrently have more than one NPI. I constructed an NPI-to-unique SNF ID crosswalk using the CMS SNF Change of Ownership database and the CMS SNF Medicare Enrollment database. The SNF Change of Ownership database provides information on the SNF ownership changes that occurred on or after January 1, 2016. Specifically, it provides the old and the new NPI for the same facility going through the ownership change. On the other hand, the CMS SNF Medicare Enrollment database provides all NPIs concurrently used by a SNF. *See* CMS SNF Change of Ownership database, *CMS,* available at https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-change-of-ownership. *See also,* CMS SNF Medicare Enrollment, *CMS,* available at https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-enrollments.

156 The raw claims data files are organized by month, and the service start date in a particular monthly file always falls in that month. As such, whenever the discharge date is missing on a claim, I assume the patient is still in the facility at the end of the respective month.

157 These claims are for patients with both Medi-Cal and Medicare coverage. I drop these claims to obtain a more accurate estimate of Medi-Cal per diem.

158 There is no stay with negative Medi-Cal payment in the data.

159 Medi-Cal patient days and revenue include both managed care and FFS.

160 The data are provided by HCAI.

The HCAI claims data are provided separately for each year from 2018 and 2023. In each year, there are three separate datasets, the first at claim line level, the second at claim level, and the third at discharge level.[161] The variables needed for my analyses are scattered across the three datasets, and I explain how I put the variables together below.

For each year, I use the discharge-level dataset to obtain "internal discharge ID," admit date, discharge date, and member ID for the discharge, and I use the other two datasets to obtain "internal rendering provider ID," "place of setting ID," and allowed amounts for the discharge.[162] Using the "internal rendering provider ID" variable, I further obtain the provider NPI, provider zip code, and provider primary taxonomy code using an auxiliary provider information table provided by HCAI.[163] I drop denied claims and denied claim lines, claims for which Medicare is not the primary payer, and discharges with multiple payers. These sampling restrictions only drop approximately 1.3 percent of discharges from 2018 to 2023. For each year, the resulting dataset for that year is a discharge-level dataset covering both hospital and SNF discharges, with de-identified patient ID, provider NPI, admit and discharge dates, and allowed amounts. Finally, I filter the discharge-level data for each year to inpatient SNF services.[164]

Based on my investigation of the data, a unique inpatient stay that spanned two consecutive years may appear as two separate records with different "internal discharge IDs" in two separate years of the discharge-level data.[165] Moreover, the service dates in the two records for the same stay can overlap. Consequently, to avoid double counting of patient days across separate records of the same stay, I combined discharge records for the same inpatient stay across different years of the discharge-level datasets.[166] I then apportion the allowed amount for each stay to each month based on the number of days the stay falls in that month. Finally, I drop providers located outside of California, which account for less than 0.2 percent of allowed amounts in the dataset.

The table below shows the number of unique SNFs, average annual number of Medicare patient days per SNF, and average annual Medicare revenue per SNF (measured by allowed amount) in the final prepared dataset, which covers from 2018 to 2023.[167]

---

161 HCAI also provides a crosswalk that can be used to match claim lines and claims to each discharge.

162 The "internal discharge ID" is internally defined by HCAI's data vendor.

The "internal rendering provider ID" is internally defined by HCAI's data vendor and is from the claim line-level dataset. The "place of setting ID" variable describes whether the service is rendered in hospitals or SNFs and is also from the claim line-level dataset. When there is conflicting information on this variable within the same discharge, I choose the information from the claim line associated with the most insurer paid amount.

The allowed amount is from the claim-level dataset.

163 Provider taxonomy code describes the provider's type or specialty, e.g., hospital or SNF.

164 Specifically, I filter to provider primary taxonomy code "314000000X" and place of setting ID "3."

165 This phenomenon may be because HCAI grouped together claims for the same inpatient stay separately for each year.

166 To do this combination, I first drop discharge records with the same "internal discharge ID" within a year, discharge records with missing admit or discharge dates, and discharge records with negative or zero allowed amount. These sampling restrictions dropped approximately 13 percent of SNF discharge records from 2018 to 2023.

167 Medicare patient days and revenue include both Medicare Advantage and Medicare FFS.

Number of Unique SNFs [A]	Average Annual Medicare Patient Days per SNF [B]	Average Annual Medicare Revenue per SNF [C]
1,235	9,870	$2.7 million

D. Diversion Calculation Methodology

I group patient discharges based on their age, gender, and location of residence. Then, for each patient group, I calculate diversion from the removed facility to other facilities proportional to shares of other facilities within this patient group. Finally, I calculate the average diversion from the removed facility to each of the other facilities across patient groups.

The variables I use to group patients include whether the patient is 65 years old or older, gender, patient zip code, and county of the zip code. I use the following algorithm to group patients: first, group patients using all these variables; for groups with less than 20 patients, remove the first variable and regroup patients; this process continues until all remaining patients are grouped only by county. I exclude patients who remain in groups with less than 20 patients when grouping only by county.

E. Regression Specification for Analyses of Past Acquisitions

I use the following DID regression specification for retrospective analyses of Ensign's prior acquisitions:

$$Y_{it} = \alpha_i + \tau_t + \sum_l \beta^l D_{it}^l + \epsilon_{it}, \quad (1)$$

where for each facility i in year (or month) t, let Y_{it} be the metric of interest, α_i be the facility-specific fixed effect, τ_t be the year (or month) fixed effect, D_{it}^l be an indicator that is equal to one if and only if facility i is l years (or months) from being acquired in year (or month) t. The coefficients on D_{it}^l are the effects of the acquisitions.

The regression is weighted by number of beds, and the standard errors are clustered at the facility level.

F. Data Sources and Data Processing for Analyses of Past Acquisitions

I rely on three data sources for the DID analyses: CMS SNF Medicare Compare data, CMS SNF Cost Report data, and Medicare claims data.[168] **Appendix C** above explained the data source and data processing for the Medicare claims data, which are used for the analysis of changes in per diems. The following table and subsections below summarize the other two data sources:

[168] SNF Medicare Compare data reported from 2019 to 2026 are available at https://data.cms.gov/provider-data/archived-data/nursing-homes. Data reported in earlier years are available at https://web.archive.org/web/20210313120649/https://data.cms.gov/provider-data/archived-data/nursing-homes/.

CMS SNF Cost Report data are available at https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year.

Metrics [A]	Data Source [B]	Years Covered [C]
Health outcome	SNF Medicare Compare	2015–2025
Nursing care staffing	CMS SNF Cost Report	2015–2024
Patient volume and length of stay	CMS SNF Cost Report	2015–2024
Patient acuity	SNF Medicare Compare	2015–2025

CMS SNF Cost Report

The CMS SNF Cost Report has data on the following variables I use in my analyses:

1. Number of beds.
2. Average length of stay.
3. Total inpatient days.
4. Total nursing hours of the following:
    a. Employed RNs,
    b. Employed LPNs,
    c. Employed NAs, and
    d. All employed nursing staff (the sum of the above three).

The CMS SNF Cost Report data are released once a year and cover freestanding SNFs. Different SNFs in the same year's CMS SNF Cost Report data release can use different time periods for their statistics. As a hypothetical example, in year 2019's Cost Report, a SNF can report statistics from October 2018 to September 2019, while another SNF can report statistics from January 2019 to October 2019. To make statistics comparable across SNFs, I calculate annualized statistics. Specifically, for each statistic of a SNF in a given year's Cost Report, I first divide the statistic by the total number of days in this SNF's reported time period, and then multiply by 365 days.

SNF Medicare Compare

The SNF Medicare Compare data have the following four health outcome measures available from 2015 to 2025:

1. Percentage of residents admitted from a hospital who were re-hospitalized for an unplanned inpatient stay or observation stay within 30 days of the start of the SNF admission.
2. Percentage of residents admitted from a hospital who had an outpatient emergency department visit within 30 days of the start of the SNF admission.
3. Number of unplanned hospitalizations among long-stay residents per 1,000 long-stay resident days.
4. Number of outpatient emergency department visits among long-stay residents per 1,000 long-stay resident days.

For each of the four metrics, the data report an "adjusted" value and an "expected" value. The adjusted value of a metric for a SNF measures patient health outcomes if the SNF were to treat a group of patients with the national average patient acuity. On the other hand, the expected value measures patient health outcomes if

the SNF's patients were treated by a SNF with "average" quality.[169] Consequently, I use the adjusted values as SNF health outcome metrics and I use the expected values as SNF patient acuity metrics.

The SNF Medicare Compare data are released on a monthly basis. Typically, the data released in a month contain health outcome metrics measured several years prior.

To ensure sufficient observations for both the pre-acquisition and the post-acquisition periods, I choose the following reporting months to construct data:[170]

Reporting Month **[A]**	**Measurement Period** **[B]**
March 2017	2015
March 2018	July 1, 2015 to June 30, 2016
December 2018	2017
September 2019	2018
November 2020	2019
September 2021	2020
September 2022	2021
September 2023	2022
September 2024	2023
September 2025	2024
March 2026	July 1, 2024 to June 30, 2025

[169] "Nursing Home Care Compare Claims-Based Quality Measure Technical Specifications," *CMS,* July 2025, available at https://www.cms.gov/files/zip/mds-qm-users-manual-v18-0-effective-1-1-2026-associated-user-manuals.zip.

[170] Metric values measured for the full calendar year 2016 and 2025 are not available.