

Health Impact Assessment and Competitive Effect Analysis of Proposed Acquisition of Bethel Lutheran Home by Bayshire Central Valley

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Submitted to:

California Office of the Attorney General

April 28, 2026

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I. Scope of Report

The Office of the California Attorney General (“OCAG”) is reviewing the proposed acquisition of Bethel Lutheran Home, Inc. (“Bethel”) by Bayshire Central Valley LLC (“Jericho”) (“Bethel” and “Jericho” together are referred to as “the parties”).¹

Bethel owns and operates a single campus located in Selma, which is in Fresno County. Bethel’s campus offers a range of facilities, which creates the potential for long-term continuity of care that can include housing, residential services, and nursing care for a resident’s lifetime. More specifically, Bethel’s campus includes three facilities:

- a skilled nursing facility (“SNF”), which is a type of facility that typically provides 24-hour inpatient skilled nursing and rehabilitative care for residents who require ongoing medical supervision. These services typically cannot be provided in a less intensive setting;²
- an assisted living facility (“ALF”), which is a type of facility that typically provides non-medical supervision, assistance with activities of daily living, meals, and supportive services in a residential setting for individuals who do not require continuous skilled nursing care;³ and
- an independent living facility (“ILF”), which is a type of facility that typically provides independent residential housing for seniors who live without regular custodial or medical support, typically with access to optional amenities and community services.⁴

¹ “Exhibit 1 to Section §999.5(d)(1)(B), Agreement for Purchase and Sale,” in Notice of Proposed Transaction and Request for Consent under Corporations Code Section 5914 by Bethel Lutheran Home, Inc., July 16, 2025 (“Bethel Notice”), p. 7 (“This Agreement for Purchase and Sale ... is made and entered into as of May 12, 2025 ... by and between Bayshire Central Valley LLC, a California limited liability company d/b/a Jericho Care Group (‘Buyer’) and its permitted assignees and designees, and Bethel Lutheran Home, Inc., a California non-profit corporation (‘Seller’).”).

² “Glossary,” *California Department of Social Services*, <https://www.cdss.ca.gov/carefacilitysearch/Glossary> (“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.”); “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> (“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.”).

³ In California, licensed ALFs are also known as Residential Care Facilities for the Elderly (“RCFE”). I will use the term ALF throughout for simplicity. “Assisted Living Facilities,” *California Department of Aging*, https://www.aging.ca.gov/Care_Options/Assisted_Living_Facilities/ (“An RCFE provides **non-medical care and supervision** for persons 60 years or older who may need assistance with activities of daily living. RCFE residents should not require on-going medical assistance from facility staff. RCFEs may also serve persons under the age of 60 who have similar needs. RCFEs may care for individuals who have dementia if the facility is adequately equipped and staff are trained and sufficient to meet the needs of all residents (emphasis in original).”).

⁴ “Understanding Differences in Senior Living Communities,” Haley Burress, *The Federal Long Term Care Insurance Program*, December 17, 2024, available at <https://www.ltcfeds.gov/care-navigator/understanding-differences-in-senior-living-communities> (“Residents in independent living communities still take care of themselves without support. These communities do not have onsite caregivers around the clock. Instead, they typically have a nurse on site a few days per week to help with questions or conduct screenings. There is usually a security staff member on site 24 hours a day who can respond to emergencies by contacting first responders.”).

Jericho owns and operates seven campuses located in Fresno County. All these campuses include SNFs and one includes an ALF and an ILF.⁵

I was asked by OCAG to assess the likely effect of the proposed transaction on SNF competition and on patients. Specifically, I have been asked to assess whether the proposed transaction risks reducing the quality of care.

I have also been asked to recommend potential conditions for the OCAG to consider as a means of addressing any concerns that my analysis raises.

I reviewed and considered the following materials in preparation of this report:⁶

- Bethel Notice to the OCAG, as well as supplemental information provided by the parties.
- Medi-Cal claims submitted by California SNFs from 2018 to 2024.⁷
- Medicare Compare data with claim-based quality metrics for California SNFs from 2017 to 2025.
- Medicare Cost Report data with patient volume and staffing metrics for California SNFs from 2017 to 2024.
- Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data (“Medi-Cal Cost Report”).
- Centers for Medicare & Medicaid Services (“CMS”) SNF Enrollment and Ownership data and Cal Health Find database, both with information on SNF ownership history.

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 transaction is unlikely to pose significant risks to competition and quality of care. These findings include that:

⁵ Jericho also owns and operates a SNF in the neighboring Madera County. See Figure 1 below.

⁶ The Appendix describes data sources and data processing steps for Medi-Cal claims (**Appendix E**), Medicare Compare (**Appendix G**), and Medicare Cost Report (**Appendix H**).

⁷ Medi-Cal is California’s Medicaid program.

- In the short term, the proposed transaction is unlikely to substantially lessen competition in the relevant market. I define the relevant market as SNFs operating within 15 miles of Bethel. Bethel and Jericho are not close substitutes, as indicated by the low diversion ratios between them. Furthermore, the proposed transaction would result in only a minimal increase in SNF market concentration, which is currently moderately concentrated but not highly concentrated, and that these changes are not structurally presumptively anticompetitive.
- Evidence suggests no systematic reduction in quality of care following prior acquisitions by Jericho and affiliated entities. Health outcome measures generally show no statistically significant changes, and there is no clear evidence of changes in staffing level or staffing composition. However, some Bayshire facilities do not treat Medi-Cal patients, raising the concern that Jericho may reduce Medi-Cal patients' access post-transaction.
- The proposed transaction includes lease payments from the operating entity (Bethel) to a real estate entity under common ownership. Reimbursement rules limit the ability to increase payments through such arrangements, but related-party transactions may still affect the economic incentives of the parties. Particularly, this 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 here.
- I was also asked to consider whether another buyer may be more suitable than Jericho. I identify Skillserv as the most likely alternative acquirer. I study the likely effects of Skillserv's ownership on Medi-Cal patient access, patient health outcome, staffing composition, patient volume, and acuity level of admitted patients. I find that Skillserv is as suitable of a buyer as Jericho based on these measures, and Skillserv may provide better access to Medi-Cal patients. In addition, since Skillserv currently does not own any SNFs in the region where Bethel is located, there would be no change in market concentration if Skillserv were to acquire Bethel. Consequently, Skillserv may potentially be a marginally preferable buyer. This provides support for the condition for continued access for Medi-Cal patients I discuss below.

In summary, the proposed acquisition is unlikely to harm competition in the short term. However, the transaction structure still raises risks related to payments to related parties and reductions in the supply of SNF services, particularly services provided to low income residents in the local area in the long term. To mitigate these long-term risks, the OCAG may want to consider the following conditions:

- **Require Bethel to continue to provide access to Medi-Cal patients**

As Medicare reimburses at higher rates than Medi-Cal, SNFs have an economic incentive to replace lower paying Medi-Cal patients (i.e., reduce the supply of services to such patients) with higher paying Medicare patients. OCAG may want to consider conditions to mitigate the risk that Jericho reduces access for Medi-Cal patients post-transaction. For example, OCAG could require Bethel to maintain a patient mix that resembles the patient mix of the broader community.

- **Implement safeguards on rental agreements and similar related-party payments**

The proposed transaction involves Bethel paying annual rent of \$1.8 million to a related party, which appears to impose above-market rent obligations on Bethel. This structure raises several concerns, including that if Bethel were to cease operating as a going concern, the number of SNFs in the local area and hence, competition would decrease and the state or another entity could be left responsible for ongoing lease obligations, even if the rent exceeds fair market value.

OCAG may want to consider implementing safeguards to mitigate this risk. 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 restrict Jericho and its related entities from burdening Bethel with debt or other liabilities as well as monitor the financial conditions of Bethel and affiliated entities (such as through a periodic review of financial statements or revenue- and utilization-related metrics) to evaluate whether there is a heightened risk of insolvency.

IV. Background on the Proposed Transaction

A. Bethel

Bethel is a California non-profit religious corporation. It owns and operates a senior living campus in Selma, California, located in Fresno County. The campus includes a SNF with 59 beds, an ALF with 33 suites, and an ILF with 36 private cottages.⁸ Bethel states that it is one of two SNFs in Selma, and its closure would devastate the residents, staff, and the community.⁹ Approximately 80 percent of Bethel's revenues is from its SNF.¹⁰

B. Jericho

Jericho was founded in 2022, and owns and operates SNFs, ALFs, and ILFs in Fresno County.¹¹ Jericho is owned by Benjamin Carter (24.5 percent), Donald Adam Salow (24.5 percent), and Scott Kirby (51 percent).¹²

Figure 1 lists Jericho's seven facilities in Fresno County, as well as its one SNF in adjacent Madera County. This figure also lists the acquisition date of the facility by Jericho.

⁸ The addresses of the campus are 2280 Dockery Avenue, Selma, CA 93662, and 1250 Rorden Avenue, Selma, CA 93662. Bethel Notice, p.2.

⁹ See Bethel Notice, p. 84.

¹⁰ Bethel's 2022 statement of operations show net patient service revenues for the SNF of \$5,577,388 (78.5 percent of Bethel's total revenue) compared to ALF assisted care residential rents of \$243,284 (3.4 percent of Bethel's total revenue) and ILF independent living rents of \$800,267 (11.3 percent of Bethel's total revenue). "Bethel Lutheran Home, Inc. Financial Statements and Supplementary Information for the Years Ended December 31, 2022 and 2021 and Independent Accountant's Report," March 15, 2023, in Bethel Notice, p. 587.

¹¹ "About Us," *Jericho Care Group*, available at <https://www.jerichocare.com/>. See also, Figure 1 below.

¹² See "Bayshire Ownership Info.docx" produced by the parties on Oct 28, 2025.

Figure 1
Jericho Campuses

Name	County	Number of SNF Beds	Type(s)	Acquisition Date
Cornerstone Care Center	Fresno	99	SNF	12/1/2022
Covenant Post Acute	Fresno	121	SNF	12/1/2022
Foundation Skilled Nursing	Fresno	59	SNF	5/1/2025
Keystone Post Acute	Fresno	65	SNF	8/1/2024
Majestic Mountain Care Center	Madera	66	SNF	5/1/2024
Morning Star Post Acute	Fresno	57	SNF	12/1/2022
Stonehaven Senior Living	Fresno	50	SNF, ALF, ILF	2/9/2024
Vineyard Care Center	Fresno	56	SNF	12/1/2022

Sources:

- [1] "Facility List - Owned by Bayshire and Jericho.xlsx" produced by the parties on Oct 28, 2025.
 [2] Medi-Cal Cost Reports.
 [3] CMS SNF Medicare Enrollment and Ownership, January 2026.
 [4] Facility websites and historical news.

Scott Kirby, Jericho's co-owner, also owns Bayshire LLC ("Bayshire").¹³ Bayshire was founded in 2016 and owns and operates campuses with SNFs, ALFs, ILFs, and short-term respite care facilities in Southern California.^{14, 15} Bayshire owns and operates seven campuses with SNFs and an additional six campuses without SNFs.¹⁶

Figure 2, below, identifies Bayshire's seven campuses with SNFs. Five of these seven campuses also have ALFs or ILFs. These seven campuses were acquired by Bayshire between March 2021 and April 2024.

With each of these acquisitions, the land and buildings were acquired by a third-party entity, CareTrust REIT. Bayshire acquired the SNF operations but leased the buildings from CareTrust REIT.¹⁷

¹³ Scott Kirby also separately owns one ALF outside of California. The ALF, Barton Creek Senior Living, is in Bountiful, Utah. See "Facility Ownership List by Kirby Carter and Sarlow.xlsx" and "Bayshire Ownership Info.docx" produced by the parties on Oct 28, 2025.

¹⁴ See "Articles - Bayshire.pdf" produced by the parties on Oct 28, 2025.

¹⁵ 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.

¹⁶ See Figure 2 and Figure 3 below.

¹⁷ "CareTrust REIT Announces First Quarter 2021 Operating Results," *Securities and Exchange Commission*, May 7, 2021, available at <https://www.sec.gov/Archives/edgar/data/1590717/000162828021009299/ex991-ctreq12021er.htm>.

"CareTrust Doubles Up in OC, Buys in Yorba Linda," *Orange County Business Journal*, April 22, 2024, available at <https://www.ocbj.com/oc-homepage/caretrust-doubles-up-in-oc-buys-in-yorba-linda>.

Figure 2
Bayshire Campuses with SNFs

Name	County	Number of SNF Beds	Type(s)	Acquisition Date
Bayshire Carlsbad	San Diego	45	SNF, ALF, ILF	3/1/2021
Bayshire Rancho Mirage	Riverside	45	SNF, ALF, ILF	3/1/2021
Bayshire San Dimas Post-Acute	Los Angeles	45	SNF, ALF	4/1/2024
Bayshire Torrey Pines Post-Acute	San Diego	45	SNF, ALF, ILF	6/30/2023
Bayshire Yorba Linda Post-Acute	Orange	45	SNF, ALF	4/1/2024
El Centro Post-Acute Care	Imperial	123	SNF	3/25/2021
Santa Fe Post-Acute	San Diego	187	SNF	4/1/2024

Sources:

[1] "Facility List - Owned by Bayshire and Jericho.xlsx" produced by the parties on Oct 28, 2025.

[2] Medi-Cal Cost Reports.

[3] CMS SNF Medicare Enrollment and Ownership, January 2026.

[4] Facility websites and historical news.

Figure 3, below, identifies Bayshire's six campuses without SNFs, all in San Diego County. All six have ALFs and five also have short-term respite care facilities.

"CareTrust REIT Invests \$60 Million in Acquisition of Three Southern California Continuing Care Retirement Communities," *CareTrust REIT*, April 2, 2024, available at <https://investor.caretrustreit.com/news/news-details/2024/CareTrust-REIT-Invests-60-Million-in-Acquisition-of-Three-Southern-California-Continuing-Care-Retirement-Communities/default.aspx>.

"CareTrust REIT Announces Second Quarter 2021 Operating Results," *Securities and Exchange Commission*, August 6, 2021, available at <https://www.sec.gov/Archives/edgar/data/1590717/000162828021015852/ex991-ctreq22021er.htm>.

Figure 3
Bayshire Campuses without SNFs

Name	County	Number of ALF Beds	Type(s)	Acquisition Date
Cloisters of the Valley	San Diego	64	ALF, SRC	6/3/2020
Heritage Hills Memory Care	San Diego	72	ALF, SRC	10/6/2017
Hidden Glenn Senior Living	San Diego	99	ALF, SRC	2017
Shadowridge Senior Living	San Diego	40	ALF, SRC	Dec. 2018
Vista del Lago Memory Care	San Diego	99	ALF, SRC	9/9/2020
Vista Gardens Memory Care	San Diego	99	ALF	Jan. 2023

Sources:

[1] “Facility List - Owned by Bayshire and Jericho.xlsx” produced by the parties on Oct 28, 2025.

[2] California ALF Facility List, California Department of Social Services, February 2026.¹⁸

[3] Facility websites and historical news.

C. The Proposed Transaction

i. Arrangement for Real Estate and Service Operations

The proposed transaction involves the sale of Bethel’s real estate to 2280 Dockery Holdings LLC for \$8,000,000.^{19, 20} 2280 Dockery Holdings LLC has the same owners as Jericho.²¹

In addition, Jericho would assume operations of Bethel’s SNF post-closing through its wholly owned subsidiary Bethel Skilled Care LLC. Bethel Skilled Care LLC would lease the real estate from 2280 Dockery Holdings LLC. Jericho would also assume operations of Bethel’s ALF and ILF through two separate subsidiaries, Bethel Assisted Living LLC and Bethel Independent Living LLC. These two entities would also lease their real estate from 2280 Dockery Holdings LLC.

The term of the three leases is 25 years, and the base monthly rent will be \$150,000 (annual rent of \$1.8 million), broken down as follows:

- Bethel Assisted Living LLC (ALF): \$30,000.
- Bethel Independent Living LLC (ILF): \$30,000.
- Bethel Skilled Care LLC (SNF): \$90,000.²²

¹⁸ This ALF Facility List is available at <https://www.cclid.dss.ca.gov/carefacilitysearch/DownloadData>.

¹⁹ Bethel Notice, pp. 2-3. Of the total purchase price, \$7,999,900 is for the SNF and ALF collectively, and \$100 is for the ILF. “First Amendment to Agreement for Purchase and Sale,” in Bethel Notice, p. 50.

²⁰ Bethel’s real estate brokerage firm valued Bethel’s real estate to be between \$8,000,000 and \$8,500,000. “Broker Opinion of Value,” in Bethel Notice, p. 90.

²¹ 2280 Dockery Holdings LLC is owned by Kirby Living Trust (51 percent), Adam Salow (24.5 percent), and Benjamin Carter (24.5 percent). Operating Agreement for 2280 Dockery Holdings LLC, in Bethel Notice, p. 482.

²² “Bethel Sen[ior] Living RCFE CHOW Application.pdf” produced by the parties on Oct 28, 2025, pp. 723-724.

ii. Non-Compete Agreement

The Agreement for Purchase and Sale for the transaction includes a non-compete agreement on Bethel's "affiliates."²³ Specifically, Jericho requires that, for a period of two years after closing, unless permitted by Jericho:

1. Bethel's affiliates cannot own, operate, or participate in or otherwise receive revenues from a "Competing Facility." Jericho defines a "Competing Facility" as "a skilled nursing facility, assisted living facility, memory care facility, independent living facility or other health care facility providing services similar to those of the Community [(Bethel)], licensed or unlicensed, existing or to be constructed that (i) competes in any direct or indirect way with, or is comparable in any way to, the Community and (ii) is located within a five (5)-mile radius of the Community."
2. Bethel's affiliates cannot poach residents or patients from Bethel.
3. Bethel's affiliates cannot poach employees from Bethel.

Jericho states that this agreement is necessary to ensure a "fair return" to Jericho's investment.²⁴

The term "affiliates" is not defined in the agreement. However, the term "Bethel's affiliate" applies—at most—to Bethel's leadership personnel because Bethel does not have other facilities under common ownership.²⁵

D. The Parties' Assessment of the Effect of the Proposed Transaction

The parties state the proposed transaction would "benefit the [Bethel] SNF and the residents it serves," and that Jericho "will be better able to serve the Selma community." The parties also state the proposed transaction would not "adversely affect the delivery, availability, or accessibility of healthcare services to the community served by the skilled nursing facility."²⁶ The parties state that Jericho would continue to serve Medicare and Medi-Cal beneficiaries post-closing;²⁷ however, Jericho's goal appears to be to increase the percentage of short-term patients, which are typically insured by Medicare plans, which has the potential to be at the expense of Medi-Cal patients.²⁸

²³ "7.8 Non-Compete Agreement, Purchase and Sale Agreement," in Bethel Notice, pp. 27-28.

²⁴ "7.8 Non-Compete Agreement, Purchase and Sale Agreement," in Bethel Notice, p. 27.

²⁵ For example, Jericho imposed similar conditions in its acquisition of Twilight Haven. In that acquisition, Jericho specifically clarified that the term "affiliates" includes seller's CEO. See "Purchase and Sale Agreement" in Attorney General's Conditional Approval of Jericho Acquisition of Twilight Haven, p. 47, available at <https://oag.ca.gov/system/files/attachments/press-docs/Twilight%20Haven-%20Order%20approving%20Stipulation%20and%20AG%20Conditions%5B1%5D.pdf>.

²⁶ Bethel Notice, p. 425.

²⁷ Bethel Notice, p. 423.

²⁸ See "Minutes of the Bethel Lutheran Home Board of Directors Meeting on October 16, 2025," produced by the parties on Jan 16, 2026.

The closing of the proposed acquisition is contingent on OCAG's approval.²⁹ However, Jericho has been consulting Bethel on its operations since July 8, 2025.³⁰

Jericho has already made several changes to Bethel's operations. In August 2025, Bethel implemented a \$100 fee for residents who required an escort to a doctor's appointment. Jericho also raised rates by ten percent effective November 2025.³¹

V. Services Provided by Bethel and Jericho

The parties' SNFs, ALFs, and ILFs provide different options for accommodations and levels of care. In the remainder of this section, I describe these options and how they are reimbursed.

A. SNFs and Reimbursement of SNF Services

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.³² Patients are typically admitted to SNFs following hospitalization (post-acute care) or when they require long-term skilled nursing services.³³ 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);

²⁹ "Agreement for Purchase and Sale," in Bethel Notice, pp. 22-23.

³⁰ For example, an email from Benjamin Carter dated September 5, 2025 stated: "Jericho hired [Jasdeep Dhariwal] to eventually become the administrator at Bethel. Part of our operating agreement is I will be the administrator, free of charge, until we close escrow. Jas will be on Jericho's payroll and will be taking a more active role in the facility to ensure a smooth transition." "08.2025 & 09.2025.pdf" produced by the parties on Oct 28, 2025.

³¹ See "08.2025 & 09.2025.pdf," p. 13, produced by the parties on Oct 28, 2025. As of 2025, Bethel charged: SNF: \$320 to \$350 a day for private pay patients and \$282.66 a day for Medi-Cal patients; ALF: \$2,325 to \$3,104 a month for single occupancy; and ILF: \$2,758 to \$3,099 a month for a cottage. Rate ranges for the ALF and ILF depend on room sizes and occupancy. See "Room Pricing 2025.pdf" produced by the parties on Oct 28, 2025.

³² "State Operations Manual: Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities," *Centers for Medicare & Medicaid Services*, February 10, 2023, pp. 18, 20, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07pdf.pdf>.

³³ See, e.g., "Medicare Benefit Policy Manual: Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance," *Centers for Medicare & Medicaid Services*, 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.").

- Room and board; and
- Social services.³⁴

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.*³⁵

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 treatments, coordinating care, educating patients and families, and, in some settings, supervising LPNs and NAs.³⁶
- 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.³⁷
- 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.³⁸

³⁴ See "Medicare Benefit Policy Manual: Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance," *Centers for Medicare & Medicaid Services*, October 05, 2023, pp. 10, 33, 47, 52, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf>.

³⁵ "Skilled Nursing Facility," Cal. Admin. Code Title. 22, § 72103, available at <https://govt.westlaw.com/calregs/Document/IB8C471C45B6111EC9451000D3A7C4BC3>.

³⁶ 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>.

³⁷ 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.

³⁸ 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>.

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 \$23.46.³⁹

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.⁴⁰
- 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).⁴¹

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.⁴²

iii. Reimbursement of SNF Services

SNF patients are often indigent and/or elderly. Many are covered by Medi-Cal (health insurance for the indigent) or Medicare (health insurance for the elderly). 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.^{43, 44}

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

³⁹ 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>.

⁴⁰ 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.

⁴¹ 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.

⁴² 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.

⁴³ See discussions on commercial payers in this section.

⁴⁴ "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.").

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.^{45, 46}

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 (Medi-Cal fee-for-service).⁴⁷ California Department of Health Care Services (“DHCS”) sets Medi-Cal fee-for-service reimbursement rates.⁴⁸ Medi-Cal reimburses freestanding SNFs under a facility-specific, cost-based per diem methodology.⁴⁹ SNFs may negotiate rates with Medi-Cal managed care plans that are higher than Medi-Cal fee-for-service rates or may receive Medi-Cal managed care rates that are the same as Medi-Cal fee-for-service rates.⁵⁰

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.⁵¹ Consequently, a SNF’s reported rent, depreciation, and most other capital costs do not affect its Medi-Cal payments.⁵² 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

⁴⁵ 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.

⁴⁶ 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/>.

⁴⁷ 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.”).

⁴⁸ “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).”).

⁴⁹ “Freestanding Skilled Nursing Facility CY 2026 Rates,” *California Department of Health Care Services*, October 31, 2025, p. 1, available at https://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/AB1629_WebUpdates/LTC-Rates-PL-26-001-SNF-CY2026.pdf.

⁵⁰ 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 fee-for-service rate.

⁵¹ 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>.

⁵² See “Skilled Nursing Facilities,” *California State Auditor*, May 01, 2018, p. 11, available at <https://information.auditor.ca.gov/pdfs/reports/2017-109.pdf>.

category.⁵³ 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 fee-for-service, 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 payers, which are referred to as Medicare Advantage (“MA”) 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 case mix and the SNF’s local labor costs.^{54, 55}

MA plans typically negotiate payment rates with SNFs,⁵⁶ 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 MA 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 MA plans in areas with bed shortages or in areas in which a SNF or group of SNFs have market power.

I evaluated 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 concluded 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.⁵⁷

⁵³ See “Skilled Nursing Facilities,” *California State Auditor*, May 01, 2018, p. 11, available at <https://information.auditor.ca.gov/pdfs/reports/2017-109.pdf>.

⁵⁴ “Skilled Nursing Facility Prospective Payment System,” *Centers for Medicare & Medicaid Services*, 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.”)

⁵⁵ Case mix is the composition of patient acuity when they are admitted to a SNF.

⁵⁶ “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.”).

⁵⁷ 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-medicare-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.”).

Private pay

Private-pay rates for individuals without insurance are set by the SNF.⁵⁸

B. ILF and ALF Services

ILFs are residential settings designed for older adults, who are generally able to live independently. ILFs are required by the California Department of Social Services to “provide private or semi-private bathrooms, a dining room, or common activities room that may also serve as a dining room.”⁵⁹ Some ILFs—including some owned by Bayshire and Jericho—provide cooking, cleaning, and laundry services.⁶⁰

ILFs do not typically provide assistance with bathing, dressing, or medication management. Residents who later require these types of care may need to arrange for supplemental home health services or transition to ALFs.

ALFs provide room, board, and personal care services for individuals who need help with activities of daily living but do not require the medical care of a SNF.⁶¹ Personal care services may include bathing, dressing, and medication management, along with limited health-related services, such as nursing oversight, care coordination, and monitoring of chronic conditions. Some facilities include specialized memory care units.⁶² In California, ALFs are licensed and inspected by the California Department of Social Services.⁶³

ILFs and ALFs typically charge residents monthly rent plus additional fees for additional services or amenities.⁶⁴ Health insurance typically does not cover the costs of ILFs and ALFs.⁶⁵

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- ⁵⁸ 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)”).
- ⁵⁹ “Provider Enrollment for Residential Care Facilities for the Elderly and Adult Residential Facilities,” *California Department of Health Care Services*, available at <https://www.dhcs.ca.gov/services/ltc/Pages/Residential-Care-Facility-and-Adult-Residential-Facility-Provider-Enrollment.aspx>.
- ⁶⁰ See, e.g., “Independent Living,” *Bayshire Rancho Mirage*, available at <https://bayshireranchomirage.com/levels-of-care/#independentliving>; “Senior Living Care Options,” *Stonehaven Senior Living*, available at <https://stonehavensl.com/levels-of-care/>
- ⁶¹ “Assisted Living Facilities,” *California Department of Aging*, available at https://aging.ca.gov/Care_Options/Assisted_Living_Facilities/.
- ⁶² Some of the Bayshire facilities have memory care units. See, e.g., “Independent Living,” *Bayshire Rancho Mirage*, available at <https://bayshireranchomirage.com/levels-of-care/#independentliving>.
- ⁶³ See “Assisted Living Facilities,” *California Department of Aging*, available at https://aging.ca.gov/Care_Options/Assisted_Living_Facilities/.
- ⁶⁴ See “Independent Living Fees: Avoid Surprises,” *Seniors Guide*, June 17, 2024, available at <https://www.seniorsguide.com/community-life/knowning-independent-living-fees>; “Assisted Living Facilities,” *California Department of Aging*, available at https://aging.ca.gov/Care_Options/Assisted_Living_Facilities/.
- ⁶⁵ See “Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care,” *National Institute on Aging*, October 12, 2023, available at <https://www.nia.nih.gov/health/assisted-living-and-nursing-homes/long-term-care-facilities-assisted-living-nursing-homes>.

VI. SNF Payer Mix

In this section, I study the share of patient days by payer type (the SNF “payer mix”) of Bethel, Jericho, and Bayshire, as well as other SNFs operating in the same regions.

Payer mix is relevant for understanding a SNF’s financial situation because SNF reimbursement differs by payer.⁶⁶

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.

A. Bethel and Jericho SNF Payer Mix

Figure 4, below, shows Bethel and Jericho SNFs’ payer mix in 2024. Approximately 83 percent of Bethel SNF’s patient days are insured by a Medi-Cal plan, which is 18 percentage points higher than the state average of approximately 65 percent.⁶⁷ Approximately 68 percent of Jericho’s patient days are insured by Medi-Cal and 26 percent by Medicare. A small share are commercially insured or self-pay patients.

⁶⁶ Individuals typically pay directly for services from ALFs and ILFs because such services are typically not reimbursed through health insurance.

⁶⁷ See Figure 6 below.

Figure 4
Bethel SNF and Jericho SNFs Share of Patient Days by Payer
2024

	Medicare (incl. Managed Care)	Medicaid (incl. Managed care)	Commercial	Self-Pay	Other
Bethel	7%	83%	0%	8%	2%
Jericho	26%	68%	1%	1%	5%
Majestic Mountain Care Center	18%	82%	0%	0%	0%
Cornerstone Care Center	32%	68%	0%	0%	0%
Covenant Post-Acute	21%	70%	0%	1%	7%
Foundation Skilled Nursing	10%	65%	8%	1%	16%
Keystone Post-Acute	24%	69%	0%	0%	7%
Morning Star Post-Acute	46%	50%	0%	0%	4%
Vineyard Care Center	29%	71%	0%	0%	0%

Notes:

[1] Stonehaven Senior Living is not included in this table because it did not submit a Medi-Cal Cost Report in 2024.

[2] The overall percentages are calculated using total annualized patient days across the seven facilities.

[3] “Self-Pay” consists of patient days for which the primary payer is the patient or patient’s family. It can also include charity care.

[4] “Other” includes patient days that do not fall into any of the defined categories. “Other” includes Veterans Administration and worker’s compensation.

Source: Medi-Cal Cost Report, 2024.

B. Bayshire SNFs Payer Mix

Figure 5 below shows Bayshire SNFs’ payer mix in 2024. The first five campuses shown in the figure do not treat Medi-Cal patients, with most of their patients insured by Medicare. Overall, 42 percent of Bayshire’s patient days are insured by Medicare, which is almost double the percentage of Californians who received SNF care through Medicare (23 percent).⁶⁸

⁶⁸ See Figure 6 below.

Figure 5
Bayshire SNFs Share of Patient Days by Payer
2024

	Medicare (incl. Managed Care)	Medicaid (incl. Managed care)	Commercial	Self-Pay	Other
Bayshire Carlsbad	99%	0%	0%	1%	0%
Bayshire Rancho Mirage	62%	0%	36%	2%	0%
Bayshire San Dimas Post-Acute	82%	0%	0%	18%	0%
Bayshire Torrey Pines Post-Acute	89%	0%	0%	11%	0%
Bayshire Yorba Linda Post-Acute	92%	0%	0%	8%	0%
El Centro Post-Acute	25%	62%	3%	0%	11%
Santa Fe Post Acute	7%	81%	8%	0%	4%
Overall	42%	44%	6%	3%	4%

Notes:

- [1] The overall percentages are calculated using total annualized patient days across the seven facilities.
- [2] “Self-Pay” consists of patient days for which the primary payer is the patient or patient’s family. It also includes charity care.
- [3] “Other” includes patient days that do not fall into any of the defined categories, including Veterans Administration and worker’s compensation.

Source: Medi-Cal Cost Report, 2024.

C. Payer Mix of Other SNFs Operating in the Same Region as the Parties

Figure 6, below, shows payer mix in 2024 for each county where Jericho SNFs and Bayshire SNFs are located, as well as across all SNFs in California. As shown, Fresno County’s SNF payer mix approximately matches the average payer mix across the state. Orange, Riverside, and San Diego Counties have slightly higher-than-average Medicare shares, whereas Madera, Los Angeles, and Imperial Counties have higher-than-average Medicaid shares.

Figure 6
SNF Share of Patient Days by Payer and County
2024

	Medicare (incl. Managed Care)	Medicaid (incl. Managed care)	Commercial	Self-Pay	Other
Counties with Jericho SNFs					
Fresno	23%	61%	3%	4%	9%
Madera	11%	76%	2%	1%	10%
Counties with Bayshire SNFs					
Imperial	19%	69%	2%	0%	9%
Los Angeles	21%	68%	3%	2%	6%
Orange	29%	63%	3%	2%	3%
Riverside	31%	53%	6%	1%	10%
San Diego	30%	59%	2%	2%	7%
California Overall	23%	65%	4%	2%	6%

Notes:

[1] The overall percentages are calculated using total annualized patient days.

[2] “Self-Pay” consists of patient days for which the primary payer is the patient or patient’s family. “Self-Pay” includes charity care.

[3] “Other” includes patient days that do not fall into any of the defined categories. “Other” includes Veterans Administration and worker’s compensation.

Source: Medi-Cal Cost Report, 2024.

VII. SNF Competitive Landscape

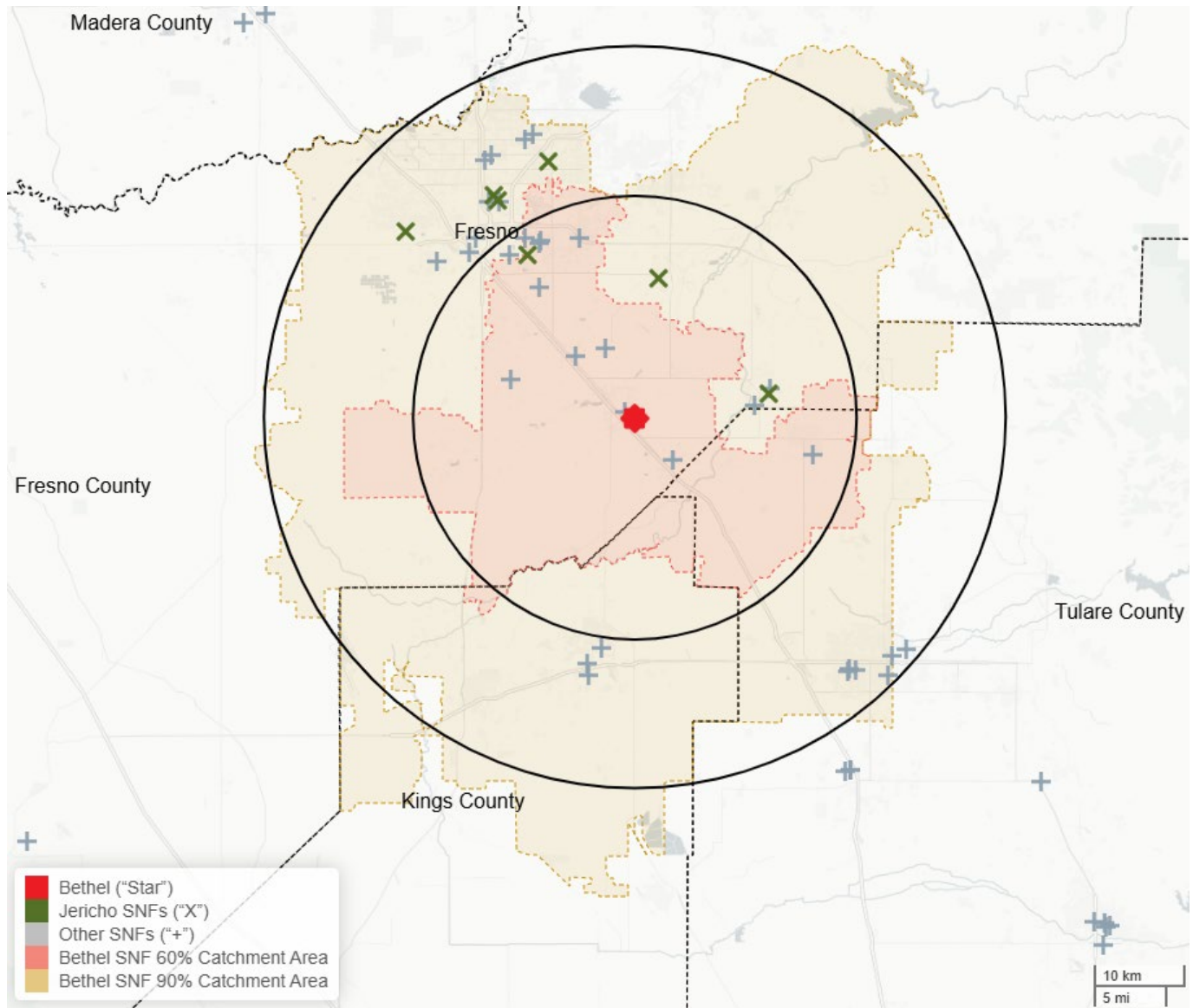
Both Bethel and Jericho operate SNFs in Fresno County. Figure 7, below, shows SNFs in this area and some SNFs in adjacent Tulare and Kings counties. There are:

- 17 SNFs within 15 miles of Bethel, three of which are part of Jericho and
- 39 SNFs within 25 miles of Bethel, seven of which are part of Jericho.

The red shaded area is the set of patient zip codes closest to Bethel that cover 60 percent of Bethel’s SNF patients (“60 Percent Catchment Area”). The orange shaded area is the set of patient zip codes closest to Bethel that cover 90 percent of Bethel’s SNF patients (“90 Percent Catchment Area”). Approximately 60 percent of Bethel’s patients reside in zip codes with 15 miles of Bethel and approximately 90 percent reside in zip codes within 25 miles of Bethel.⁶⁹

⁶⁹ “Resident Information Query.xlsx” produced by the parties on Mar 16, 2026. To calculate catchment areas, I excluded five (out of 268) Bethel SNF patients between 2021 and March 2026 who do not have a resident zip code in Bethel’s admission records.

Figure 7
SNFs around Bethel
15-Mile Radius and 25-Mile Radius Centered on Bethel



Notes:

- [1] The map shows the seven Jericho SNFs in Fresno County.
- [2] Bayshire's campuses do not appear on this map because they are located in Southern California.
- [3] To calculate catchment areas, I excluded five (out of 268) Bethel SNF patients between 2021 and March 2026 who do not have a resident zip code in Bethel's admission records.

Sources:

- [1] CMS SNF Medicare Enrollment and Ownership, January 2026.
- [2] "Resident Information Query.xlsx" produced by the parties on Mar 16, 2026, at sheets "SNF 2021," "SNF 2022," "SNF 2023," "SNF 2024," "SNF 2025," and "SNF 2026."

Figure 8 below shows admission shares for SNFs within 15 miles and 25 miles of Bethel. Jericho owns three SNFs accounting for approximately 13.5 percent of admissions among SNFs within 15 miles of Bethel. Bethel accounts for approximately 1.3 percent of admissions among SNFs within 15 miles of Bethel.

Figure 8
SNF Share of Admissions Around Bethel

	Within 15 Miles of Bethel		Within 25 Miles of Bethel	
	Count of SNFs	Share of Admissions	Count of SNFs	Share of Admissions
Bethel	1	1.3%	1	0.5%
Jericho	3	13.5%	7	15.0%
Other	13	85.2%	29	84.5%
Total	17	100.0%	37	100.0%

Notes:

[1] The shares of admissions are calculated using annualized admissions based on 2022-2024 Medicare Cost Reports.

[2] Three SNFs within 25 miles of Bethel appear in the CMS Enrollment data for 2026, but do not appear in the Medicare SNF Cost Reports in 2022-2024. As a result, they are excluded from this figure. One of the three facilities, Sunnyside Convalescent Hospital / Grace Healthcare Center, is in Fresno. The other two facilities, Community Subacute & Transitional Care Center in Fresno and Kaweah Health Skilled Nursing Center in Visalia, are distinct parts of hospitals.⁷⁰

[3] There is one SNF within 25 miles of Bethel (Promenade Care Center in Fresno) that appears in the 2022 Medicare Cost Reports but does not appear in the CMS Enrollment data as of January 2026. This facility is also excluded from the table above. It closed temporarily and did not reopen until 2025 (as Burnett Extended Care Center, now a distinct part of a hospital).⁷¹

[4] One Jericho SNF, Majestic Mountain Care Center located in Madera County, is excluded as the SNF is located more than 25 miles from Bethel.

Sources:

[1] Medicare SNF Cost Reports, 2022-2024.

[2] CMS SNF Medicare Enrollment and Ownership, January 2026.

VIII. Analysis of Effects of the Proposed Transaction

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 transaction is likely to lessen competition in the short term. However, that is different from the longer-term effects in the market from the change to Jericho as the buyer as discussed throughout the report.

⁷⁰ See "Community Subacute and Transitional Care Center," *HCAI Hospital Profile*, available at <https://hcai.ca.gov/facility/community-subacute-and-transitional-care-center/>; "Kaweah Health Skilled Nursing Center," *HCAI Hospital Profile*, available at <https://hcai.ca.gov/facility/kaweah-health-skilled-nursing-center/>.

⁷¹ See "Facility History" of Burnett Extended Care Center, *HCAI*, available at <https://ifis.hcai.ca.gov/Facility/History/206100685>; "Worker Adjustment and Retraining Notification (WARN) Notices" of Promenade Care Center LLC, *USA Today*, August 3, 2022, available at <https://data.usatoday.com/see-which-companies-announced-mass-layoffs-closings/promenade-care-center-llc/ca-2223-00119/>; "Community's new skilled nursing facility holds grand opening in downtown Fresno," *Community Medical Centers*, October 1, 2025, available at <https://www.communitymedical.org/about-us/newsroom/communitys-new-skilled-nursing-facility-holds-grand-opening-in-downtown-fresno>.

In **Section VIII.A**, I analyze if the transaction could increase market power. In **Sections VIII.B** and **VIII.C**, I analyze if it could affect outcomes by altering Bethel's mission, as the facility would convert from a religious nonprofit to a for-profit. Specifically, I examine the effects of Jericho's prior acquisitions (**Section VIII.B**) and Bayshire's prior acquisitions (**Section VIII.C**) on quality of care, staffing composition, patient volume, and patient case mix,⁷² which provide evidence of how similar transactions have affected quality and access.

Finally, I examine the specific arrangement in the proposed transaction where one entity would operate Bethel and pay rents to a related party under common ownership. In **Section VIII.D**, 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.

A. Change in Market Power and Market Concentration

In this section, I assess the potential effect of the proposed transaction on market power and market concentration. I perform these analyses for SNF services. From this analysis, I find that Bethel and Jericho are not close competitors, and the proposed transaction does not significantly increase the parties' market power or market concentration.

Despite these findings, there is a risk that if Jericho continues to acquire SNFs in this market, the market concentration may eventually become much higher, and Jericho may be able to eventually achieve considerable market power. Jericho as described below does already operate in a moderately concentrated market for skilled nursing services. In such a scenario, Jericho could exercise this considerable market power to secure higher reimbursements from Medi-Cal managed care plans than those paid under the fee-for-service Medi-Cal program. This risk of price increases would be even more likely if network adequacy requirements compelled plans to contract with certain facilities or if there were bed shortages for Medi-Cal patients in the area. Jericho could also potentially exert its market power by reducing services to Medi-Cal patients.

[REDACTED]

In **Section VIII.A.i**, I calculate the diversion ratios between Bethel and Jericho.⁷³ The diversion ratio from Bethel to Jericho is the share of Bethel's SNF patients who would go to Jericho's SNFs should Bethel's SNF close.⁷⁴ Higher diversion ratios indicate closer competition between the parties and more potential for the proposed acquisition to lessen competition.

In **Section VIII.A.ii** and **Section VIII.A.iii**, I define the markets relevant to the proposed transaction and assess whether the proposed acquisition significantly increases market concentration under the thresholds established in the federal antitrust authorities' Merger Guidelines.

⁷² I study patient case mix to examine whether prior acquisitions led to selective admissions of sicker or less sick patients.

⁷³ See Ravel, Devesh, et al., "A Semiparametric Discrete Choice Model: An Application to Hospital Mergers," *Economic Inquiry*, 55(4): 1919-1944, October 2017.

⁷⁴ The diversion ratio from the target to the acquirer also represents the share of the target's patients who would substitute to the acquirer if the target loses patients by lowering the quality of care that it provided.

i. Diversion Ratios between Bethel and Jericho

I calculate the diversion ratios between Bethel’s SNF and Jericho’s SNFs using the patient discharges in the Medi-Cal claims data from 2024, the latest year of claims data available to me.^{75, 76} The diversion ratio calculation considers patient age, gender, and patient zip code.⁷⁷ As shown in the figure below, I find that the diversion ratios are low between Bethel’s SNF and Jericho’s SNFs, indicating that they are not close competitors.⁷⁸

Figure 9
Diversion Ratios between Bethel’s SNF and Jericho’s SNFs
Based on 2024 Medi-Cal Claims

From Bethel to Jericho	4.4%
From Jericho to Bethel	0.6%

Note:

[1] Stonehaven Senior Living, one of Jericho’s facilities in Fresno, is not included in this calculation because it was temporarily closed in 2024 and is not in the 2024 claims data.

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 Bethel and Jericho offer SNF services.

To evaluate the geographic market appropriate for the proposed transaction, I consider two sources of evidence: (1) diversions from Bethel to other facilities and (2) the scope of the geographic areas Jericho used to identify competitors in Fresno County.

Based on this evidence, I use SNFs within 15 miles of Bethel as the geographic market.

Evidence Based on Diversions from Bethel to Other SNFs

In Figure 10 below, I show diversions from Bethel to other SNFs. Approximately 68 percent of Bethel’s patients would choose SNFs within 15 miles of Bethel, which is likely sufficient for this to be a well-defined

⁷⁵ A technical description of the claims data processing steps is in **Appendix E**.

⁷⁶ I calculate diversion ratios based on Medi-Cal claims data. I would expect my conclusions to hold for patients more broadly. This is because a majority of patients in Bethel’s catchment area are covered by Medi-Cal. Furthermore, all the SNFs located in Bethel’s catchment area treat at least some Medi-Cal patients.

⁷⁷ As an extreme illustrative example, if two facilities are located relatively close 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.

⁷⁸ Stonehaven Senior Living, one of Jericho’s facilities in Fresno, is not included in this calculation because it was temporarily closed in 2024 and is not in the 2024 claims data. This data limitation means the diversion from Bethel to Jericho is underestimated.

antitrust market.⁷⁹ Approximately 91 percent of Bethel’s patients would choose SNFs within 25 miles of Bethel.

Figure 10
Diversions from Bethel to Other SNFs
Based on 2024 Medi-Cal Claims

As-the-Crow-Flies Distance (Miles)	Total Diversion to SNFs within This Distance
5	36%
10	54%
15	68%
20	78%
25	91%

Note:

[1] Stonehaven Senior Living, one of Jericho’s facilities in Fresno, is not included in this calculation because it was temporarily closed in 2024 and is not in the 2024 claims data.

Source: Medi-Cal claims data, 2024.

Evidence Based on How Jericho Views the Competitive Landscape in Fresno County

I look at the geographic area Jericho used to identify competitors in Fresno County. Jericho has used narrower geographic areas to identify competitors. In its non-compete conditions in the agreement to purchase Bethel, Jericho defines competing facilities as being within five miles of Bethel.⁸⁰ In its non-compete conditions in the 2023 agreement to purchase Twilight Haven, which is also located in Fresno County, Jericho defined competing facilities as those within ten miles of Twilight Haven.⁸¹

These views from Jericho further support that the area within 15 miles of Bethel is a well-defined geographic market. Bethel’s competitors from Jericho’s perspective would all be located within 5 miles of Bethel—which would be an even smaller market than the 15-mile area that I use.

iii. Change in Market Concentration

Figure 11 below calculates the Herfindahl-Hirschman Index (“HHI”) and changes in HHI for services provided by SNFs located within 15 (and 25) miles of Bethel due to Jericho’s past acquisitions and the proposed acquisition. Absent Jericho’s acquisitions (i.e., unwinding Jericho’s past acquisitions), the SNF market within 15 miles of Bethel would have an HHI of approximately 1,246, which is moderately—but not highly—

⁷⁹ This follows from the logic of the hypothetical monopolist test. A hypothetical monopolist of SNFs within 15 miles of Bethel likely would impose a small but significant 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 Bethel and the second choice of 68 percent of Bethel’s patients. (Diversions represent second choices and 68 percent of diversions would be to other SNFs controlled by the hypothetical monopolist.) Such an insurer would likely prefer to accept a SSNIP at Bethel than lose access to the preferred SNFs treating so many of Bethel’s patients.

⁸⁰ See **Section IV.C.ii** above.

⁸¹ See “Purchase and Sale Agreement,” in Attorney General’s Conditional Approval of Jericho Acquisition of Twilight Haven, p. 33, available at <https://oag.ca.gov/system/files/attachments/press-docs/Twilight%20Haven-%20Order%20approving%20Stipulation%20and%20AG%20Conditions%5B1%5D.pdf>.

concentrated under the federal Merger Guidelines.⁸² Under the current ownership structure (i.e., accounting for Jericho's past acquisitions), this market has an HHI of approximately 1,299, which is again moderately concentrated. The proposed transaction would raise the HHI to 1,335 (an increase of approximately 36). Neither Jericho's acquisition of Bethel nor Jericho's full series of acquisitions trigger the structural presumption in the federal Merger Guidelines.⁸³ Expanding the geographic market to include SNFs within 25 miles of Bethel, neither Jericho's acquisition of Bethel nor Jericho's full series of acquisitions trigger the structural presumption in the federal Merger Guidelines. To be clear, that is not the same as saying there are no competitive impact concerns.

⁸² "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).").

⁸³ 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 11
Change in SNF Market HHI Due to Jericho Acquisitions
Based on Shares of Admissions
SNFs Within 15 and 25 Miles of Bethel

	HHI	
	Within 15 Miles	Within 25 Miles
[A] Absent Jericho's Acquisition of Its Current In-Market Facilities	1,246	1,208
[B] Current	1,299	1,264
[C] Current + Proposed Acquisition of Bethel	1,335	1,280
[D] <i>Change in HHI from [A] to [B]</i>	53	56
[E] <i>Change in HHI from [B] to [C]</i>	36	16

Notes:

[1] HHI is calculated as the sum of the squared system shares of SNF admissions, multiplied by 10,000. I use the annualized admission numbers underlying Figure 8 above for this HHI calculation.

[2] A "system" is defined using the "Affiliation Entity Name" in the CMS Medicare Enrollment data and the Jericho facilities identified in Figure 1.

[3] Row [A] is calculated by re-assigning Jericho's shares to the previous owners of its seven facilities in this market. Of these seven facilities, Stonehaven Senior Living was a standalone facility prior to Jericho's acquisition, and Keystone Post Acute was in a system with no other facility in this market. The other five facilities all belonged to a group of owners including AHT Holdings, LLC and several other organizations and individuals. The owners prior to Jericho acquisitions are from ownership information in the Medi-Cal Cost Reports and CMS SNF Medicare Enrollment and Ownership data.

Sources:

[1] Medicare SNF Cost Reports, 2022-2024.

[2] CMS SNF Medicare Enrollment and Ownership, January 2026.

[3] Medi-Cal Cost Reports, 2022-2024.

[4] Figure 1.

B. Analysis of Jericho's Past Acquisitions

I evaluate whether Jericho's past acquisitions have been followed by changes in quality of care or access. For quality of care, I analyze metrics on health outcomes, staffing levels, and staffing compositions. For access, I analyze metrics on patient volume and patient case mix.⁸⁴

Both quality of care and access are relevant for analyzing SNF competition. Quality of care is a key dimension of competition among SNFs because Medicare and Medi-Cal fee-for-service rates are set by government agencies. Also, a SNF with higher quality of care 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 access is relevant for analyzing SNF competition because reducing access reduces the supply of SNF care and thus reduces competition. A SNF that avoids admitting specific groups of patients (e.g., based on insurance type or acuity of need) reduces competition among SNFs supplying care to those types of patients.

I use a difference-in-differences ("DID") approach to evaluate the effect of Jericho's acquisitions in 2022 on quality of care and access. 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

⁸⁴ These metrics are from CMS SNF Cost Reports and CMS SNF Medicare Compare data.

in outcome of the acquired facilities before and after the year of their acquisitions with the difference in average outcome of a set of benchmark facilities before and after the same year. The benchmark SNFs are SNFs in counties located in the Central Valley region of California and without Jericho SNFs. These counties are Kern, Merced, San Joaquin, Stanislaus, and Yolo counties.

I focus on the four Jericho SNF acquisitions in California in 2022, which are the earliest Jericho acquisitions. These four SNFs are shown in Figure 12 below.

Figure 12
Jericho Acquisitions in 2022

Name	County	Number of SNF Beds	Type(s)	Acquisition Date
Cornerstone Care Center	Fresno	99	SNF	12/1/2022
Covenant Post Acute	Fresno	121	SNF	12/1/2022
Morning Star Post Acute	Fresno	57	SNF	12/1/2022
Vineyard Care Center	Fresno	56	SNF	12/1/2022

Source: Figure 1.

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

- **Health outcome metrics:** I find no (statistically and economically significant) change among health outcome metrics.⁸⁵
- **Staffing:** I find that Jericho might have substituted RN hours with LPN hours. However, any effect of Jericho’s acquisitions on staffing is difficult to disentangle from changes in nursing in 2021 that were likely caused by the COVID-19 pandemic. Total RN hours per patient day decreased during the COVID-19 pandemic and remained below pre-pandemic levels, whereas total LPN hours per patient day increased post-acquisition.
- **Patient volume:** I find an (economically and statistically significant) increase in the average number of admissions per bed immediately following these acquisitions. Specifically, I find that, on average, the SNFs acquired by Jericho had 25 percent to 50 percent more admissions per bed after the acquisitions.
- **Case mix of admitted patients:** Of the five case mix measures that I study, I find changes in one. I find a (statistically significant) decrease in the “expected” percentage of patients with unplanned re-hospitalizations within 30 days of SNF admission. This suggests that Jericho may be targeting patients with a lower average acuity.

I am unable to use the DID approach to study the effect of Jericho’s acquisitions on payer mix because of data limitations.⁸⁶ However, I documented above that some Bayshire facilities do not serve Medi-Cal patients.

⁸⁵ For the rest of the report, I will use the five percent level to report statistical significance.

⁸⁶ Prior to 2024, Medi-Cal Cost Report asked SNFs to report patient volumes for “Medicare,” “Medi-Cal,” and “Managed Care.” In 2024, Medi-Cal Cost Report re-organized the payer categories by breaking down the “Managed Care” category to MA and Medi-Cal managed care. These changes in reporting categories mean that the volume of patients covered by Medi-Cal

This pattern is indicative of a risk of Jericho adopting a strategy of increasing the number of Medicare patients it treats post-acquisition at the expense of Medi-Cal patients.

Appendix A of my report includes charts for each of the metrics that I analyzed, showing trends in the pre- and post-transaction periods. A technical discussion on the data sources, data processing considerations, and regression specifications is in **Appendix G** and **Appendix H**.

C. Analysis of Bayshire's Past Acquisitions

I evaluate whether quality of care and access changed after Bayshire's prior acquisitions.

I study Bayshire's three acquisitions in California in 2021, which are Bayshire's earliest SNF acquisitions. These three SNFs are shown in Figure 13 below.

Figure 13
Bayshire Acquisitions in 2021

Name	County	Number of SNF Beds	Type(s)	Acquisition Date
Bayshire Carlsbad	San Diego	45	SNF, ALF, ILF	3/1/2021
Bayshire Rancho Mirage	Riverside	45	SNF, ALF, ILF	3/1/2021
El Centro Post-Acute Care	Imperial	123	SNF	3/25/2021

Source: Figure 2.

I use the DID approach to evaluate the effect of these acquisitions. I use other counties in Southern California where Bayshire does not operate (San Bernardino and Ventura counties) as the benchmark. My findings are similar to those based on Jericho's prior acquisitions:

- **Health outcome metrics:** I find no (economically or statistically significant) change in health outcome metrics.
- **Staffing:** Total nursing hours seem to decrease post-acquisition. However, as described in the prior section, some of these changes may have been caused by the COVID-19 pandemic. For example, total nursing hours decreased in 2021 and remained lower than pre-pandemic levels. Still, the risk of a continuation of trends in staffing reductions post-acquisition raises long-term concerns about quality of care.
- **Patient volume:** I find an (economically and statistically significant) increase in the average number of admissions per bed immediately following these acquisitions. Specifically, I find that, on average,

(inclusive of managed care) or covered by Medicare (inclusive of MA) cannot be tracked reliably over time for each SNF using the Medi-Cal Cost Report.

For the Medicare Cost Report data I use in my analysis, CMS asked SNFs to report patient volumes for Medicare and Medicaid without specifying whether Medicare includes MA and whether Medicaid includes Medicaid managed care. I compared the 2024 Medi-Cal Cost Report patient volumes by payer with the 2024 Medicare Cost Report, and found that some SNFs included MA in Medicare in their Medicare Cost Report, while others did not. Similarly, some SNFs included managed care in Medicaid, while others did not. This means that payer mix from the Medicare Cost Report is not comparable across SNFs. In addition, due to the lack of clear reporting requirements, it is not clear if a SNF would consistently include or exclude MA or managed care from Medicare or Medicaid in different years of their reporting in the Medicare Cost Report.

the SNFs acquired by Bayshire had more than 50 percent more admissions per bed after the acquisitions.

- **Case mix of admitted patients:** I find no (statistically significant) change in case mix metrics.

Appendix B of my report includes charts for each of the metrics I analyzed, showing trends in the pre- and post-transaction periods.

D. Related-Party Payments by SNFs

The proposed transaction involves the SNF operator, Bethel Skilled Care LLC, paying rent to a related party, 2280 Dockery Holdings LLC. There are at least three concerns about this type of related party payment: (1) it may be inflated to obtain higher reimbursement rates, which are passed along to related parties without benefiting a SNF's quality of care, (2) it may signify that the owner intends to use fewer resources to hire additional staff or invest in capital improvements to improve quality of care, and (3) if Bethel 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.⁸⁷

I find there is the greatest risk from the third concern.

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.⁸⁸ 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.⁸⁹

These studies likely understate the prevalence and magnitude of inflated related-party payments because SNFs are not required to substantiate these payments.⁹⁰ Economists have found that this lack of oversight contributes to misreporting in the Medicare Cost Reports.⁹¹ And a federal government agency also found that some SNFs were noncompliant with related-party payment and disallowance reporting requirements.⁹²

⁸⁷ 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>.

⁸⁸ 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>.

⁸⁹ See Gandhi, Ashvin, and Andrew Olenski, "Tunneling and Hidden Profits in Health Care," *National Bureau of Economic Research Working Paper*, September 2025, p. 24.

⁹⁰ 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.

⁹¹ See Gandhi, Ashvin, and Andrew Olenski, "Tunneling and Hidden Profits in Health Care," *National Bureau of Economic Research Working Paper*, September 2025, p. 4.

⁹² 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>.

For the proposed transaction, Bethel would pay annual rent of \$1.8 million to a related party. This implies a capitalization rate (the rate of return earned by the property holder) of approximately 22 percent, given that the appraised market value of the Bethel property is \$8 to \$8.5 million. 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 2024.⁹³ This suggests Bethel's rent to 2280 Dockery Holdings LLC will be substantially above typical market levels. In other words, this arrangement appears to tunnel profits from Bethel to affiliated entities. I next consider whether profit-tunneling could raise competitive concerns, such as higher prices, lower quality, restrictions on patient access, or an increased risk that Bethel may not remain a going concern.

I find that profit tunneling is unlikely to meaningfully change a SNF's Medicare or Medi-Cal reimbursement rates. Specifically, as discussed in **Section V.A.iii** above, traditional Medicare (i.e. non-MA 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.

SNFs may still have incentives to inflate related-party payments even if profit tunnelling does not affect prices for traditional government payments. These incentives include shielding assets from malpractice liabilities and lowering tax burden.^{94, 95} 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.

Above-market rent may also increase the likelihood that Jericho 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 Bethel may not remain a going concern. In 2016, Steward Health Care entered a sale-leaseback arrangement of all its hospital buildings and land to Medical Properties Trust,⁹⁶ 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

⁹³ 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.

⁹⁴ 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.

⁹⁵ 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>.

⁹⁶ 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.

average.⁹⁷ 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.⁹⁸

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.⁹⁹

IX. Suitability Analysis

In this section, I consider whether another buyer may be more suitable than Jericho. Specifically, I identify Skillserve as the most likely alternative acquirer. I study the likely effects of Skillserve's ownership on quality of care, staffing composition, patient volume, and acuity levels of admitted patients. As described in more detail below, Skillserve is as suitable of a buyer for Bethel as Jericho based on these measures—and it provides better access to Medi-Cal patients. Since Skillserve currently does not own any SNFs in the region where Bethel is located, there would be no change in market concentration if Skillserve were to acquire Bethel. Consequently, Skillserve would potentially be a marginally preferable acquirer. This provides support for the condition for this transaction related to Bethel's continued service of Medi-Cal patients.

A. Bethel's Proposal-Seeking Process and Other Potential Buyers

During the proposal-seeking process, Bethel's board wanted the property to continue to be used as a care facility and sold to a local, hands-on buyer that would provide a smooth transition and continue Bethel's mission.¹⁰⁰ Bethel engaged Jericho and three other potential buyers:¹⁰¹

⁹⁷ 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>.

⁹⁸ 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.").

⁹⁹ 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>.

¹⁰⁰ See Bethel Notice, p. 86.

¹⁰¹ See Bethel Notice, p. 86.

- **Adventist Health** is a large non-profit health system with 27 hospitals across the West Coast and Hawaii.¹⁰² It operates a hospital, Adventist Health Selma, located adjacent to Bethel.¹⁰³ Adventist Health was interested in a “management agreement” but not an “asset acquisition,” which Bethel’s board determined would not address Bethel’s financial issues. As a result, Adventist Health’s offer was not considered further.¹⁰⁴
- **Community Medical Centers** is a local non-profit health system with four hospitals in the Central Valley.¹⁰⁵ It also operates two SNFs, both located in Fresno.¹⁰⁶ Community Medical Centers did not make an offer to purchase Bethel.¹⁰⁷
- **Skillserv** operates eighteen SNFs and at least six ALFs in Southern California, including Los Angeles, Orange, San Bernardino, and Ventura counties.¹⁰⁸ Additionally, it serves as a landlord to numerous long-term care operators throughout California. The company is headquartered in Long Beach, California, and is family-operated, with more than 30 years of experience in the industry.¹⁰⁹

Bethel ultimately received offers from Skillserv for \$8.5 million and from Jericho for \$8 million.¹¹⁰ Bethel’s board did not solicit additional bids. It selected Jericho’s bid, despite Jericho offering a lower purchase price

[REDACTED]¹¹¹ The board stated that Jericho was better equipped to ensure a smooth transition and provide a standard of care

¹⁰² See “About Us: Welcome to Adventist Health,” *Adventist Health*, available at <https://www.adventisthealth.org/about-us/>.

¹⁰³ See “Adventist Health Selma,” *Adventist Health*, available at <https://www.adventisthealth.org/locations/adventist-health-selma/>.

¹⁰⁴ Bethel Notice, p. 86.

¹⁰⁵ See “Community Medical Center: About Us,” *Community Medical Centers*, available at <https://www.communitymedical.org/about-us>.

¹⁰⁶ One of the SNFs, Community Subacute & Transitional Care Center, is shown in Figure 7. The other SNF, Burnett Extended Care Center, is not displayed because it recently opened in October 2025 and is not reported in the CMS SNF Medicare Enrollment and Ownership data as of January 2026.

See “Community Subacute & Transitional Care Center,” *Community Medical Centers*, available at <https://www.communitymedical.org/locations/community-subacute-transitional-care-center>; “Community’s new skilled nursing facility holds grand opening in downtown Fresno,” *Community Medical Centers*, available at <https://www.communitymedical.org/about-us/newsroom/communitys-new-skilled-nursing-facility-holds-grand-opening-in-downtown-fresno>.

¹⁰⁷ See Bethel Notice, p. 86.

¹⁰⁸ The Cal Health Find Database reports that the Mandelbaum family members, owners of Skillserv, currently own eighteen SNFs. “Cal Health Find Database,” *California Department of Public Health*, available at <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx>.

¹⁰⁹ Bethel Notice, p. 566.

¹¹⁰ Neither of these offers include the purchaser assuming litigation liability. Jericho initially offered to buy Bethel for \$6.5 million and to assume litigation liability. Then Bethel’s board countered Jericho’s initial offer. During negotiations, Bethel and Jericho were unable to agree on the present and future litigation liability that Jericho would assume. Consequently, Bethel and Jericho agreed to raise the purchase price to \$8 million and not have Jericho assume litigation liability. See Bethel Notice, p. 86.

¹¹¹ [REDACTED]

that would benefit the Selma community.¹¹²

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B. Analysis of Skillserve’s Past Acquisitions

Figure 14 below presents information on Skillserve’s SNF acquisitions in California.

Figure 14
Skillserve Acquisitions in California

Name	County	Number of SNF Beds	Earliest Acquisition or Control Date
Beachside Post Acute	Los Angeles	90	No later than 12/1/2021
Bellflower Post Acute	Los Angeles	59	11/22/2021
Buena Park Nursing Center	Orange	143	No later than 1/1/2023
Chapman Care Center	Orange	99	12/1/2021
Coastal View Healthcare Center	Ventura	96	No later than 12/1/2021
Community Extended Care Hospital of Montclair	San Bernardino	140	1/2/2019
Foothill Heights Care Center	Los Angeles	49	4/1/2019
Garden Grove Post Acute	Orange	99	12/1/2021
Grand Valley Health Care Center	Los Angeles	99	2/12/2016
Guardian Rehabilitation Hospital	Los Angeles	93	12/1/2021
La Palma Nursing Center	Orange	72	1/2/2019
Leisure Court Nursing Center	Orange	115	1/2/2019
Long Beach Post Acute	Los Angeles	78	No later than 9/1/2021
New Vista Post-Acute Care Center	Los Angeles	116	4/29/2025
Pacific Care Nursing Center	Los Angeles	99	1/1/2023
Sunland Post Acute	Los Angeles	121	4/29/2025
The Gardens of El Monte	Los Angeles	53	11/1/2016
Ventura Post Acute	Ventura	71	No later than 12/1/2021

Sources:

[1] Cal Health Find Database.

[2] SNF common ownership reporting in Medi-Cal Cost Reports.

[3] CMS SNF Medicare Enrollment and Ownership, January 2026.

I examine Skillserve SNFs payer mix, which is shown in Figure 15 below. I find that, in contrast to some of the SNF facilities operated by Bayshire, all of Skillserve’s SNFs serve a significant share of Medi-Cal patients. Overall, Skillserve’s SNFs have approximately 67 percent of Medi-Cal patients.

¹¹² See Bethel Notice, pp. 86-87.

¹¹³

Figure 15
Skillserv SNFs Share of Patient Days by Payer
2024

	Medicare (incl. Managed Care)	Medicaid (incl. Managed care)	Commercial	Self-Pay	Other
Beachside Post Acute	17%	54%	0%	0%	29%
Bellflower Post Acute	45%	52%	0%	0%	2%
Buena Park Nursing Center	23%	68%	1%	0%	8%
Chapman Care Center	25%	70%	0%	3%	2%
Coastal View Healthcare Center	34%	57%	1%	1%	8%
Community Extended Care Hospital Of Montclair	21%	78%	0%	0%	1%
Foothill Heights Care Center	34%	58%	0%	0%	8%
Garden Grove Post Acute	23%	72%	0%	0%	5%
Grand Valley Health Care Center	36%	59%	0%	1%	4%
Guardian Rehabilitation Hospital	35%	60%	0%	2%	2%
La Palma Nursing Center	33%	62%	0%	0%	5%
Leisure Court Nursing Center	25%	72%	0%	0%	3%
Long Beach Post Acute	43%	57%	0%	0%	0%
New Vista Post-Acute Care Center	8%	77%	0%	1%	14%
Pacific Care Nursing Center	24%	74%	0%	0%	1%
New Vista Nursing And Rehabilitation Center	6%	81%	0%	0%	13%
The Gardens Of El Monte	46%	53%	0%	0%	1%
Ventura Post Acute	26%	69%	0%	4%	0%
Overall	26%	67%	0%	1%	6%

Notes:

[1] The overall percentages are calculated using total annualized patient days across the seven facilities.

[2] "Self-Pay" consists of patient days for which the primary payer is the patient or patient's family. It can also include charity care.

[3] "Other" includes patient days that do not fall into any of the defined categories, including Veterans Administration and worker's compensation.

Source: Medi-Cal Cost Report, 2024.

Similar to my analysis for Jericho's and Bayshire's past acquisitions, I examined changes in health outcomes, staffing, patient volume, and case mix for Skillserv's past acquisitions. I focus on Skillserv's four SNF acquisitions in California in 2021: Bellflower Post Acute, Chapman Care Center, Garden Grove Post Acute, and Guardian Rehabilitation Hospital. I use counties in Southern California where Skillserv does not operate (Santa Barbara and San Diego counties) as the benchmark.

- **Health outcome metrics:** I find no (statistically and economically significant) change among health outcome metrics.
- **Staffing:** I find no (statistically significant) changes in total nursing hours per patient day or LPN and NA hours per patient day. Nursing hours per patient day of employed RNs increased (statistically significantly) post-acquisition, by approximately 0.15 to 0.2 hours per patient day.
- **Patient volume:** I find no (statistically significant) change in patient volume post-acquisition.
- **Case mix of admitted patients:** I find no (statistically significant) changes in case mix.

I present the charts supporting this analysis in **Appendix C**. Based on this analysis, I find that, overall, there is no clear reason to conclude that Skillserve would be a less suitable buyer of Bethel than Jericho from a quality or market access perspective.

SNFs acquired by Jericho and Bayshire experienced significant increase in patient volume, but SNFs acquired by Skillserve did not. There is some evidence that Skillserve might have increased RN hours, while there is no evidence that Jericho did the same. However, SNFs acquired by Jericho and Skillserve both experience no change or some (statistically insignificant) improvement in health outcomes. The average patient acuity admitted by SNFs acquired by Jericho may have decreased, but this may be due to increased access rather than substituting sicker patients with less sick patients. Taken together, the evidence suggests that Skillserve's acquisitions have not led to quality or access improvements that would support a preference for Skillserve over Jericho or that Skillserve would have been a less suitable buyer on these dimensions.

Finally, Skillserve, unlike Jericho, does not have facilities that do not treat any Medi-Cal patients.¹¹⁴ However, the risk of Jericho reducing Medi-Cal patients' access to Bethel could be mitigated by requiring Jericho to maintain an adequate level of Medi-Cal patients post-acquisition, which I discuss in the next section below.

X. Recommended Conditions for Approving the Transaction

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 competitively problematic in the short term. As a nonprofit, Bethel's assets should be put to public use. Once Bethel'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 Bethel to continue to provide access to Medi-Cal patients**

Because Jericho may seek to increase the percentage of Medicare patients at the expense of Medi-Cal patients, and because some Bayshire facilities do not treat Medi-Cal patients, OCAG may want to consider conditions to mitigate the risk that Jericho reduces access for Medi-Cal patients post-transaction. For example, OCAG could require Bethel to maintain a patient mix that resembles the patient mix of the broader community.¹¹⁵ In conjunction with such a condition, OCAG may want to monitor Bethel'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.¹¹⁶

- **Implement safeguards on rental agreement**

¹¹⁴ It is unclear from the available information if Skillserve would transfer the same higher than market rents to a related entity as Jericho proposes doing. Though all things being equal, the literature indicates that above market rents being paid to a related entity are not a necessary component of operating a skilled nursing facility. See **Section VIII.D**.

¹¹⁵ I found that 61 percent of SNF patients in Fresno County were insured by Medi-Cal, and 65 percent of patients treated at SNFs located within 15 miles of Bethel were insured by Medi-Cal. See Figure 6 and Appendix Figure D1.

¹¹⁶ As there is not up-to-date publicly available data on patient mix, Bethel may need to provide periodic reports of its census data so that OCAG could conduct this monitoring.

The proposed transaction requires Bethel to pay annual rent of \$1.8 million to a related party, 2280 Dockery Holdings LLC. As described previously in **Section VIII.D**, this rent payment implies a capitalization rate of approximately 22%, which is well above the capitalization rates typically earned by owners of SNF properties and well above the rate of return in most competitive markets.¹¹⁷ As such, the transaction seems to impose above-market rent obligations on Bethel.

As I discussed in **Section VIII.D**, above-market rent can harm local SNF competition and the state in several ways.

The 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 Jericho and 2280 Dockery Holdings LLC from encumbering Bethel with debt, or other liabilities, to the point of placing the short-term or long-term financial viability at substantial risk and/or reducing staffing levels.

As part of such conditions, OCAG could monitor Bethel 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.

Christopher Whaley, Ph.D.



Date:

April 28, 2026

¹¹⁷ For example, the S&P 500's average return over the last 30 years is approximately 10 percent. See "What is the S&P 500 Average Return?" *Fidelity*, available at <https://www.fidelity.com/learning-center/trading-investing/sp-500-average-return>.

XI. Appendix

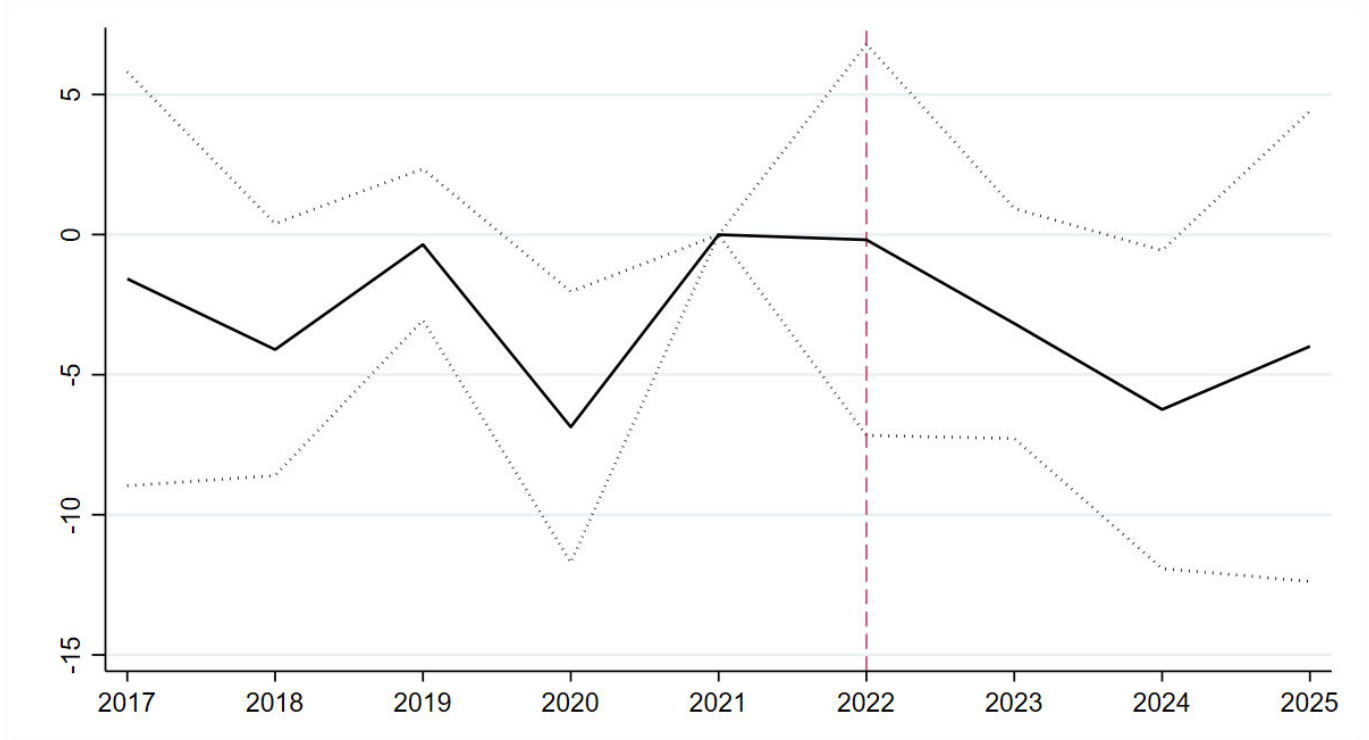
A. Figures for Analysis of Jericho's Prior Acquisitions

i. Health Outcome Metrics

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.

Figure A1
Jericho Acquisitions
Percentage of Patients with Unplanned Re-Hospitalization within 30 Days of SNF Admission
Lower Percentage Is Better



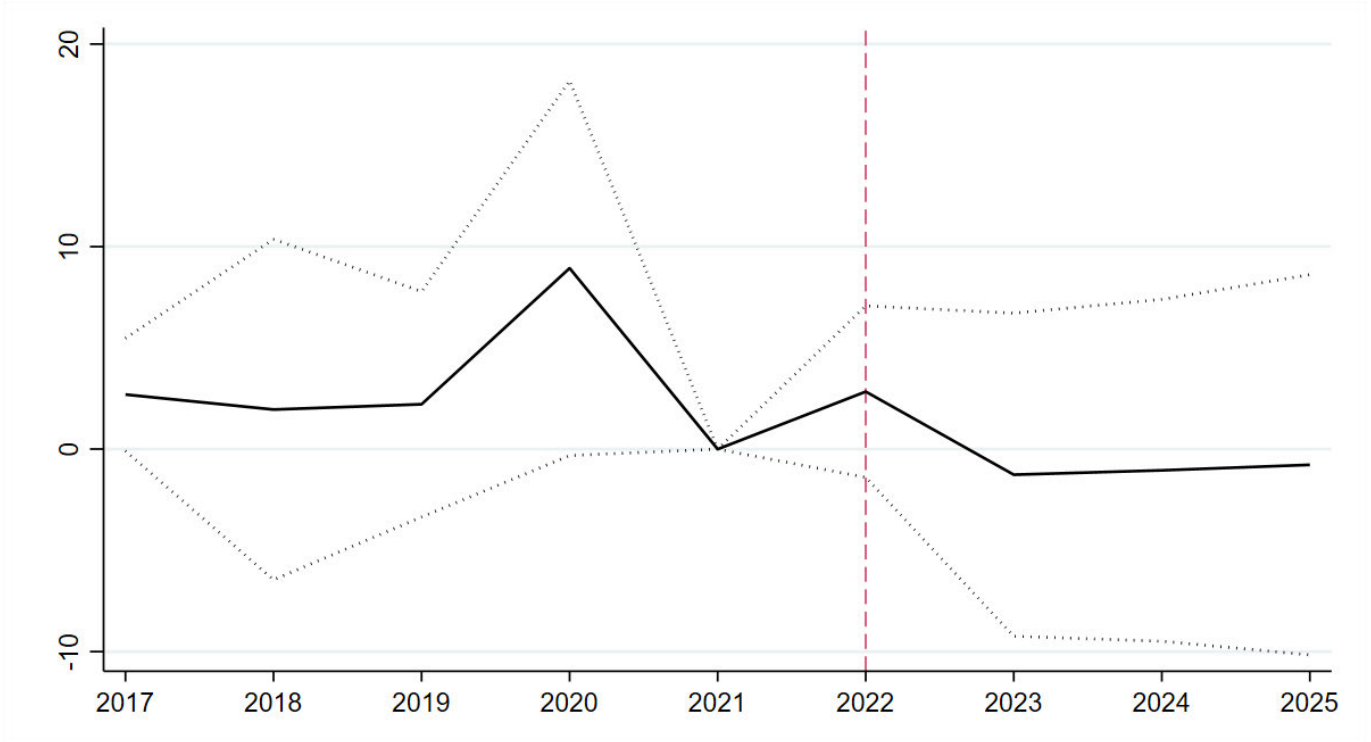
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS SNF Medicare Compare, 2017–2025.

Figure A2
Jericho Acquisitions
Percentage of Patients with Emergency Room Visits within 30 Days of SNF Admission
Lower Percentage Is Better



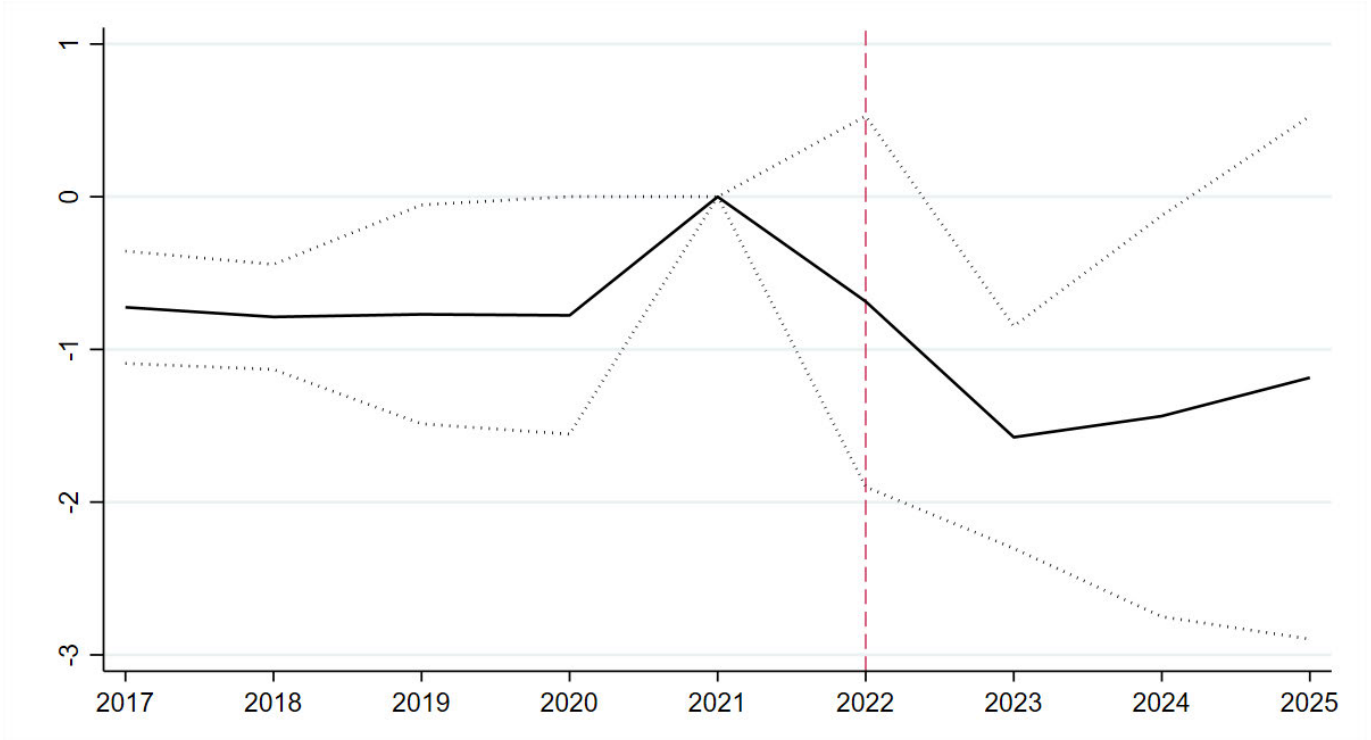
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure A3
Jericho Acquisitions
Number of Unplanned Hospitalizations per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



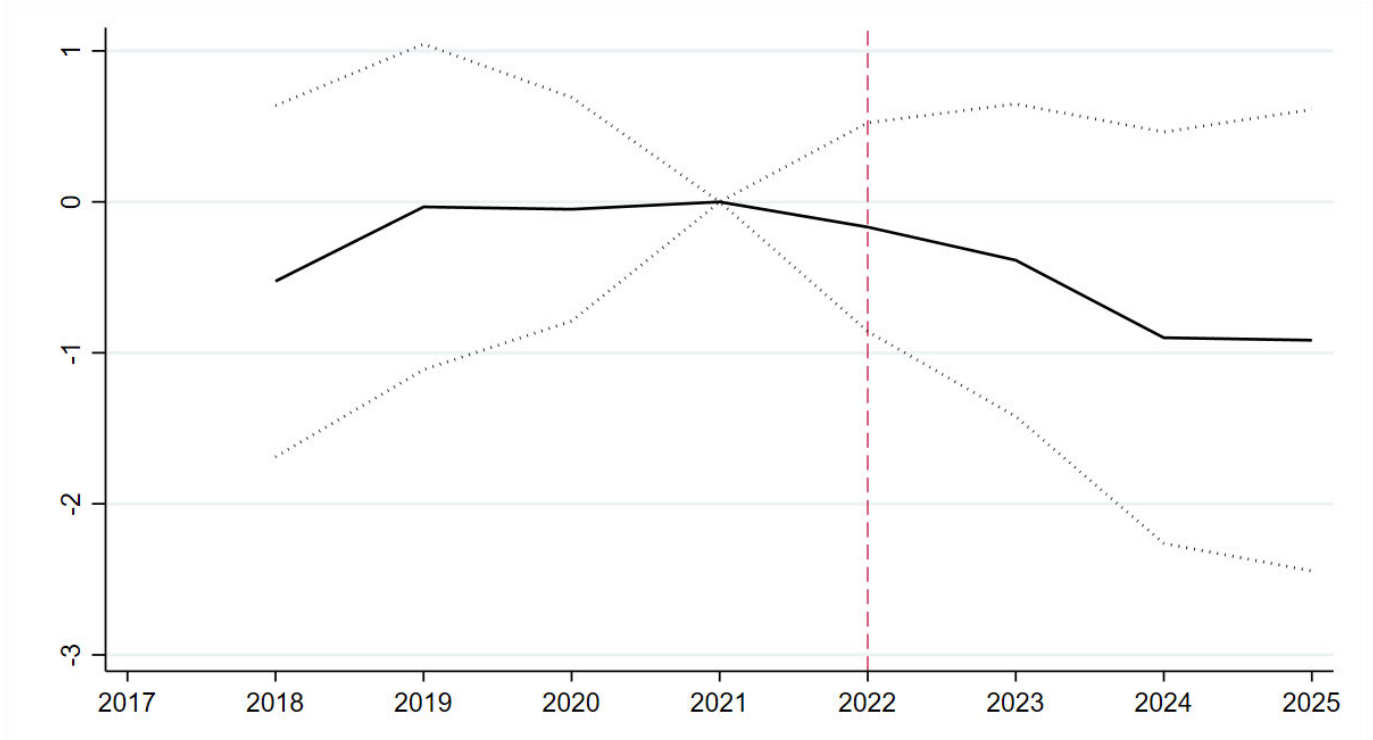
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure A4
Jericho 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 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. 2021 is used as the pre-acquisition reference period.

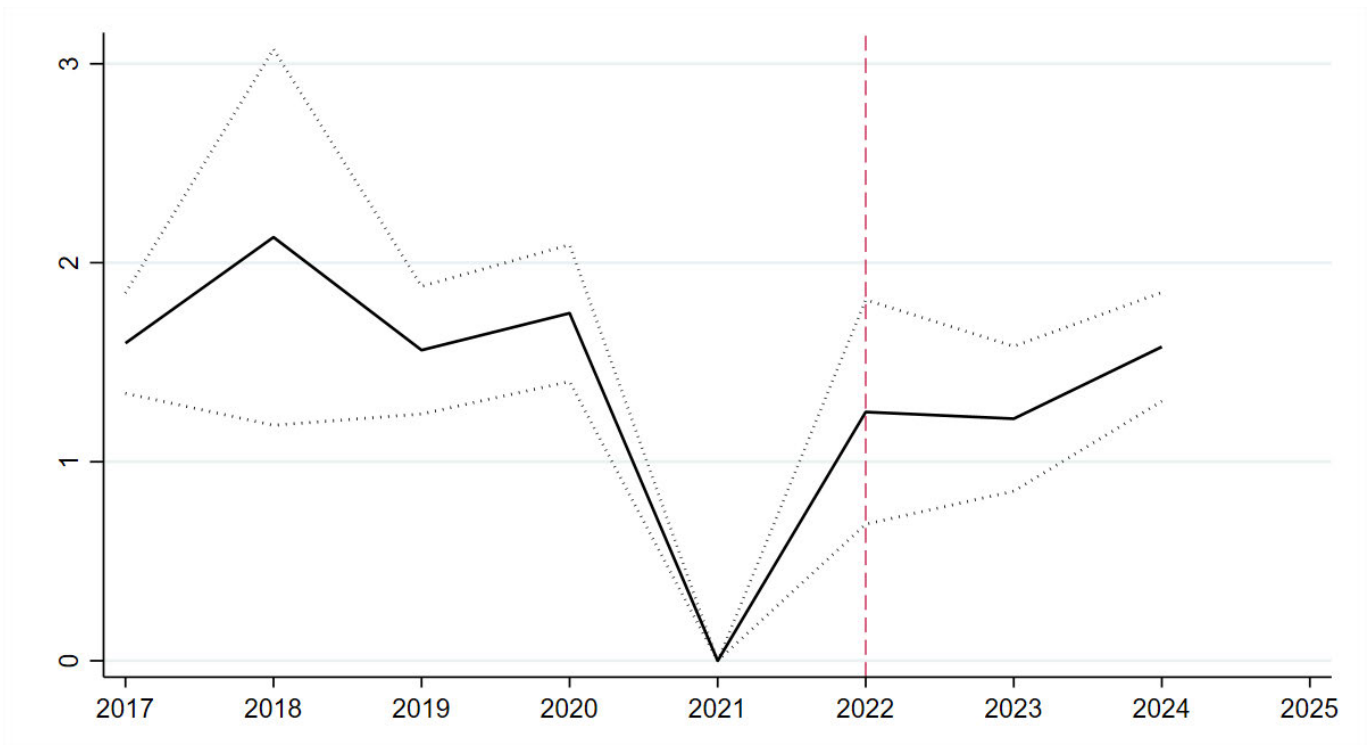
Source: CMS Medicare Compare, 2017–2025.

ii. Nursing Care Staffing

I use the SNF Medicare Cost Report for the analyses on nursing staff. Specifically, in figures below, I show the estimated effects of the 2022 Jericho acquisitions on total nursing hours per patient day of the following:

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

Figure A5
Jericho Acquisitions
Total Nursing Hours per Patient Day of Employed Nursing Staff



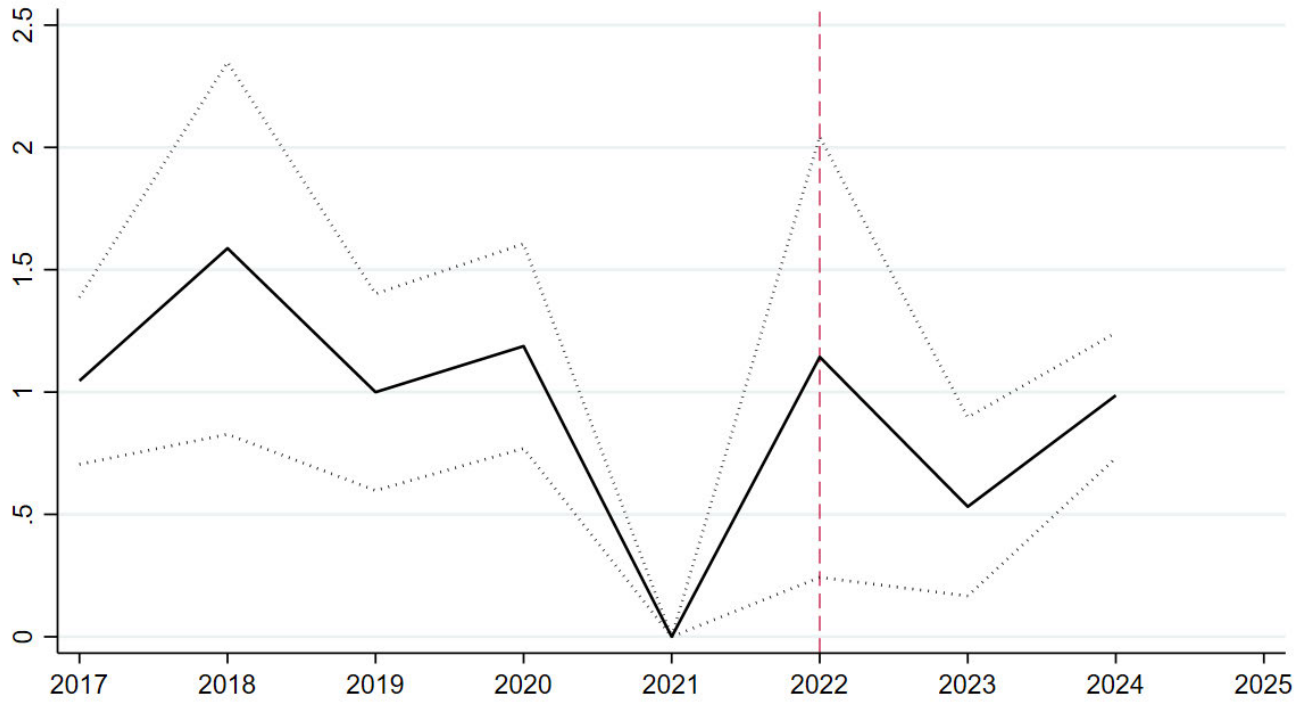
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure A6
Jericho Acquisitions
Total Nursing Hours per Patient Day of Employed and Contracted Nursing Staff



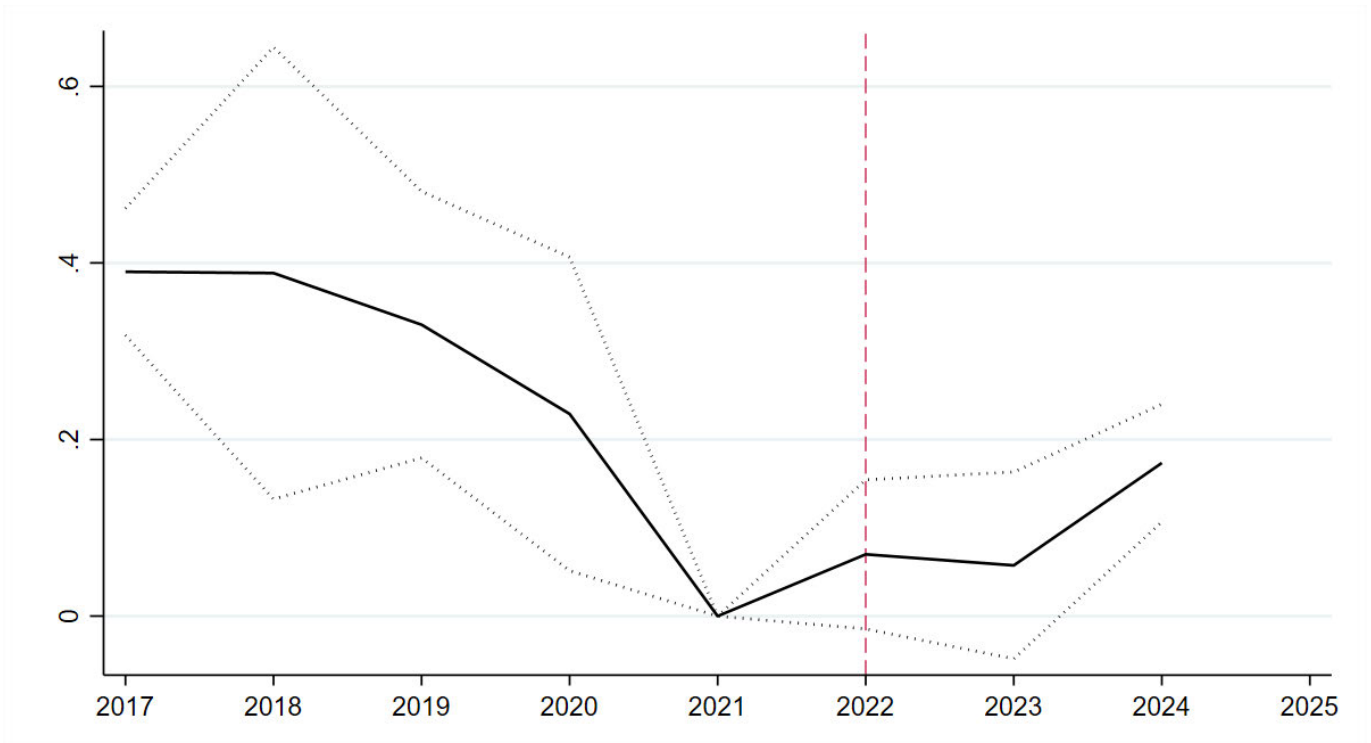
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure A7
Jericho Acquisitions
Total Nursing Hours per Patient Day of Employed RNs



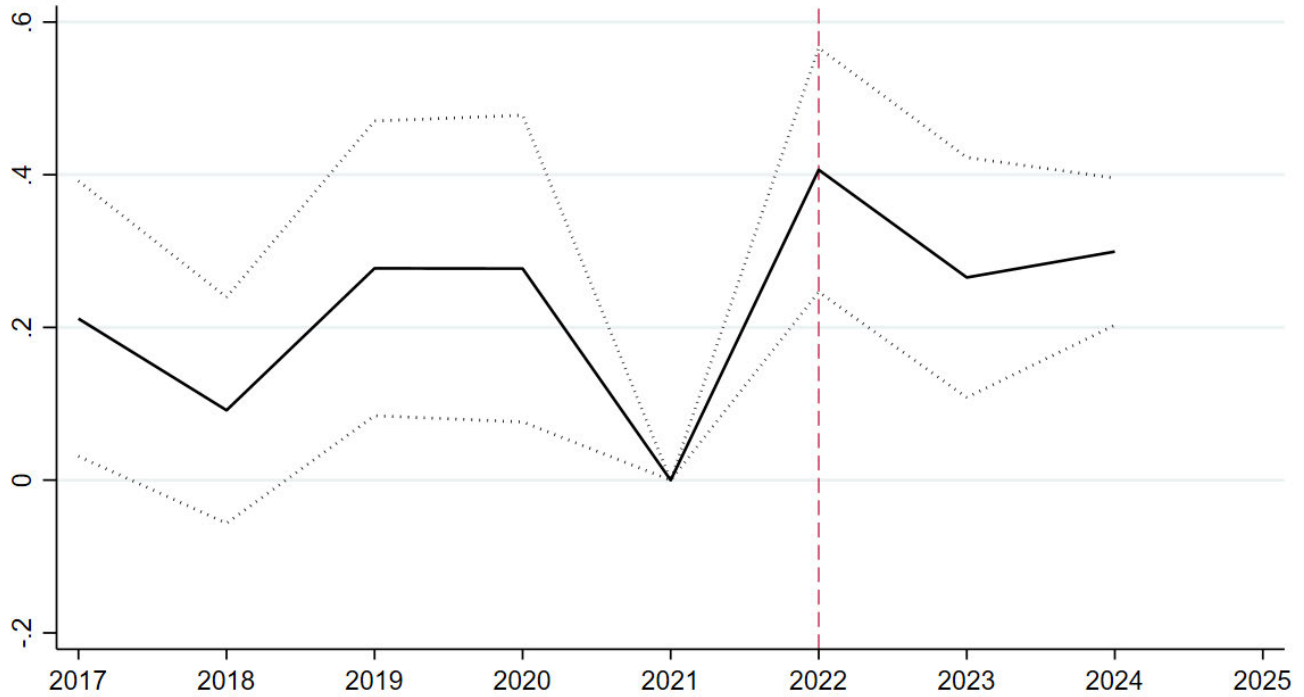
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure A8
Jericho Acquisitions
Total Nursing Hours per Patient Day of Employed LPNs



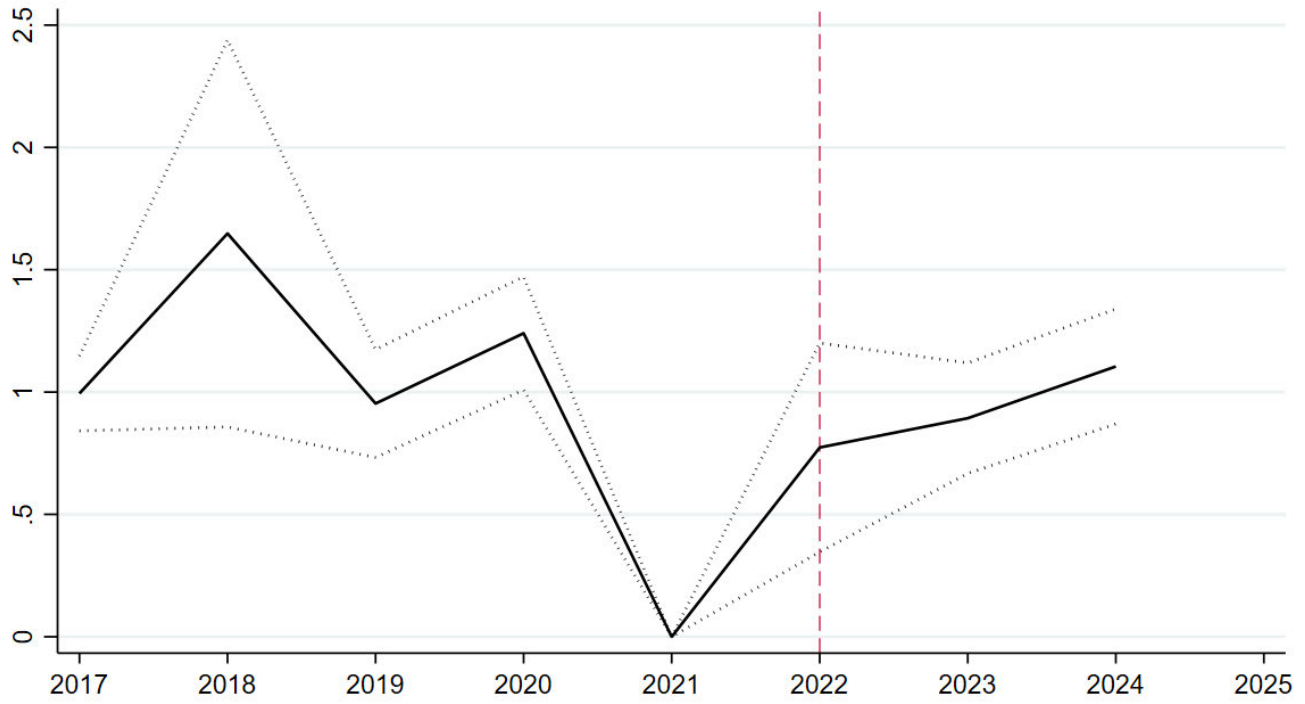
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure A9
Jericho Acquisitions
Total Nursing Hours per Patient Day of Employed NAs



Notes:

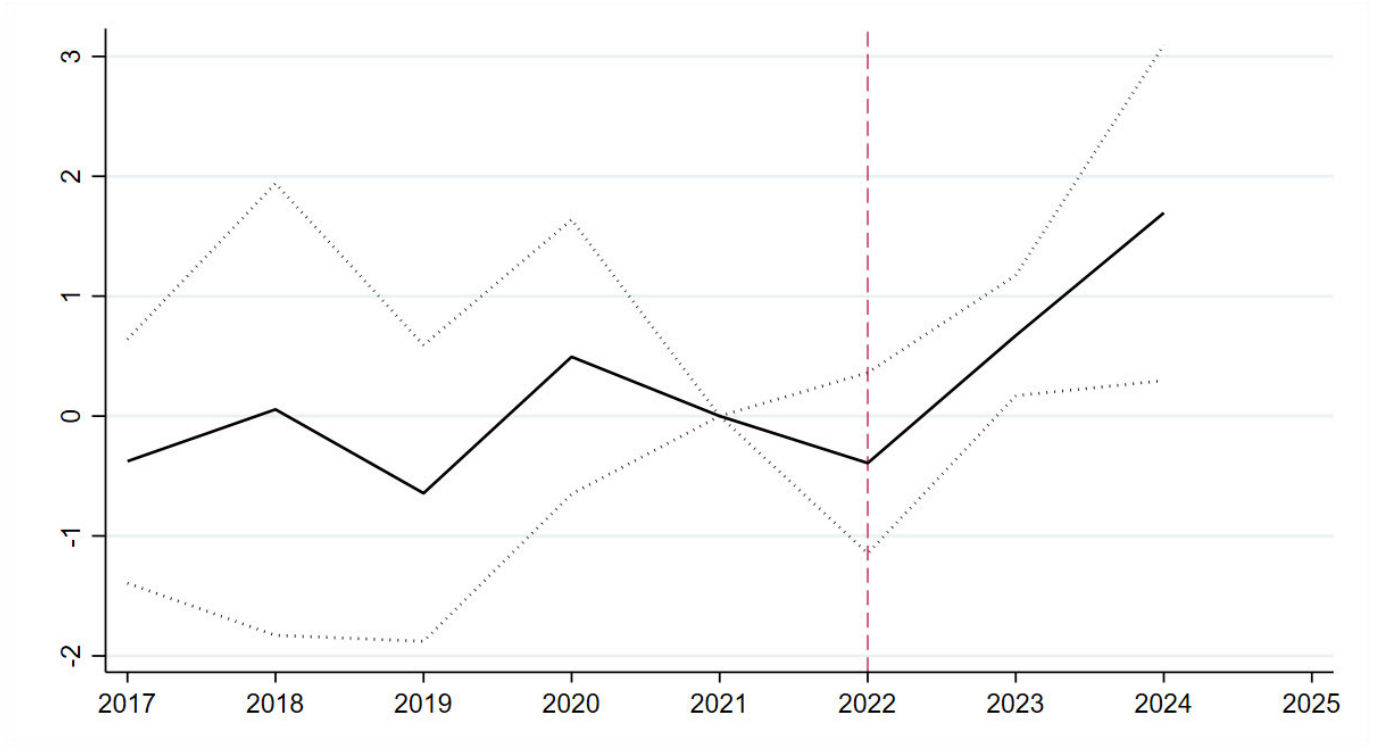
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

iii. Patient Volume

Figure A10
Jericho Acquisitions
Average Number of Admissions per Bed



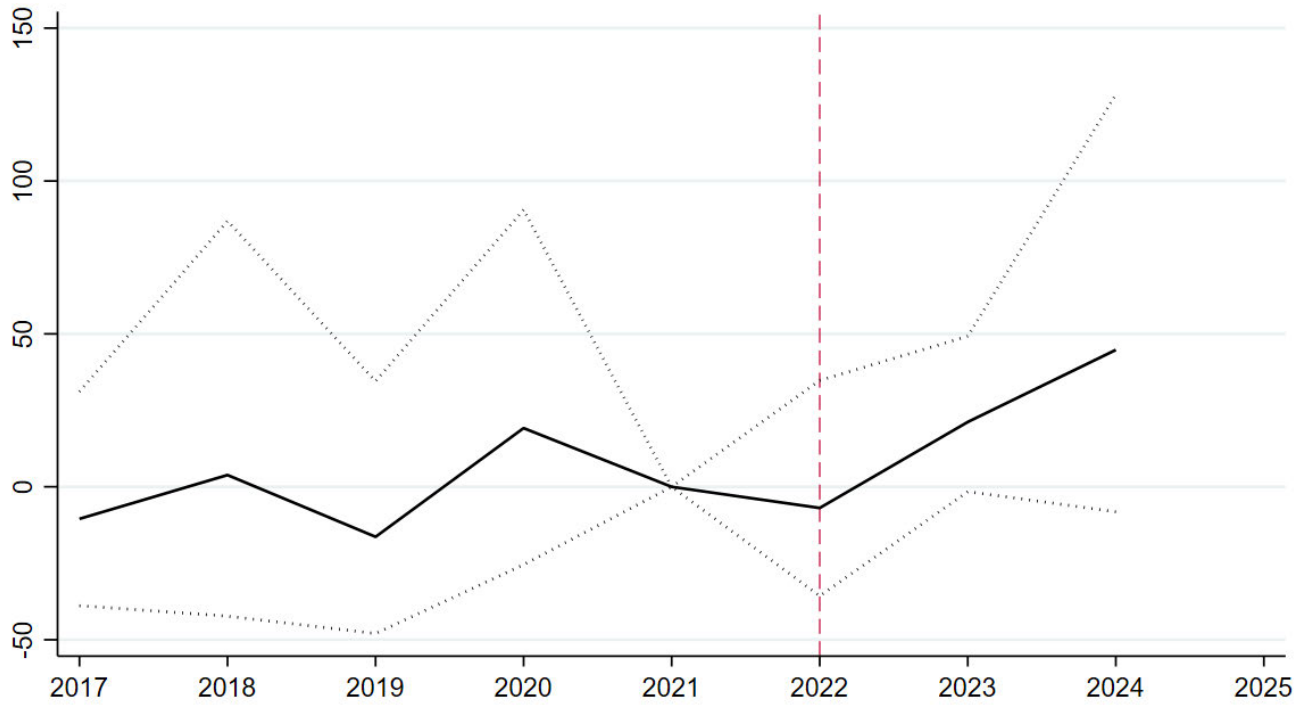
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure A11
Jericho Acquisitions
Percentage Change in Average Number of Admissions per Bed



Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

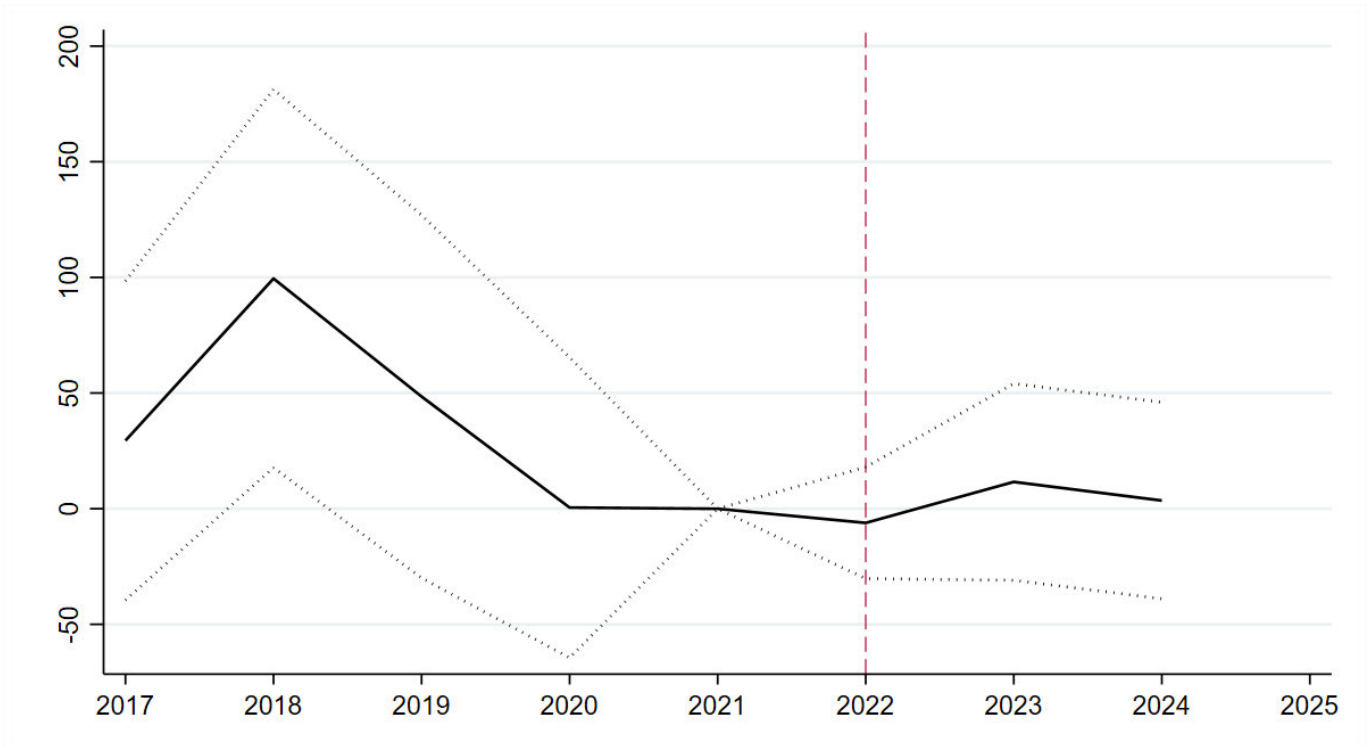
[2] Analysis includes facility effects and year fixed effects. The solid line connects point estimates of the effect of the acquisitions, and the dotted lines show the 95 percent confidence interval for those coefficients, based upon standard errors that are clustered by facility. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

iv. Case Mix

To study the effects of prior acquisitions on case mix, I first look at the average length of stay of patients, defined as total inpatient days divided by total number of discharges. Additionally, for each of the four health outcome metrics I studied above in **Section XI.A.i**, 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 case mix metrics.

Figure A12
Jericho Acquisitions
Average Length of Stay



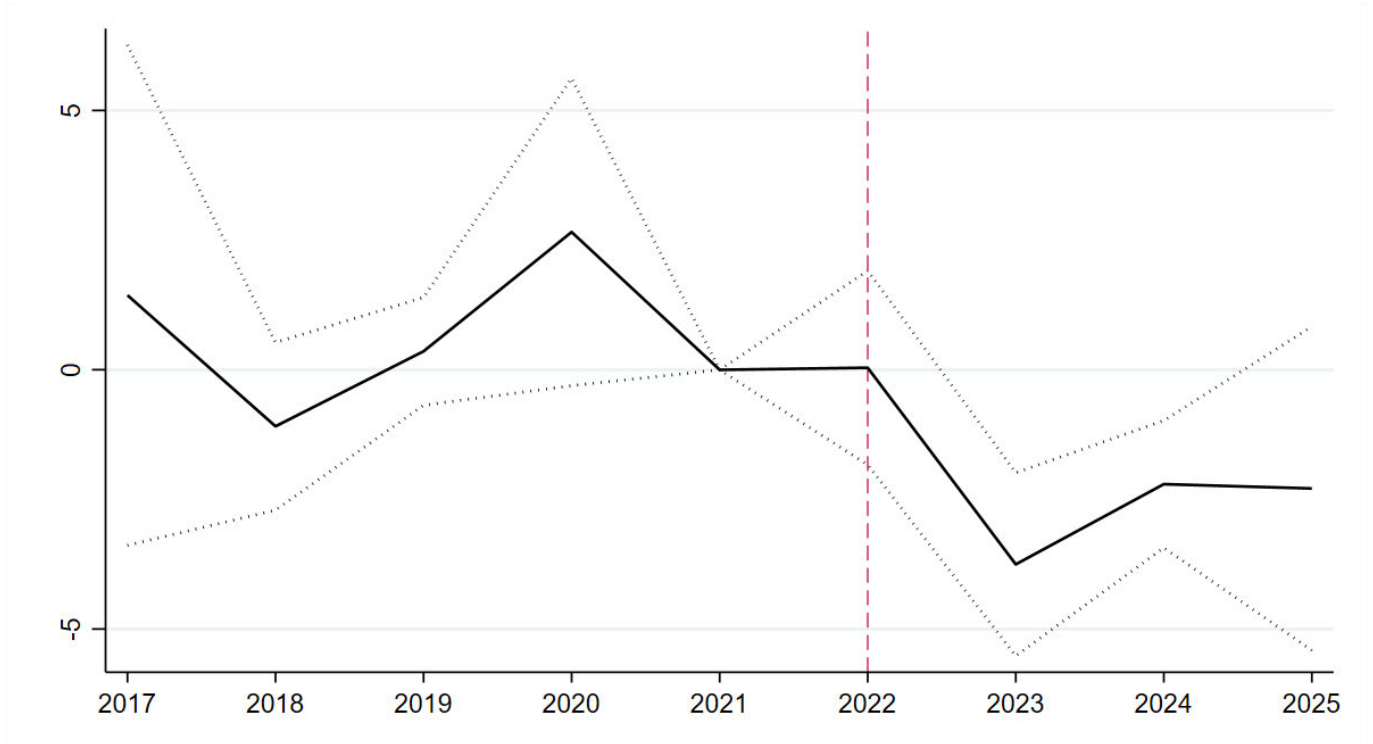
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017–2024.

Figure A13
Jericho Acquisitions
“Expected” Percentage of Patients with Unplanned Re-Hospitalization within 30 Days of SNF Admission
Lower Percentage Is Better



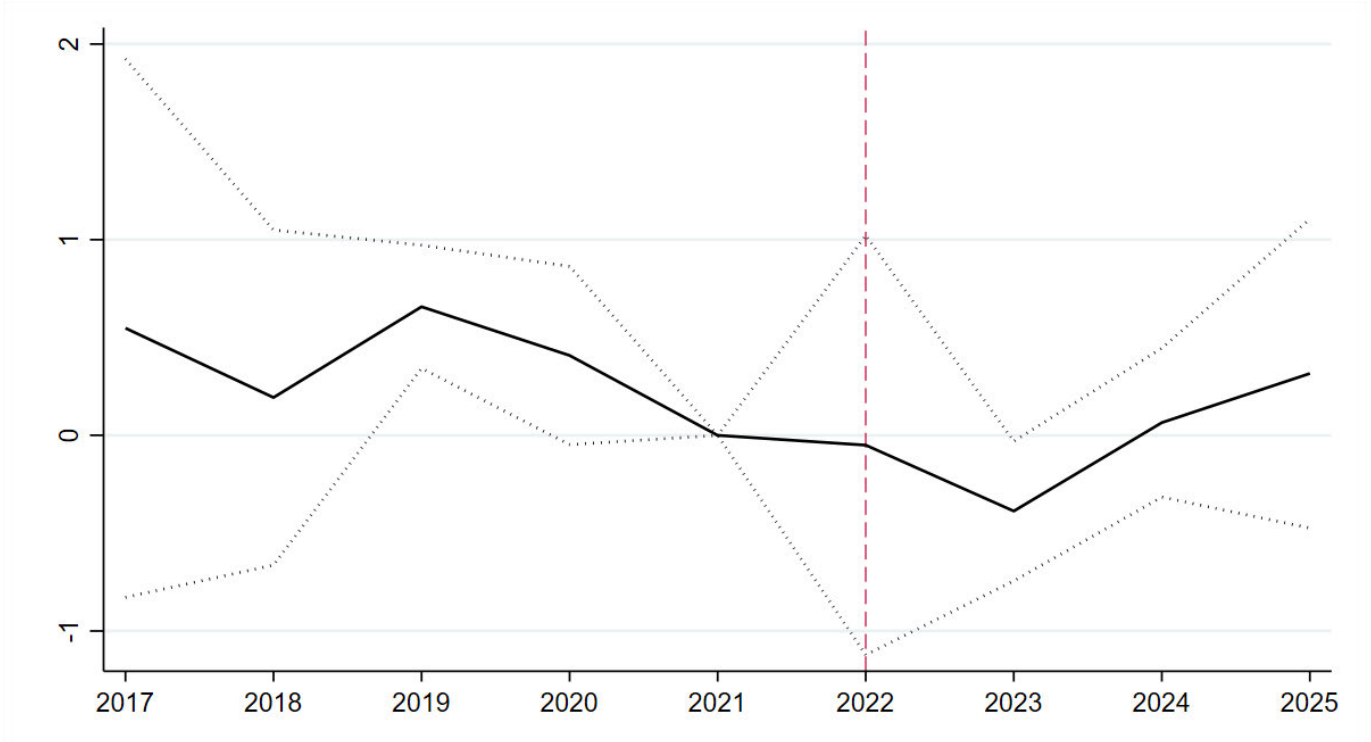
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure A14
Jericho Acquisitions
“Expected” Percentage of Patients with Emergency Room Visits within 30 Days of SNF Admission
Lower Percentage Is Better



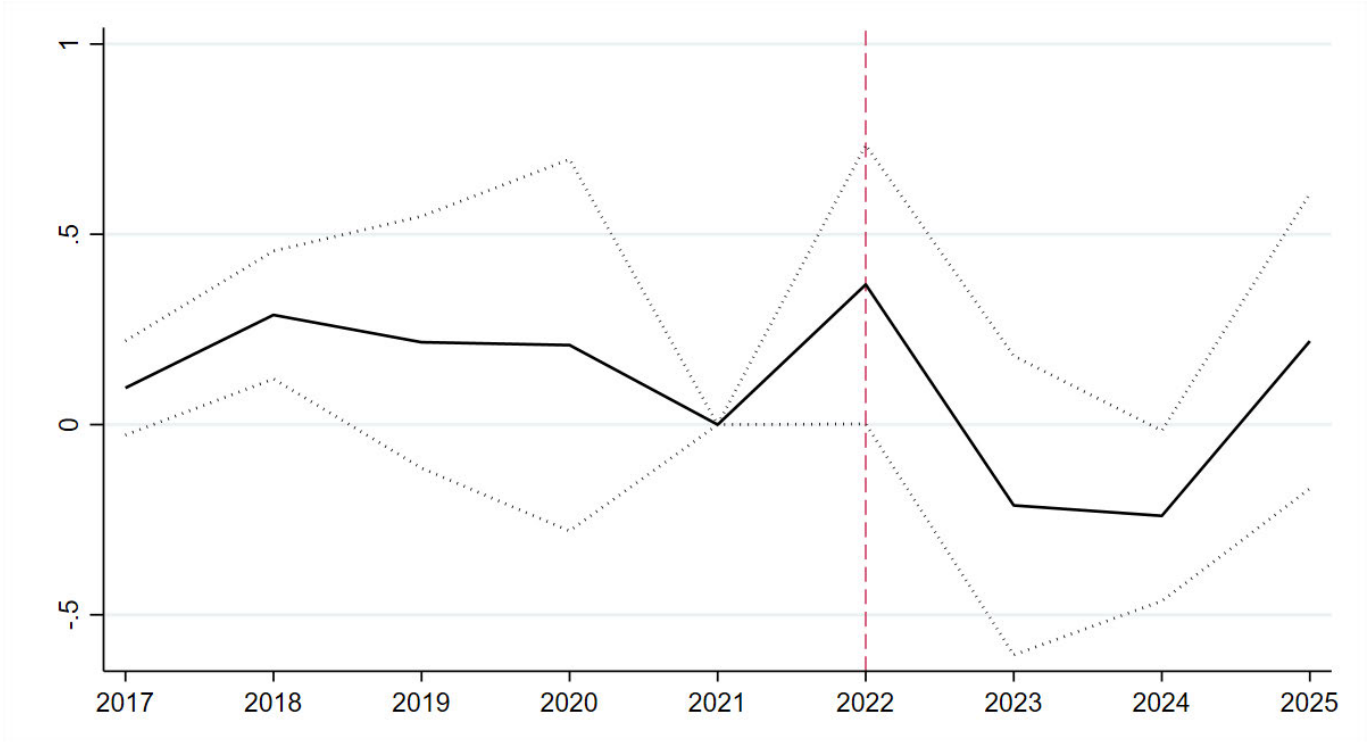
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure A15
Jericho Acquisitions
“Expected” Number of Unplanned Hospitalizations per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



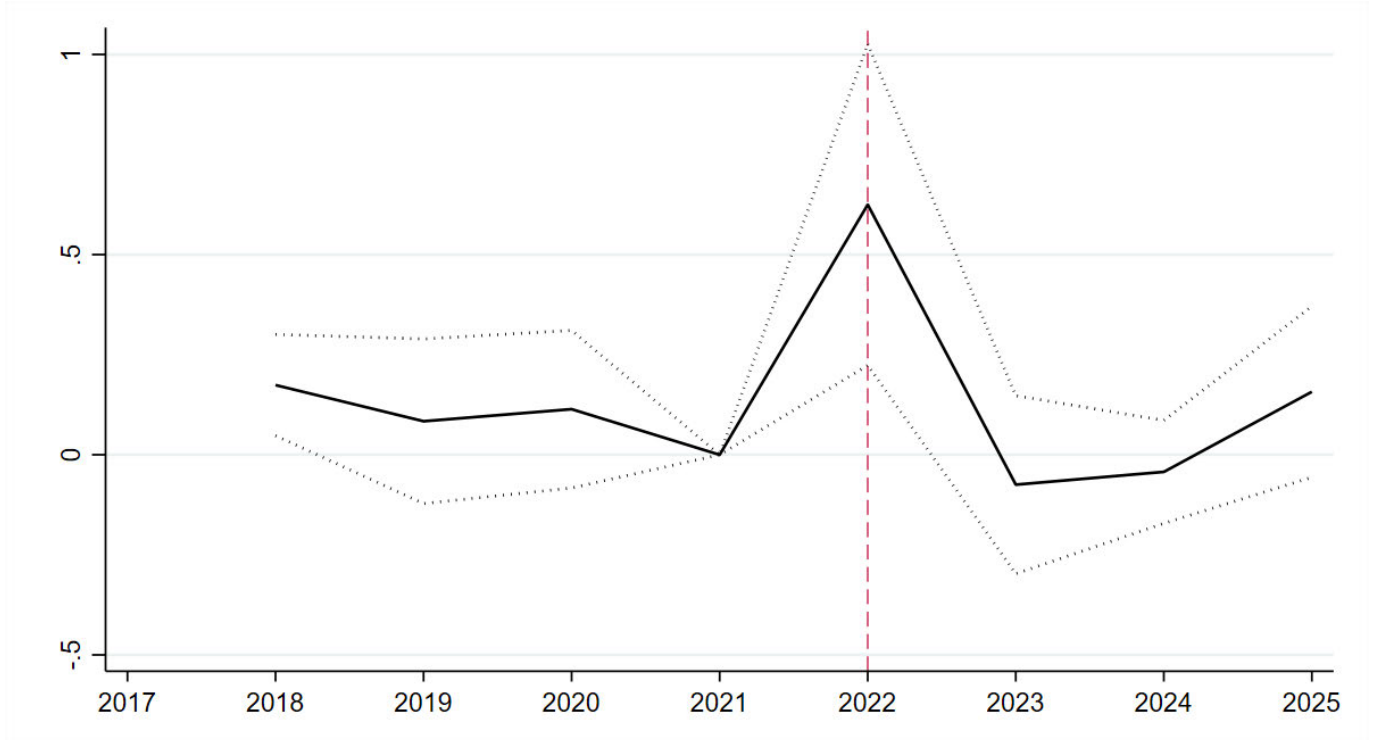
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2021 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure A16
Jericho 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.

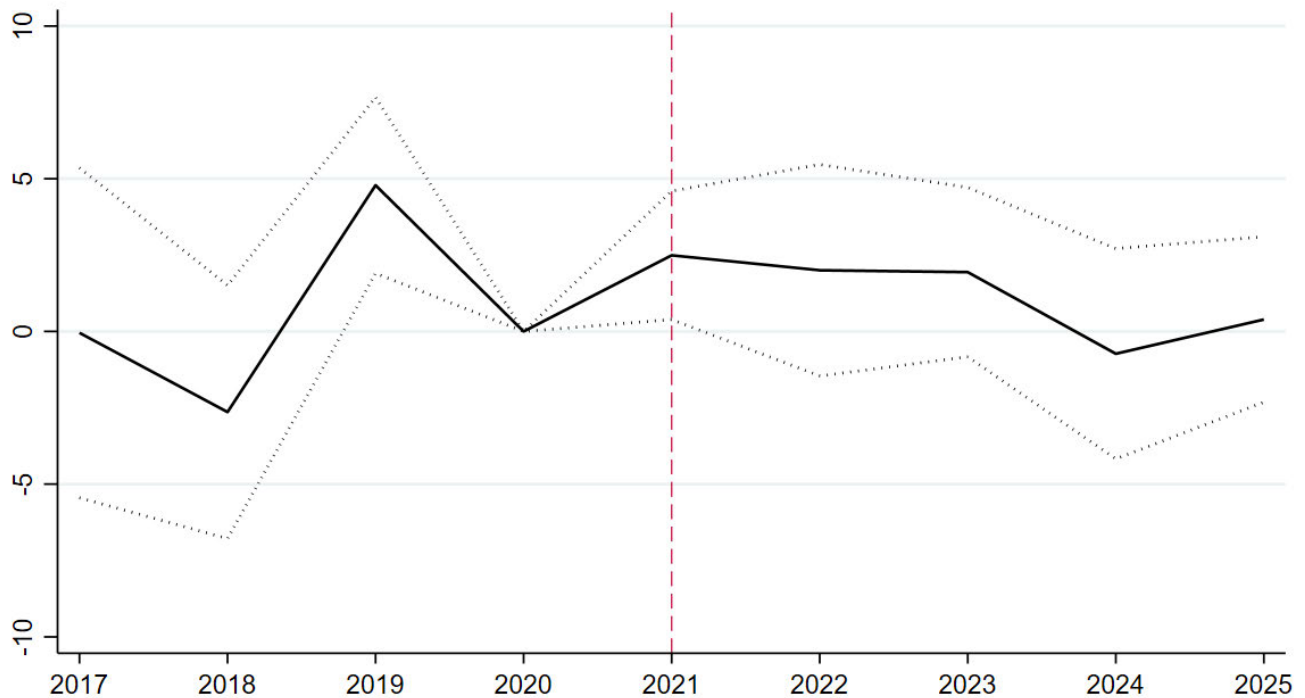
[2] Analysis includes facility effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. 2021 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

B. Figures for Analysis of Bayshire’s Prior Acquisitions

i. Health Outcome Metrics ¹¹⁸

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



Notes:

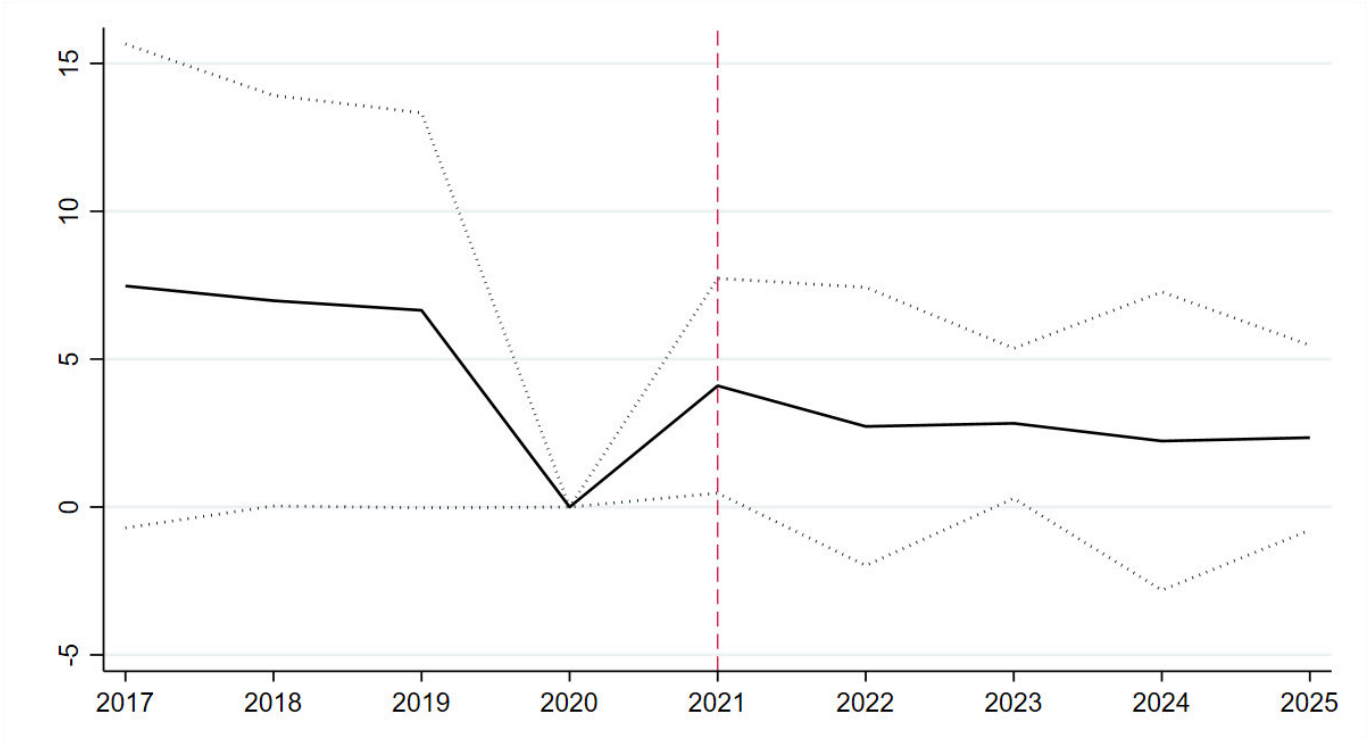
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS SNF Medicare Compare, 2017–2025.

¹¹⁸ I use the first two metrics I studied in **Appendix A.i**. The other two metrics I looked at for Jericho acquisitions are not available for almost all of the SNFs acquired by Bayshire in 2021.

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



Notes:

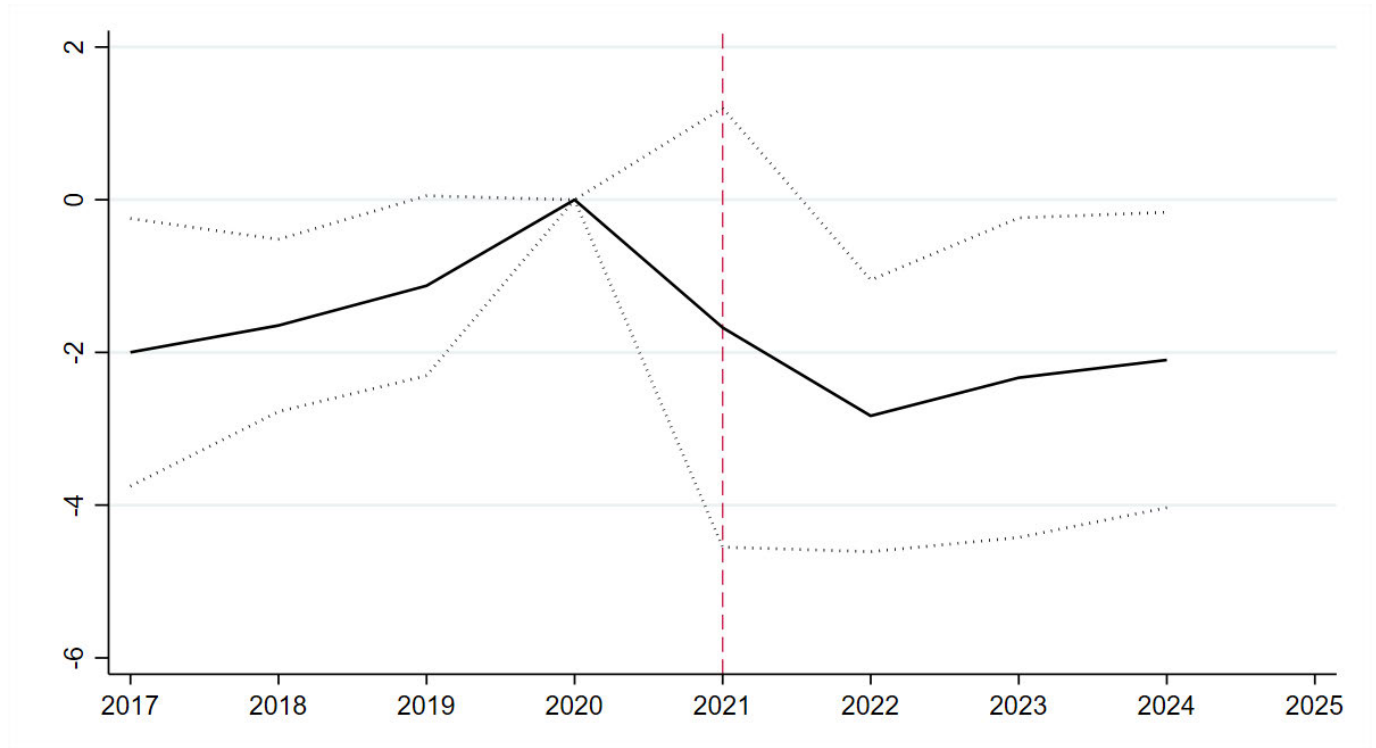
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

ii. Nursing Care Staffing

Figure B3
Bayshire Acquisitions
Total Nursing Hours per Patient Day of Employed Nursing Staff



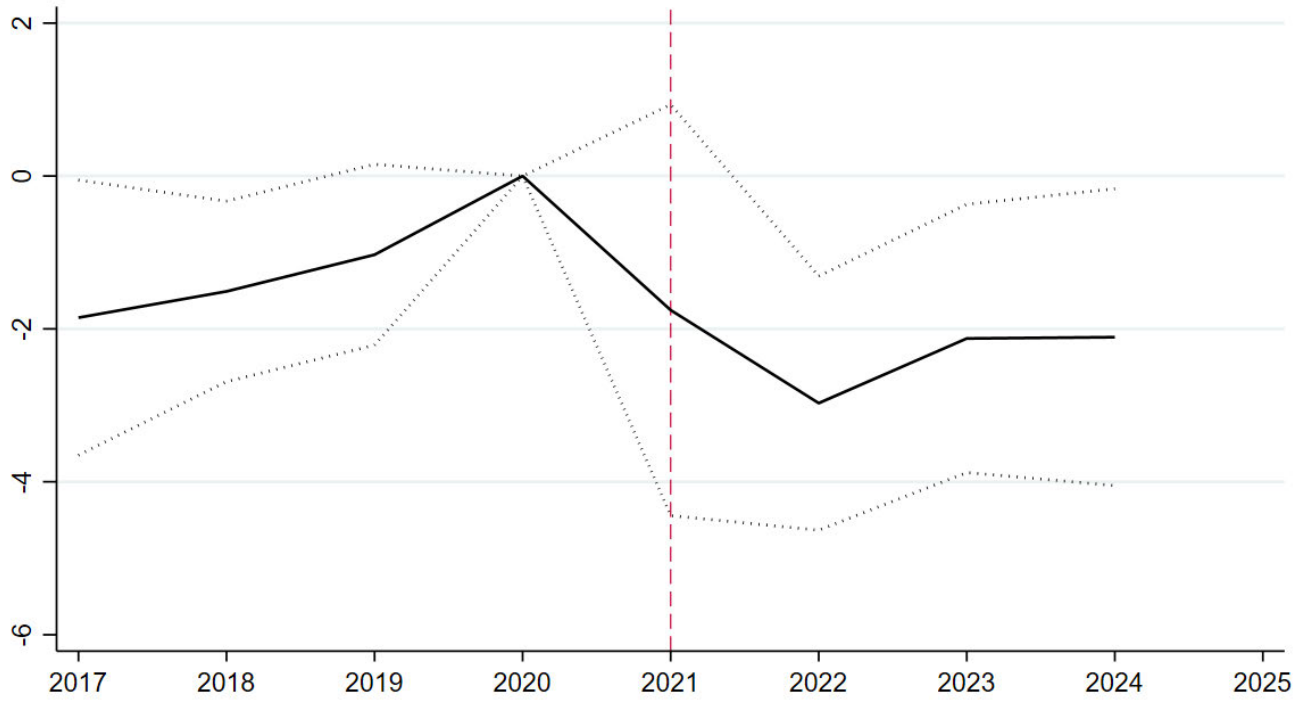
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure B4
Bayshire Acquisitions
Total Nursing Hours per Patient Day of Employed and Contracted Nursing Staff



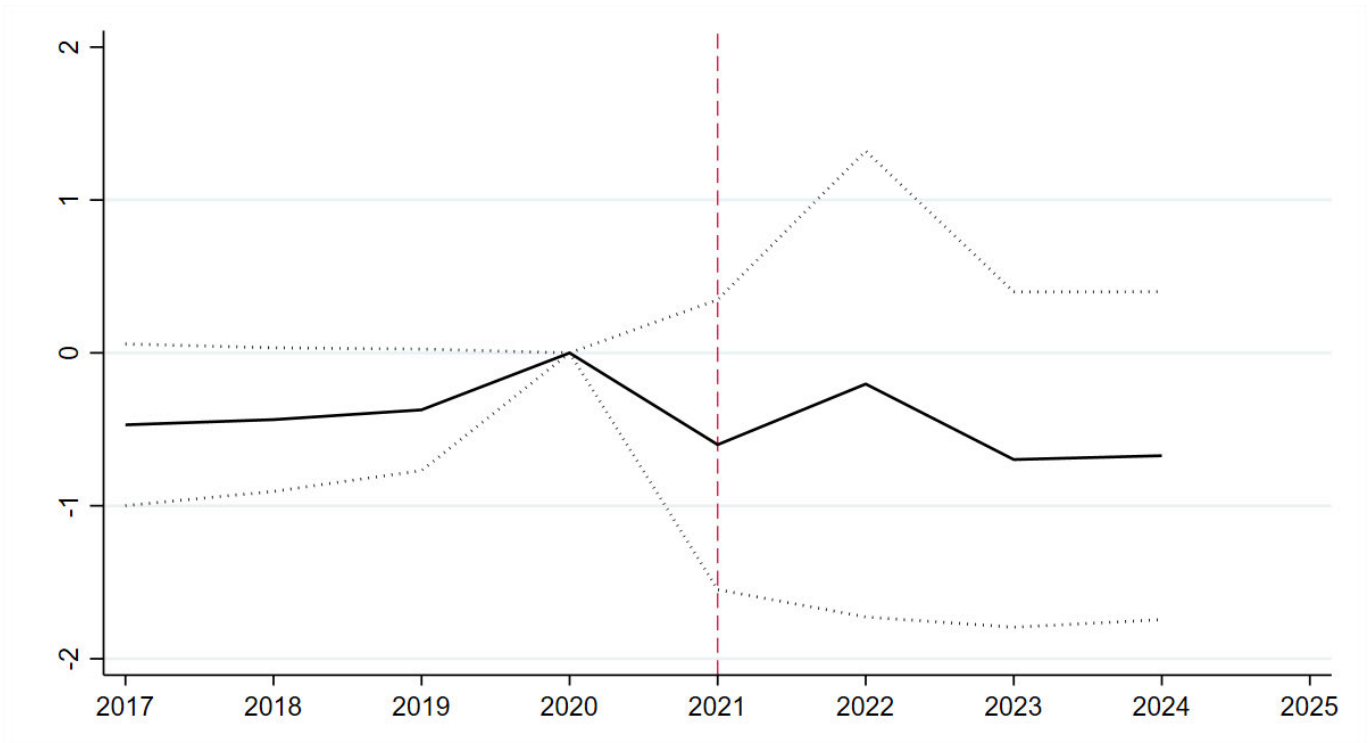
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure B5
Bayshire Acquisitions
Total Nursing Hours per Patient Day of Employed RNs



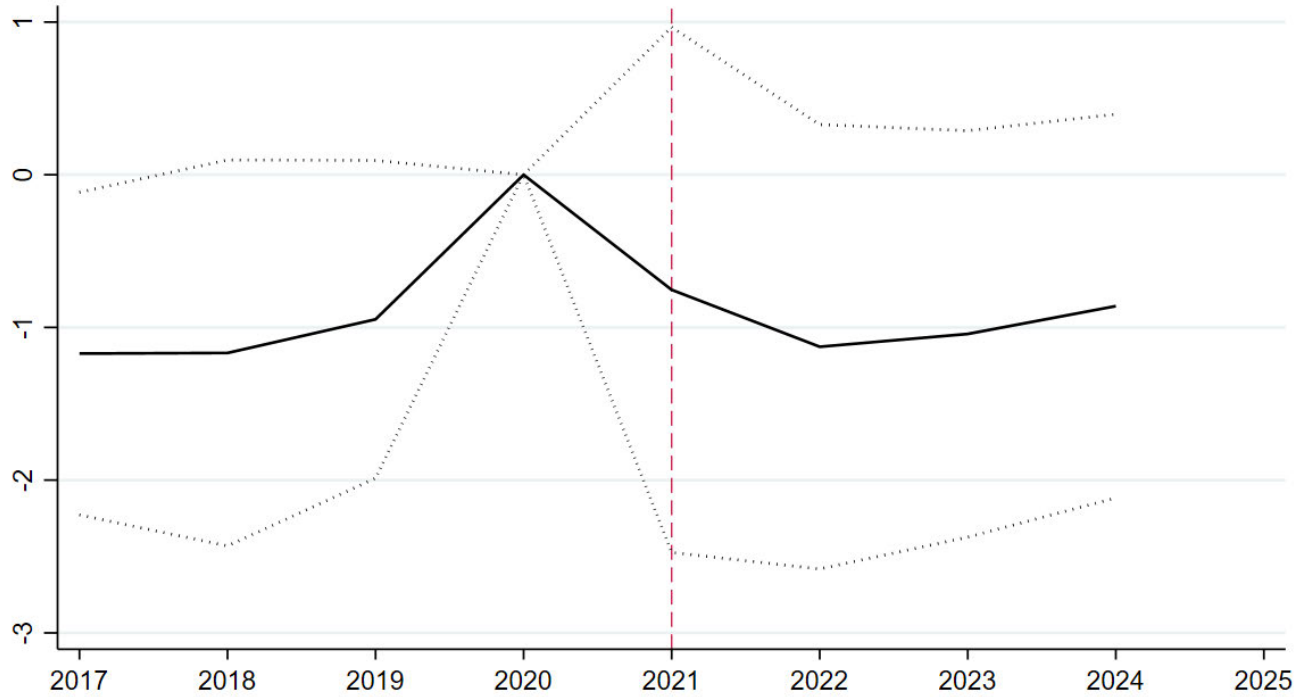
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure B6
Bayshire Acquisitions
Total Nursing Hours per Patient Day of Employed LPNs



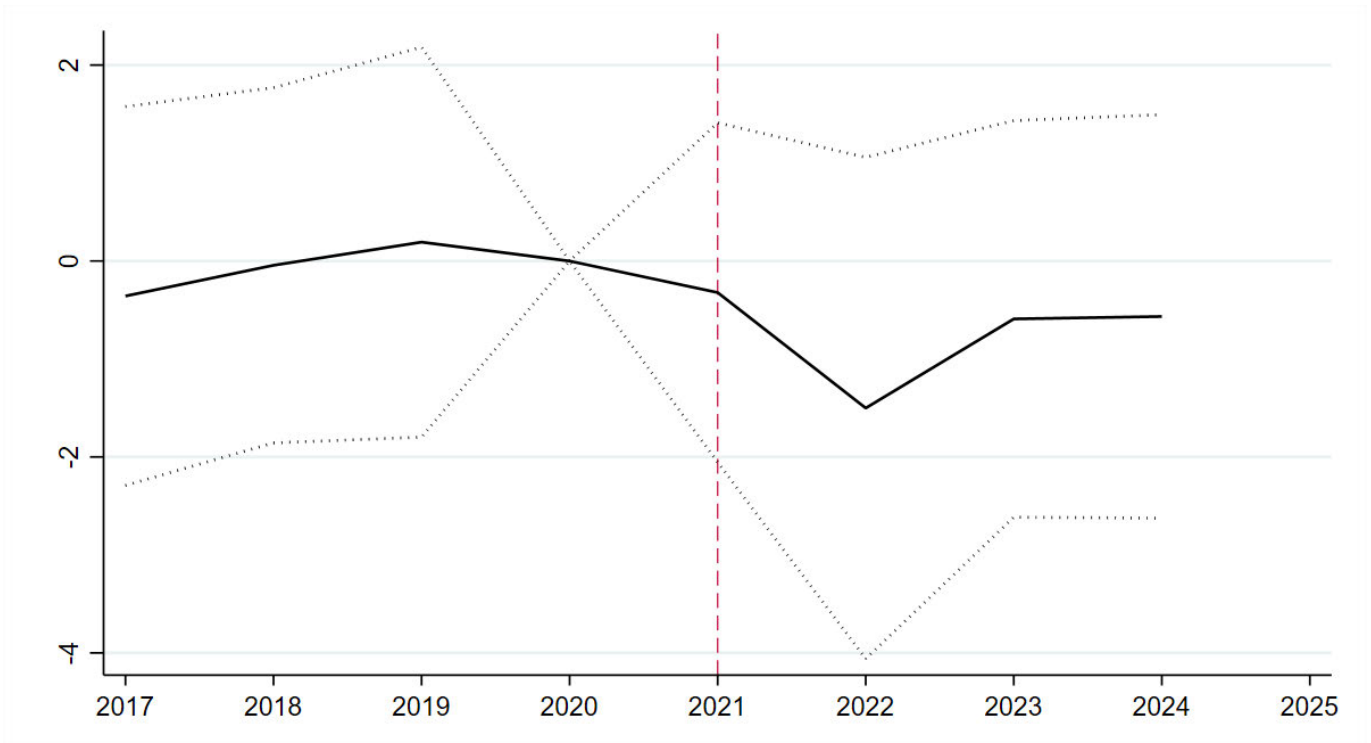
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure B7
Bayshire Acquisitions
Total Nursing Hours per Patient Day of Employed NAs



Notes:

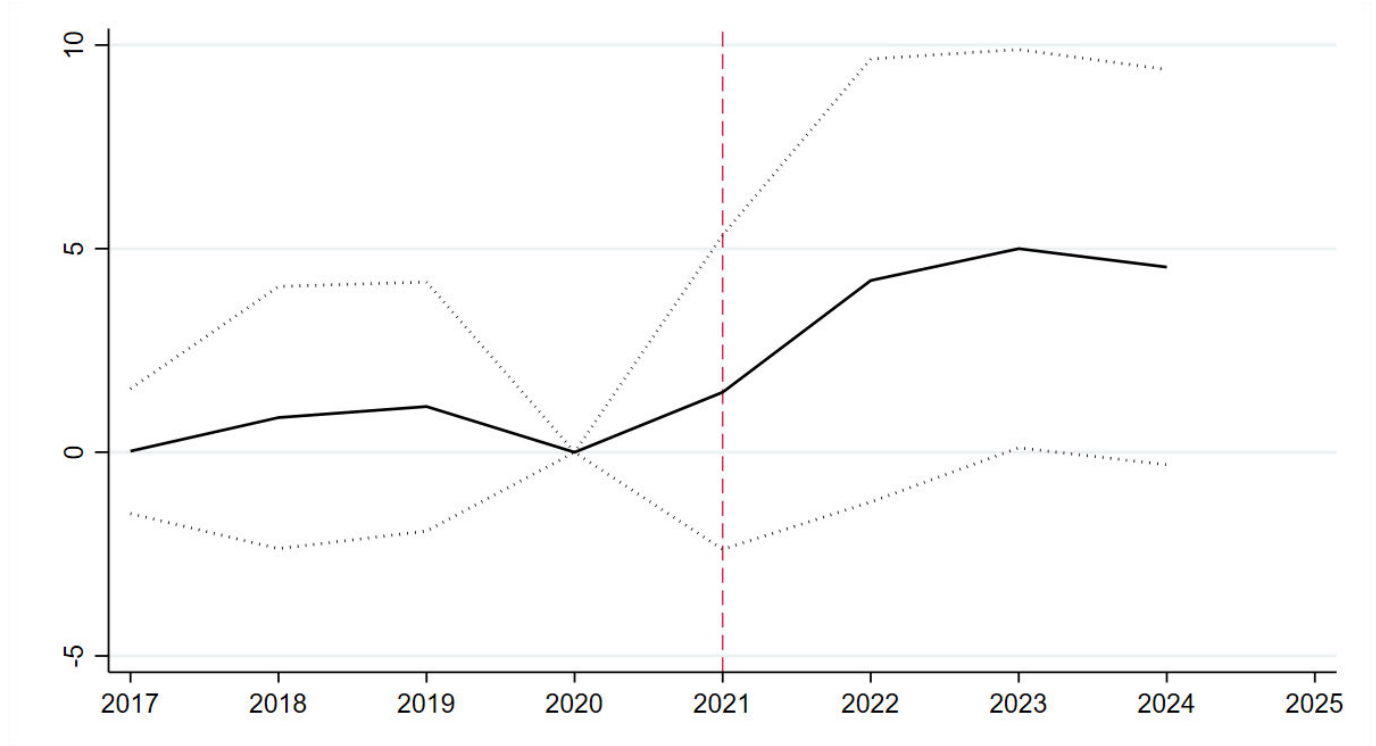
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

iii. Patient Volume

Figure B8
Bayshire Acquisitions
Average Number of Admissions per Bed



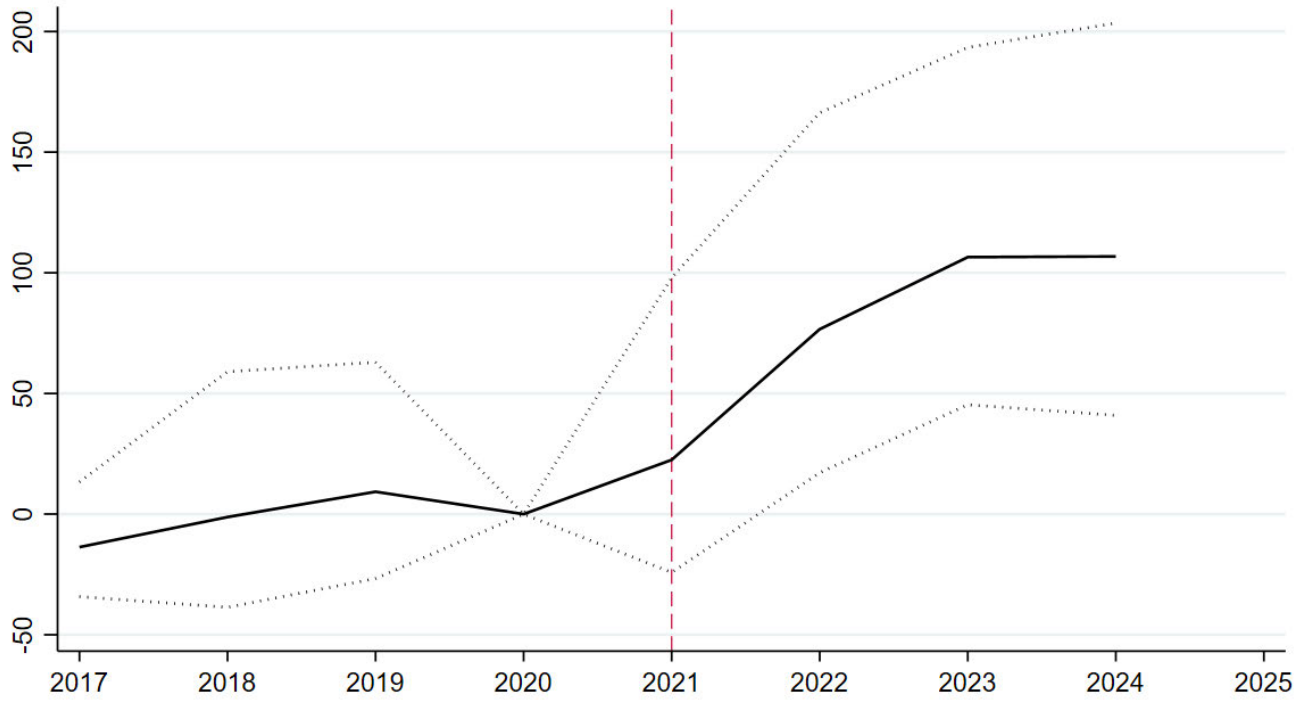
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure B9
Bayshire Acquisitions
Percentage Change in Average Number of Admissions per Bed



Notes:

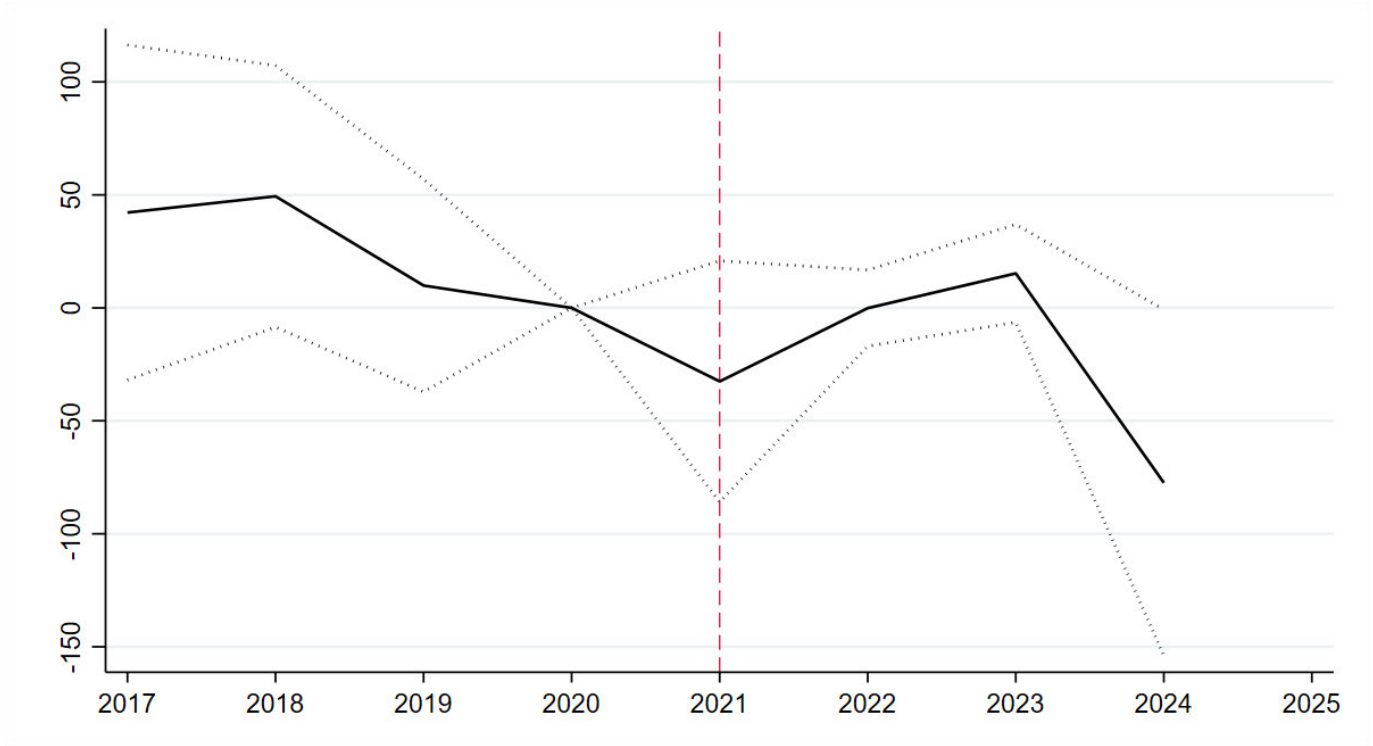
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

iv. Case Mix

Figure B10
Bayshire Acquisitions
Average Length of Stay



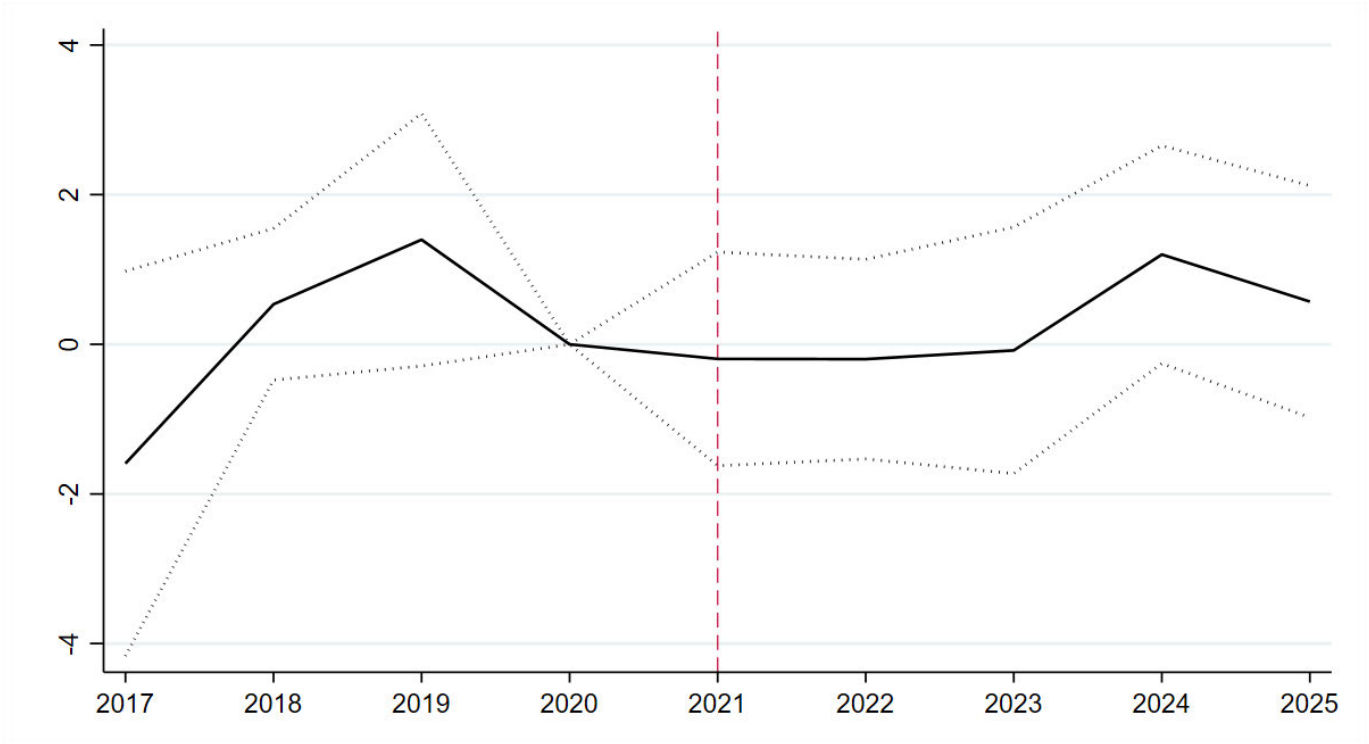
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017–2024.

Figure B11
Bayshire Acquisitions
“Expected” Percentage of Patients with Unplanned Re-Hospitalization within 30 Days of SNF Admission
Lower Percentage Is Better



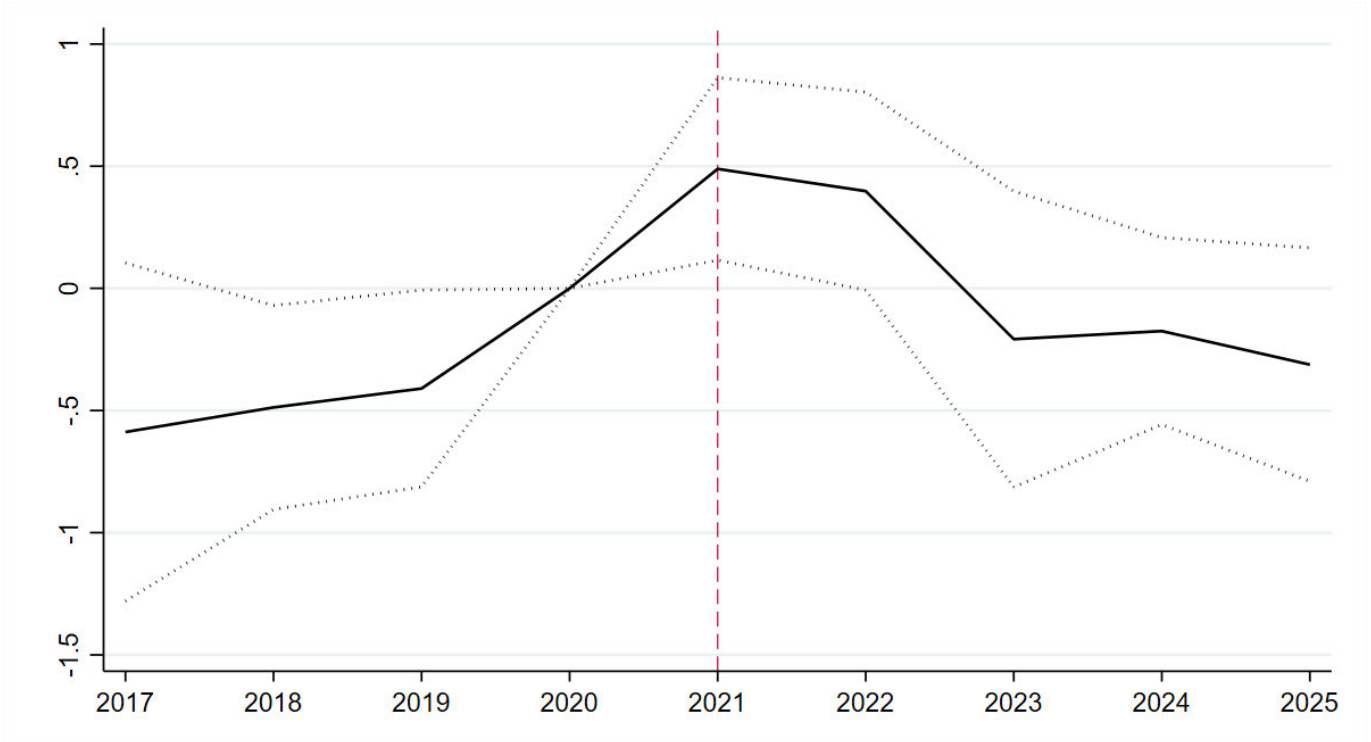
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure B12
Bayshire 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.

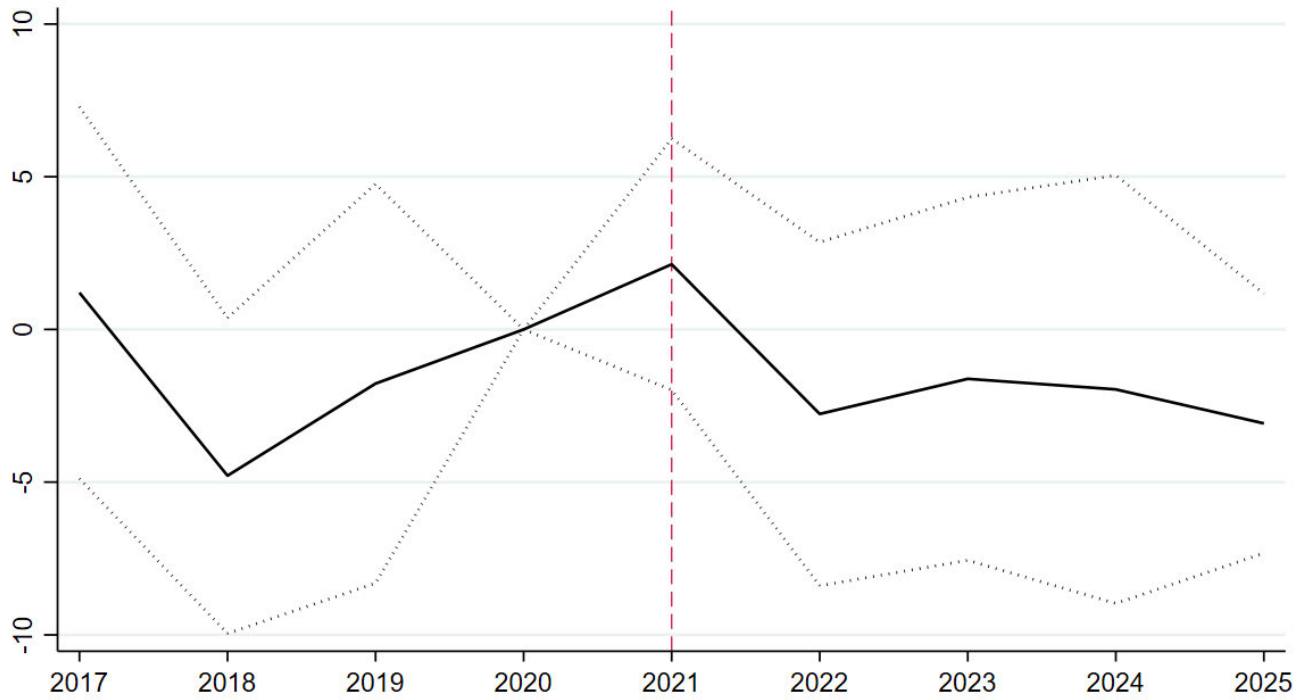
[2] Analysis includes facility effects and year fixed effects. The solid line connects the point estimates, and the dotted lines show the 95 percent confidence interval, based on standard errors that are clustered by facility. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

C. Figures for Analysis of Skillserve’s Prior Acquisitions

i. Health Outcome Metrics

Figure C1
Skillserve Acquisitions
Percentage of Patients with Unplanned Re-Hospitalization within 30 Days of SNF Admission
Lower Percentage Is Better



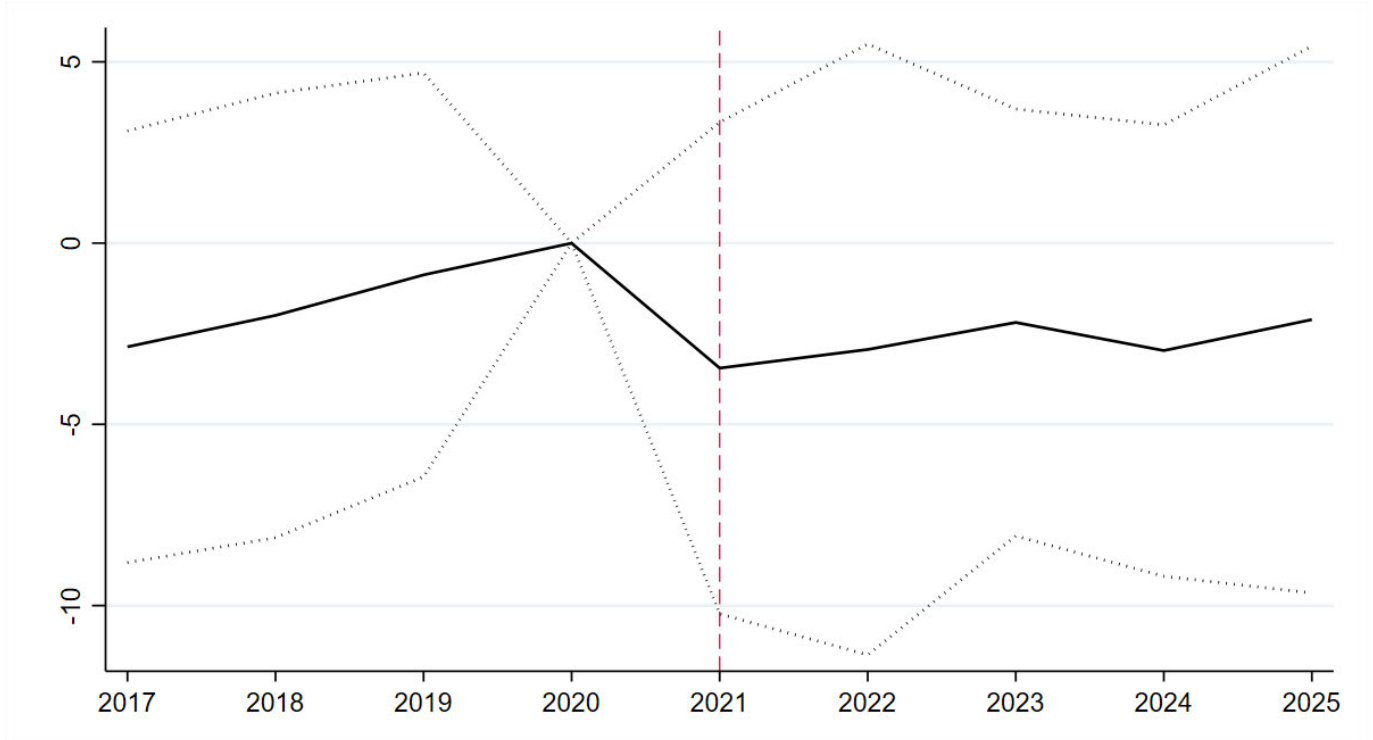
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS SNF Medicare Compare, 2017–2025.

Figure C2
Skillserv Acquisitions
Percentage of Patients with Emergency Room Visits within 30 Days of SNF Admission
Lower Percentage Is Better



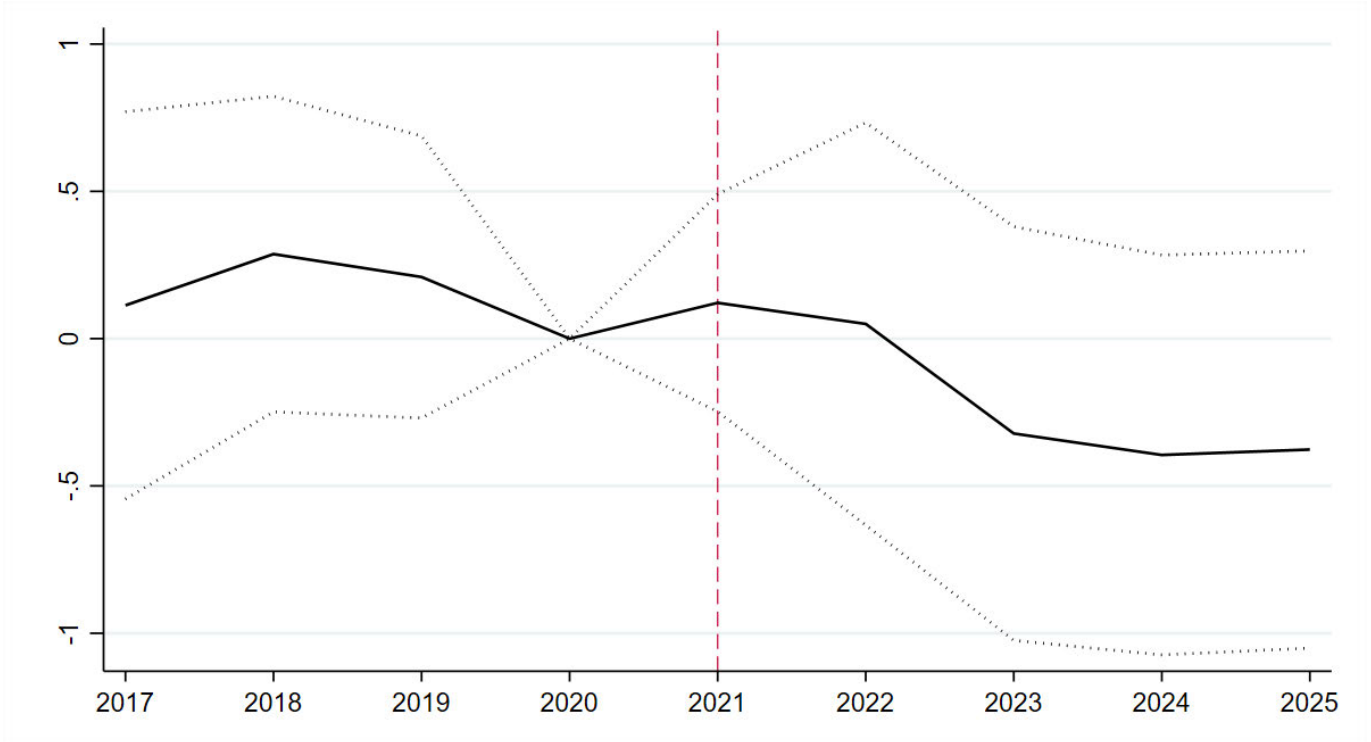
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure C3
Skillserv Acquisitions
Number of Unplanned Hospitalizations per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



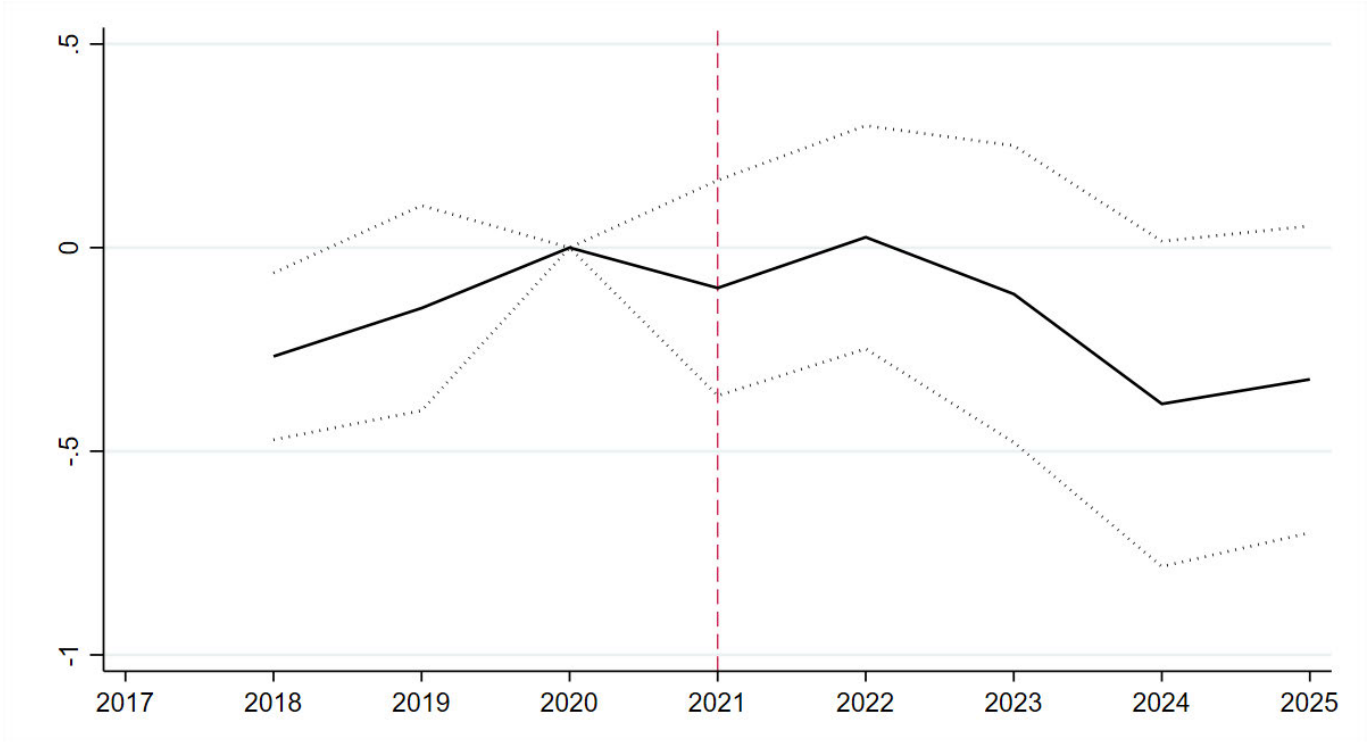
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure C4
Skillserv Acquisitions
Number of Emergency Room Visits per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



Notes:

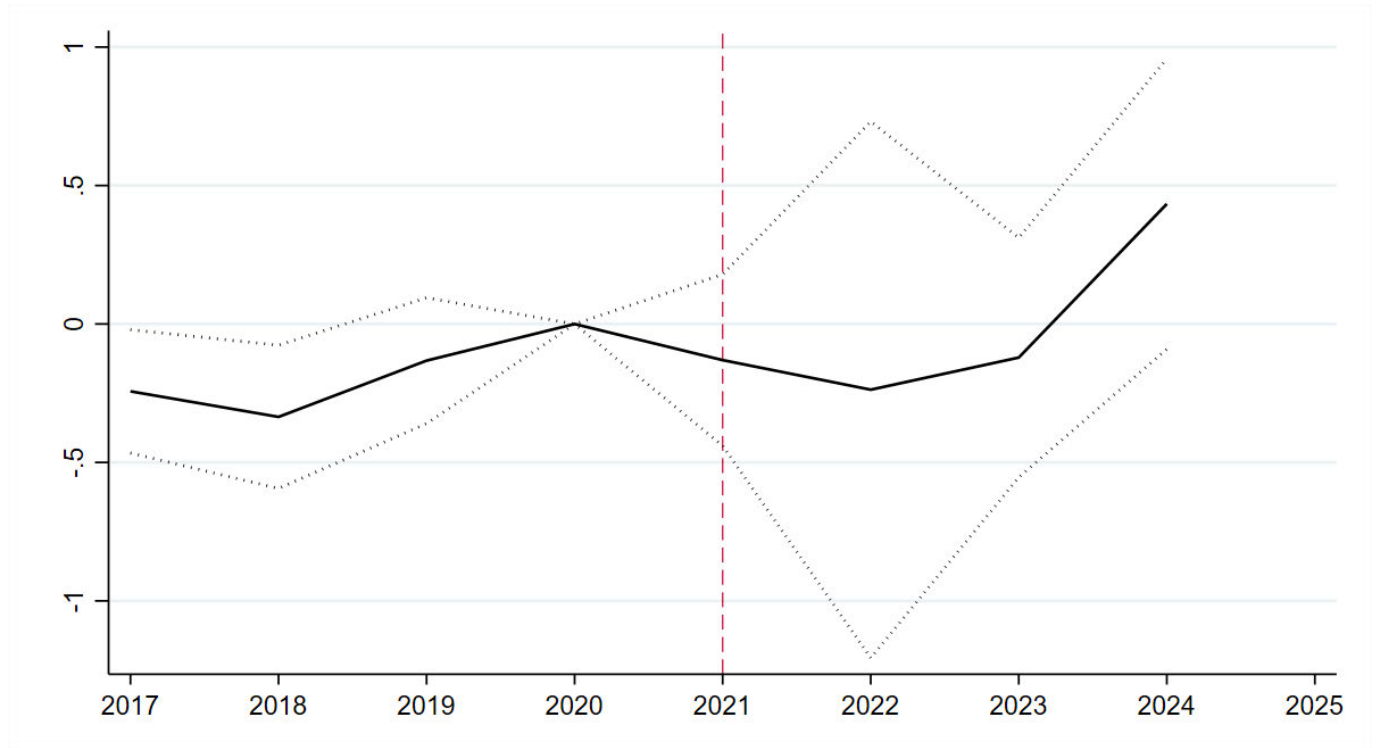
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

ii. Nursing Care Staffing

Figure C5
Skillserv Acquisitions
Total Nursing Hours per Patient Day of Employed Nursing Staff



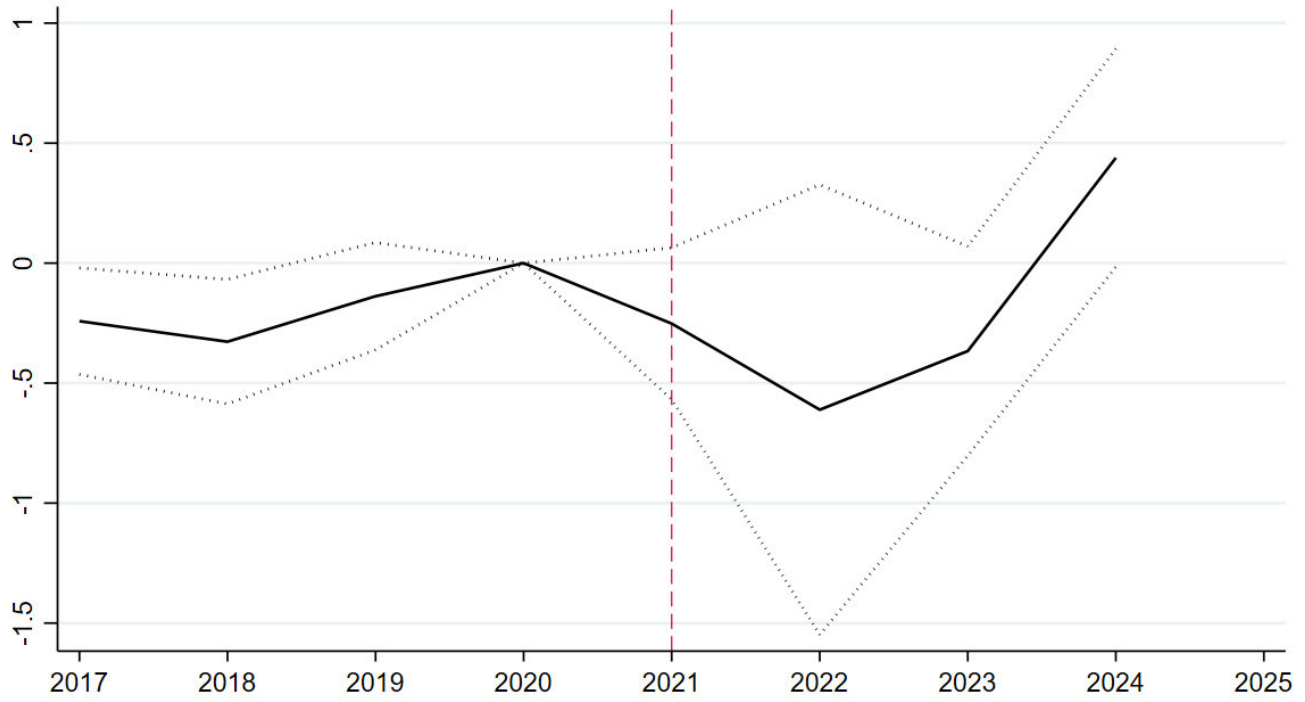
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure C6
Skillserv Acquisitions
Total Nursing Hours per Patient Day of Employed and Contracted Nursing Staff



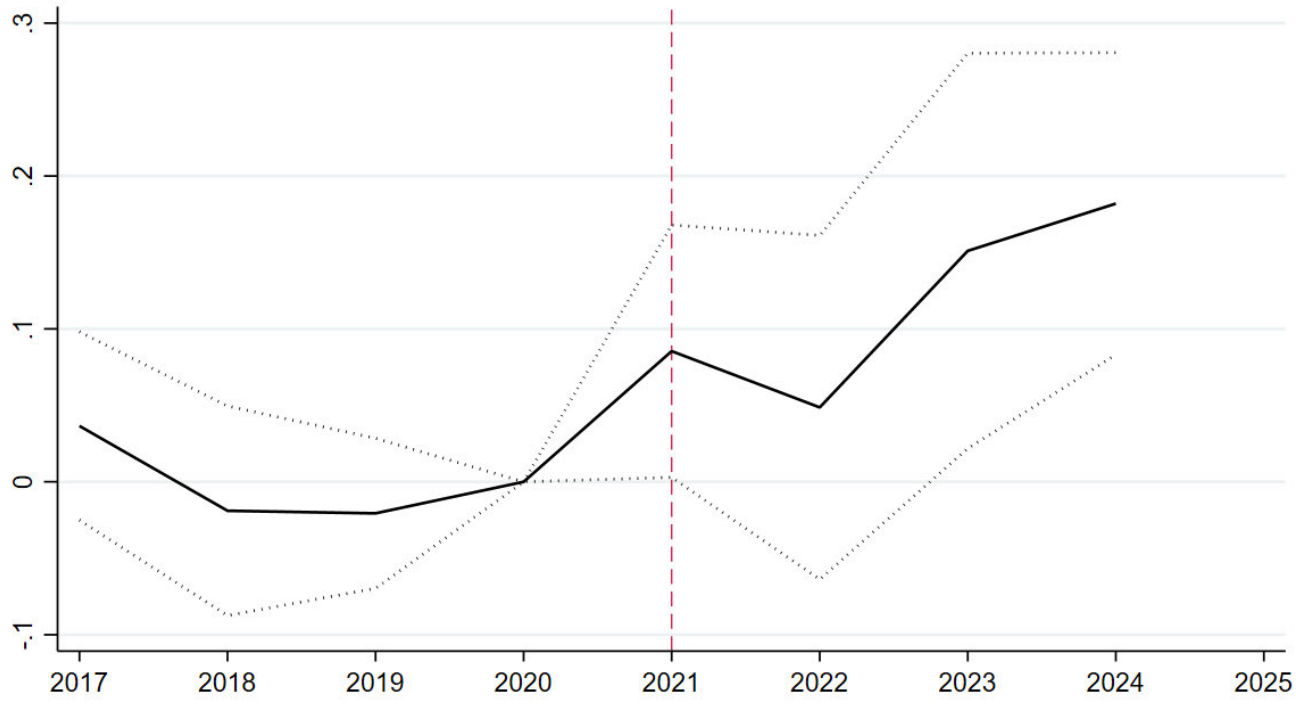
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure C7
Skillserv Acquisitions
Total Nursing Hours per Patient Day of Employed RNs



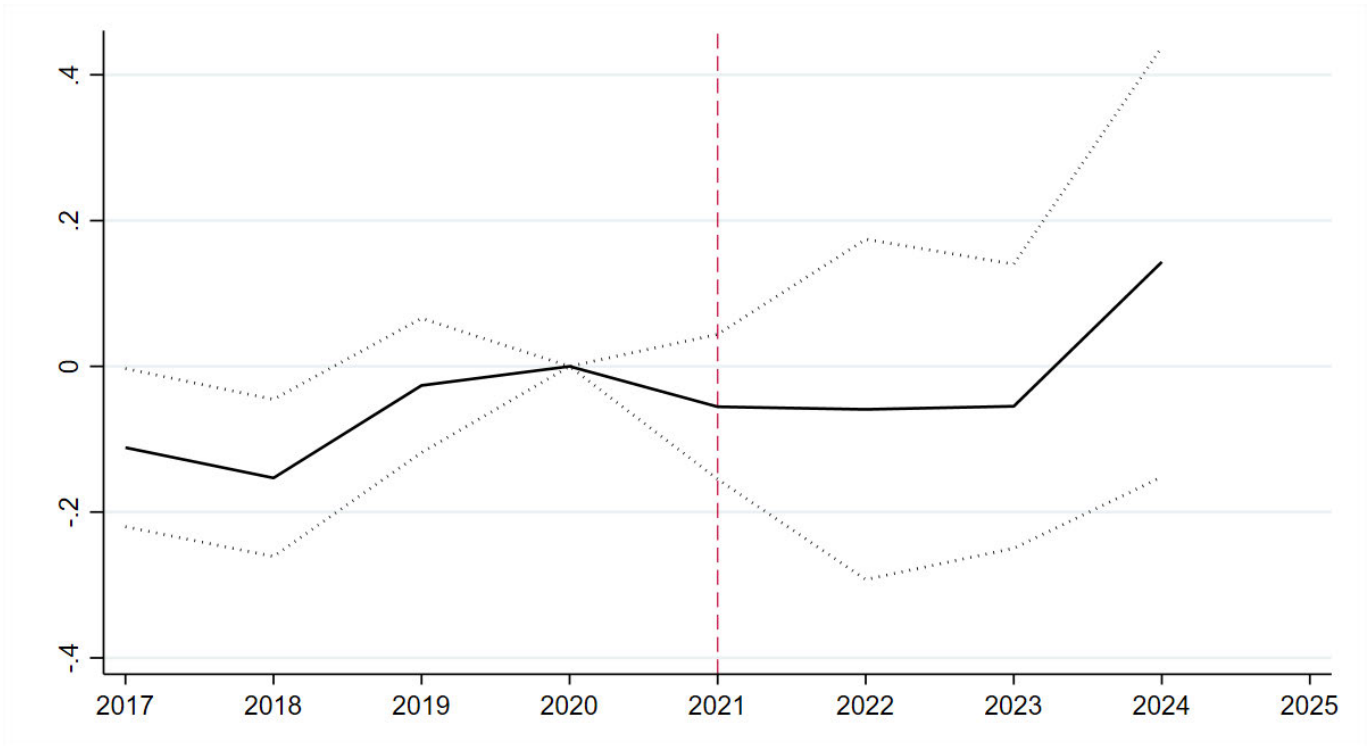
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure C8
Skillserv Acquisitions
Total Nursing Hours per Patient Day of Employed LPNs



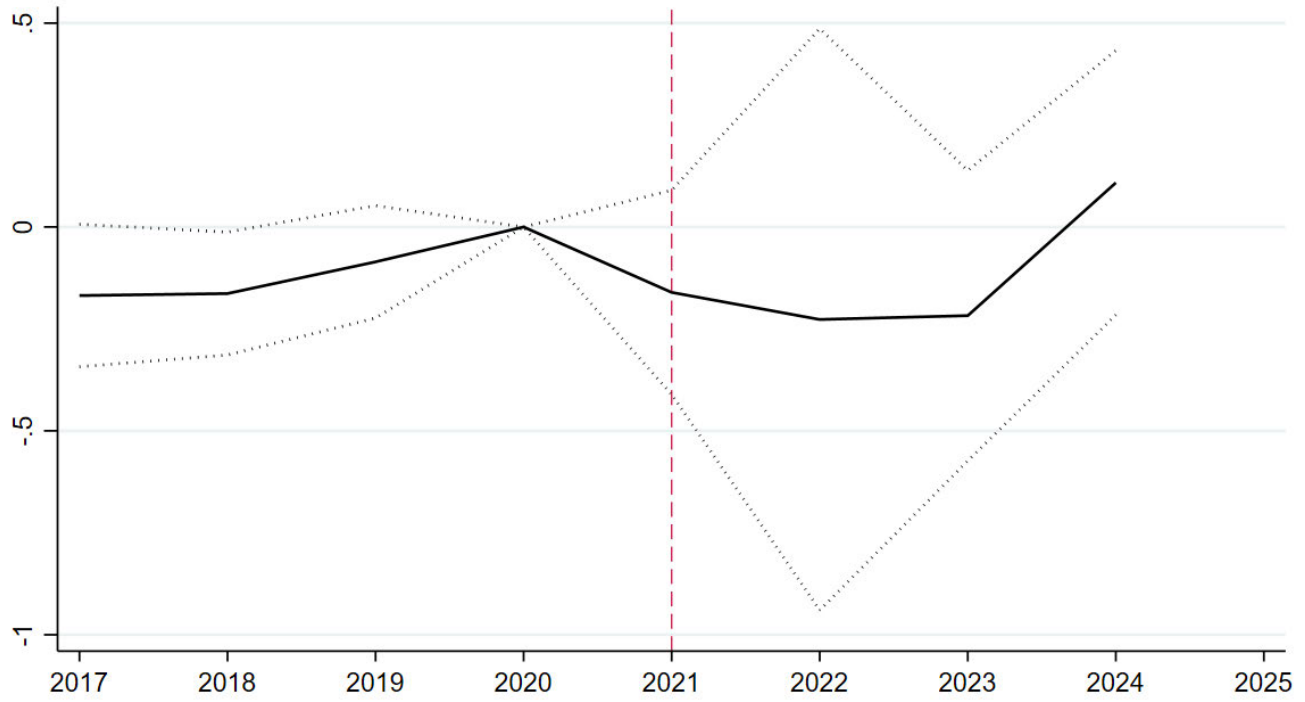
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure C9
Skillserv Acquisitions
Total Nursing Hours per Patient Day of Employed NAs



Notes:

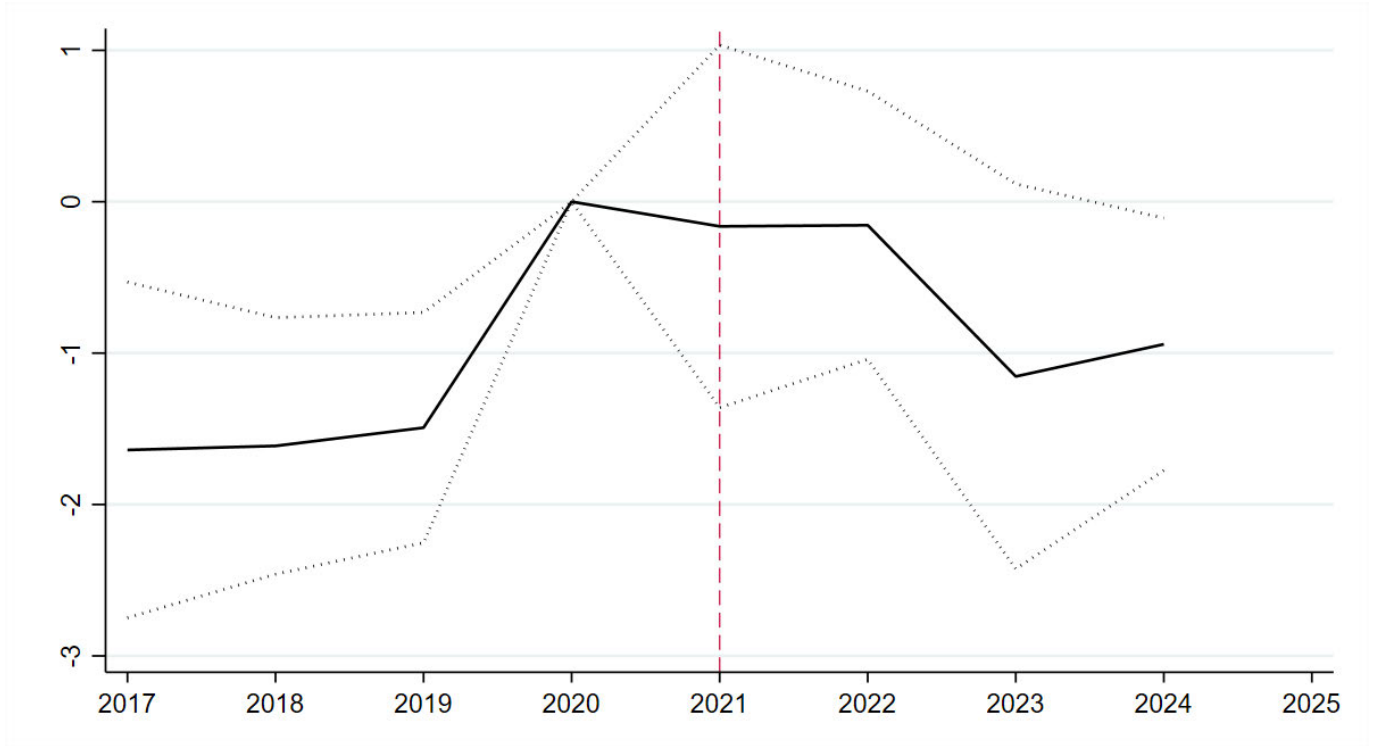
[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

iii. Patient Volume

Figure C10
Skillserv Acquisitions
Average Number of Admissions per Bed



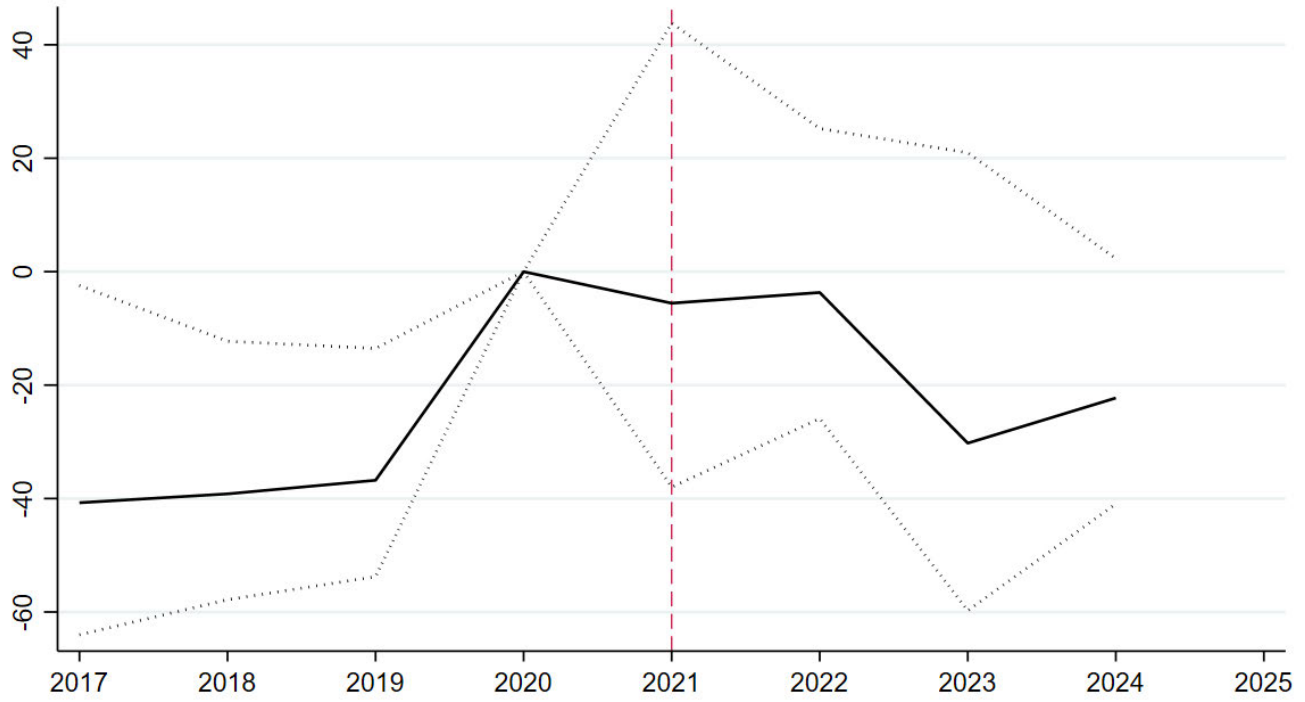
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

Figure C11
Skillserv Acquisitions
Percentage Change in Average Number of Admissions per Bed



Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Skilled Nursing Facility Cost Reports, 2017-2024.

iv. Case Mix

Figure C12
Skillserv Acquisitions
Average Length of Stay

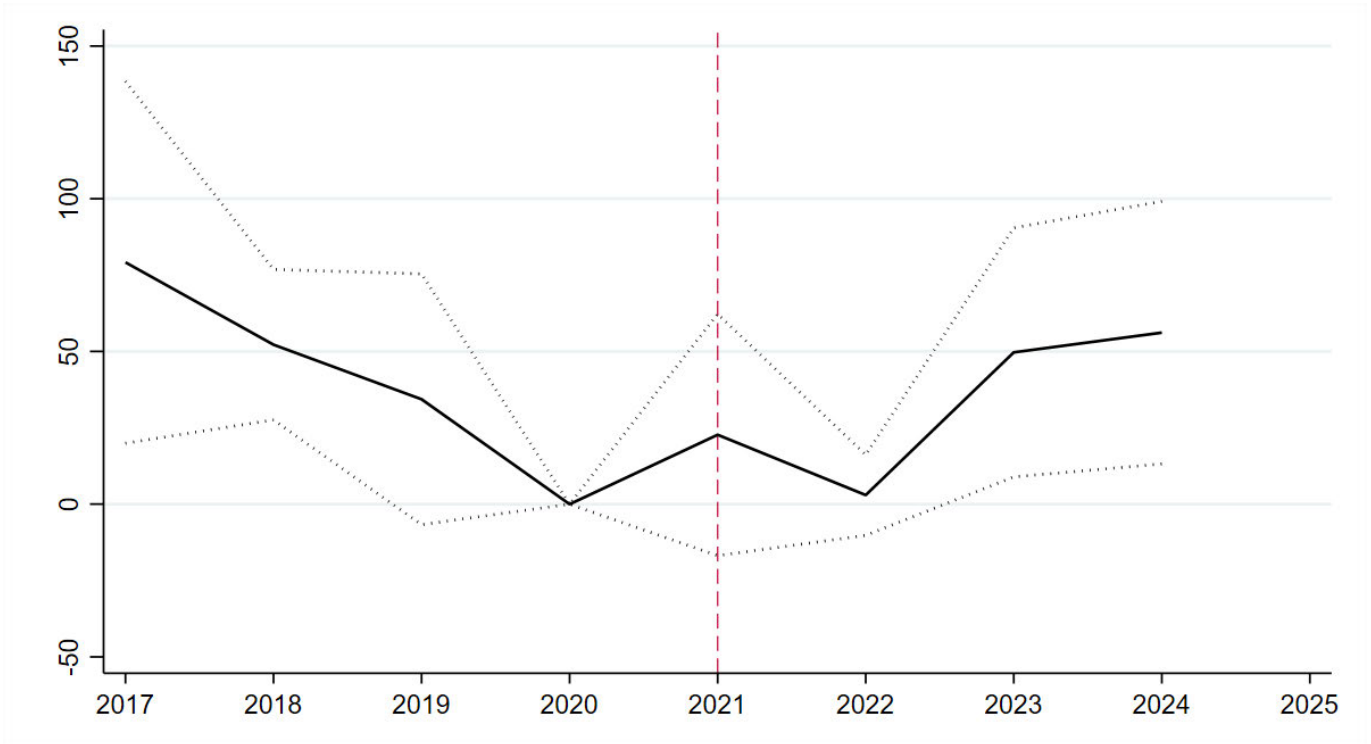
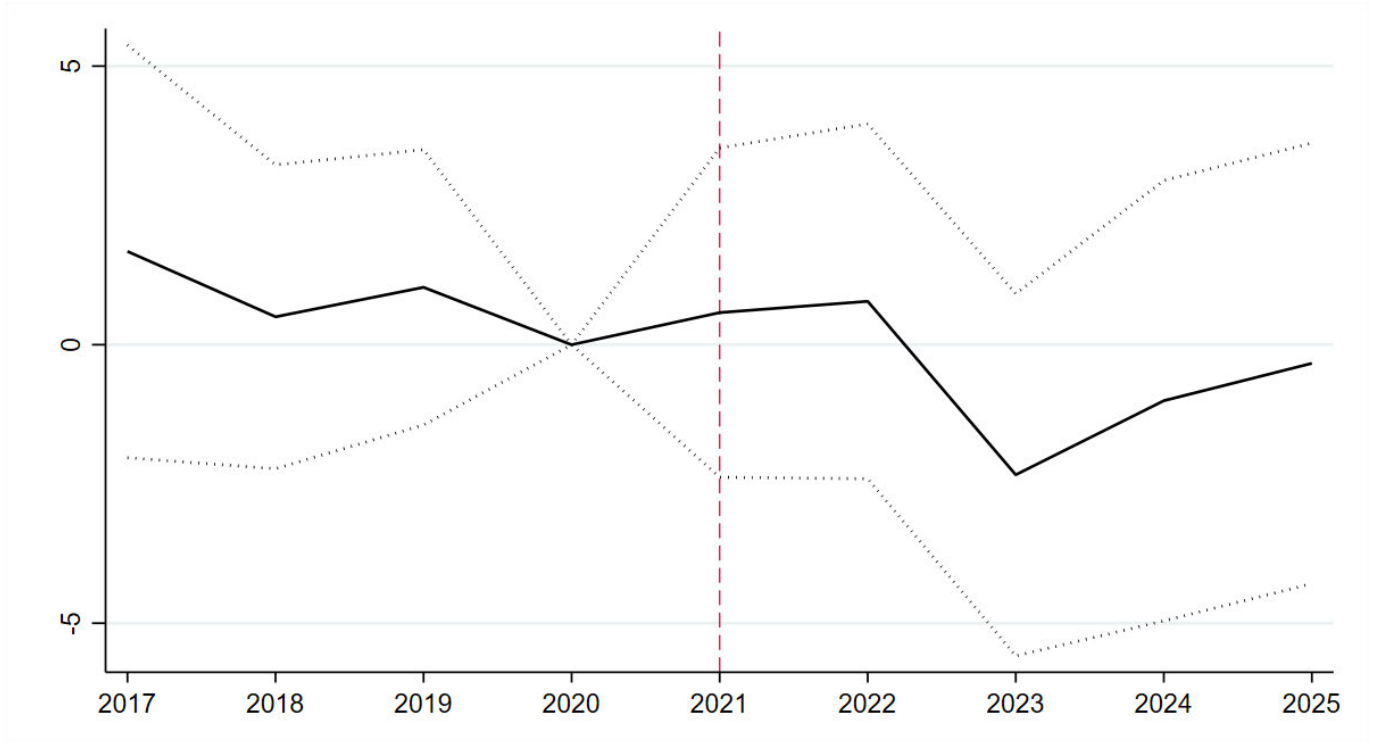


Figure C13
Skillserv Acquisitions
“Expected” Percentage of Patients with Unplanned Re-Hospitalization within 30 Days of SNF Admission
Lower Percentage Is Better



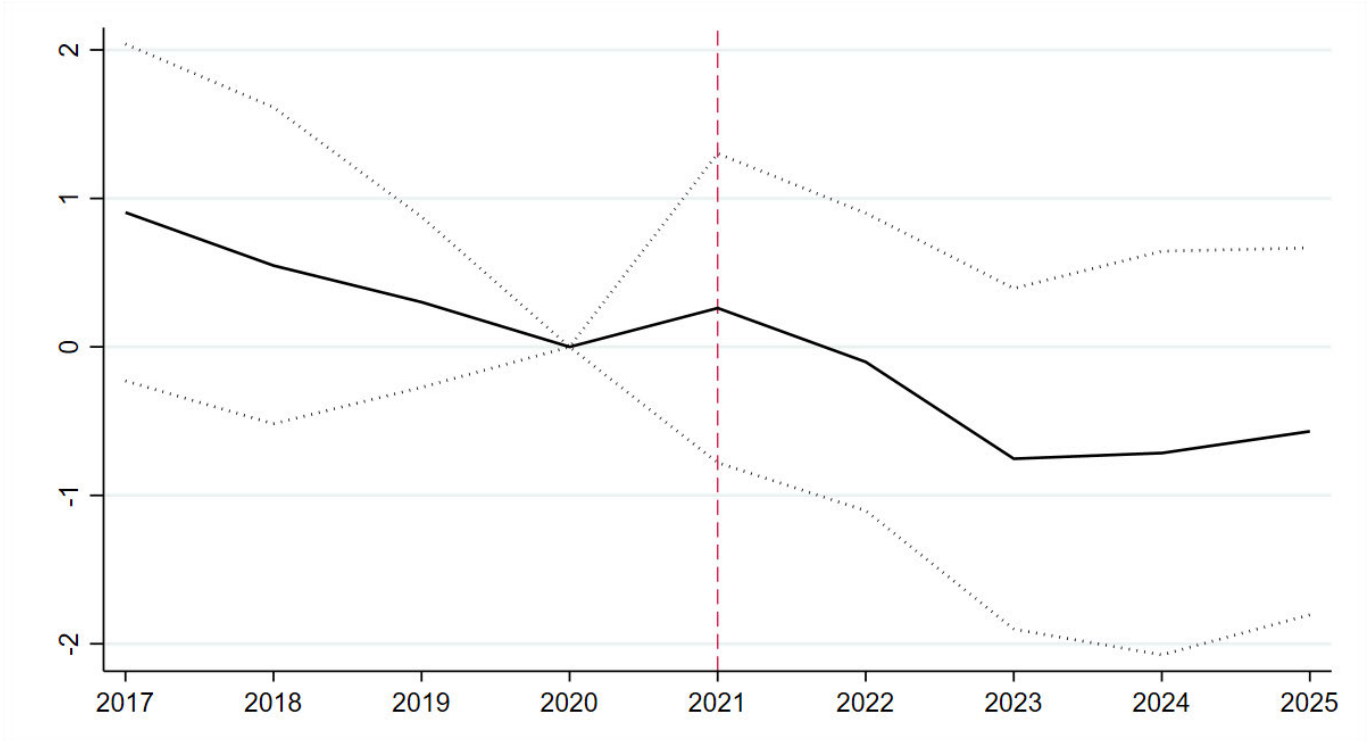
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure C14
Skillserv Acquisitions
“Expected” Percentage of Patients with Emergency Room Visits within 30 Days of SNF Admission
Lower Percentage Is Better



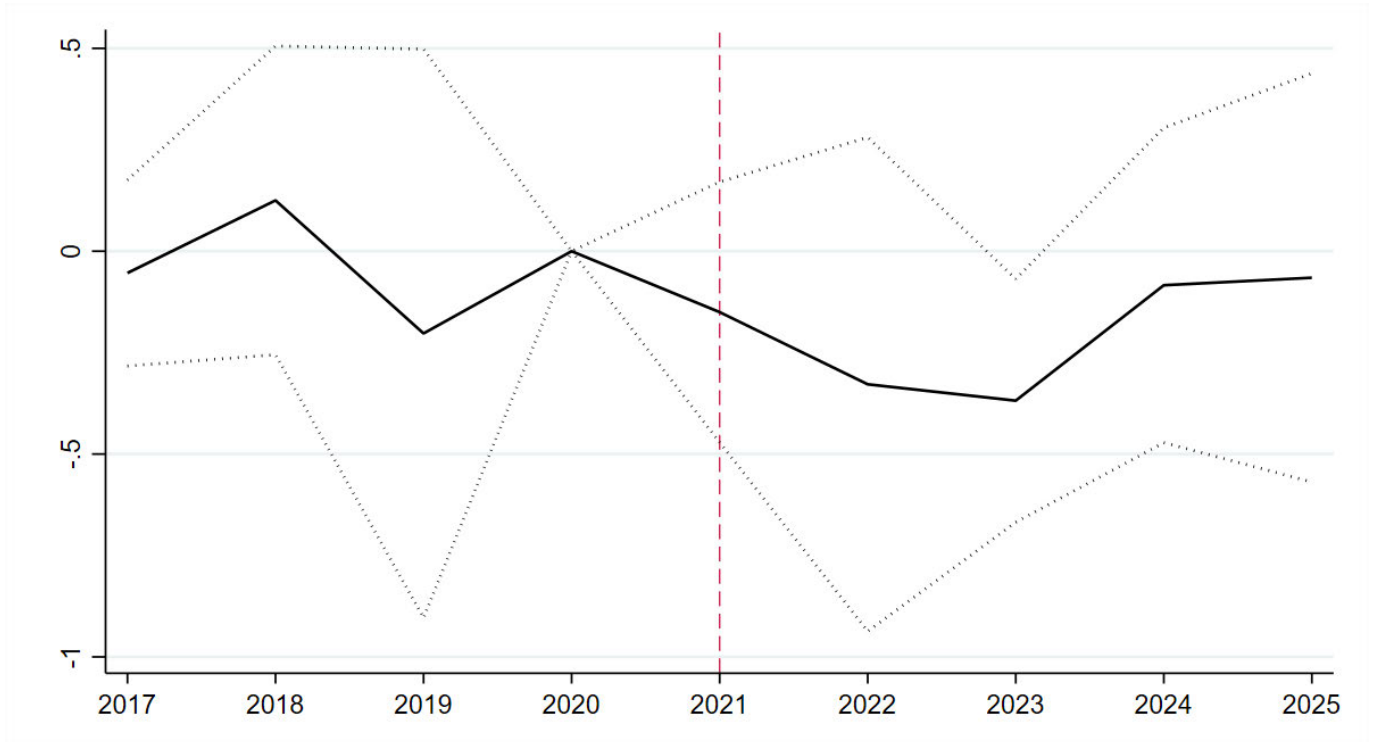
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure C15
Skillservive Acquisitions
“Expected” Number of Unplanned Hospitalizations per 1,000 Long-Stay Resident Days
Lower Percentage Is Better



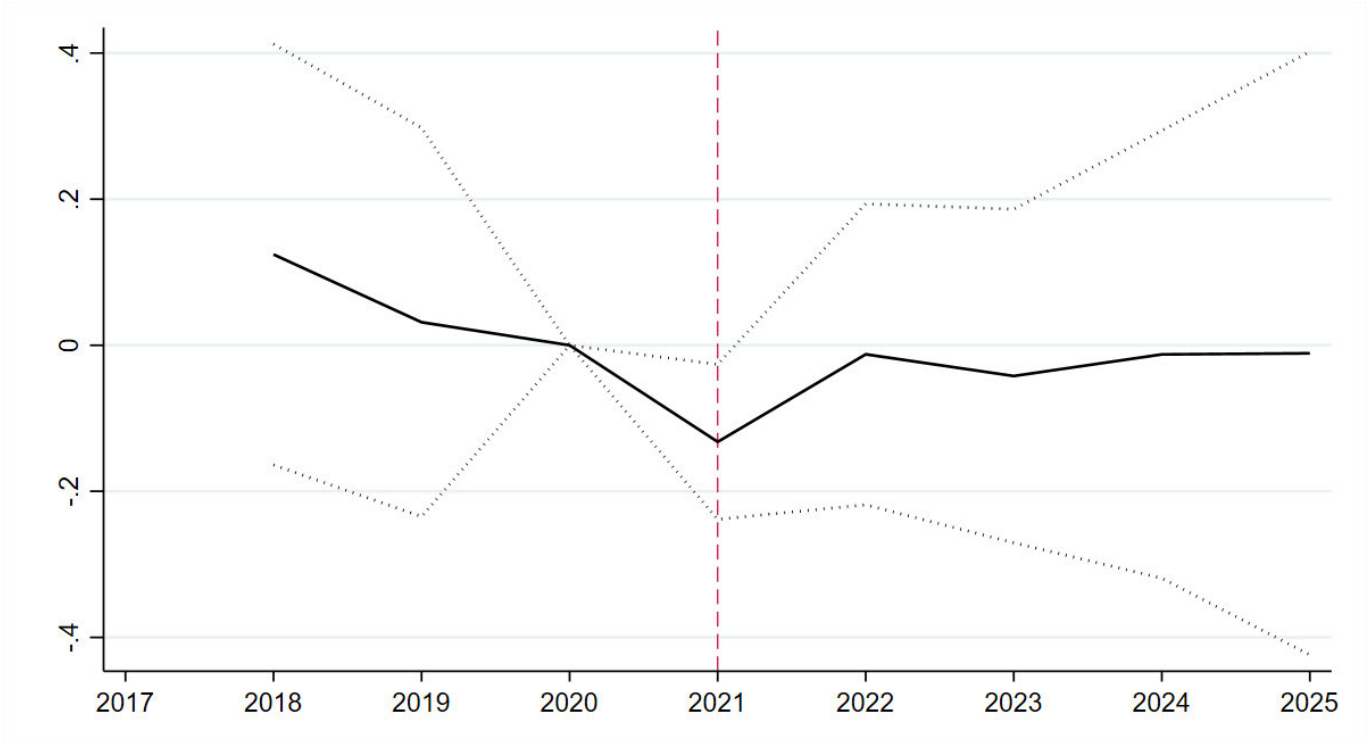
Notes:

[1] Dashed vertical line indicates the year when the acquisitions happened.

[2] Analysis includes facility 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

Figure C16
Skillserv 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 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. 2020 is used as the pre-acquisition reference period.

Source: CMS Medicare Compare, 2017–2025.

D. SNF Payer Mix Around Bethel

Figure D1
SNF Share of Patient Days by Payer Around Bethel
2024

	Within 15 Miles of Bethel	Within 25 Miles of Bethel
Medicare (incl. Managed Care)	21%	22%
Medicaid (incl. Managed care)	65%	63%
Commercial	3%	3%
Self-Pay	5%	3%
Other	7%	9%

Notes:

[1] The overall percentages are calculated using total annualized patient days.

[2] “Self-Pay” consists of patient days for which the primary payer is the patient or patient’s family. “Self-Pay” includes charity care.

[3] “Other” includes patient days that do not fall into any of the defined categories. “Other” includes Veterans Administration and worker’s compensation.

Source: Medi-Cal Cost Report, 2024.

E. 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 fee-for-service and Medi-Cal managed care claims and are at the claim line level.¹¹⁹ I focus on the data for 2024 since it is the latest year available to me.

I filter the data to inpatient claims submitted by long-term care facilities with a place of service of SNF.¹²⁰ 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).

I further collapse the claims-level data to discharge level. A discharge is a unique patient-facility pair in the data.¹²¹ I exclude 2,384 discharges with missing patient gender, patient zip code, or patient county. The table below shows the number of discharges, number of unique patients, and number of facilities for 2024 in the prepared dataset.

¹¹⁹ In addition, the data include claims for individuals with dual coverage from Medi-Cal and Medicare.

¹²⁰ 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).”

¹²¹ I define a unique facility as the combination of its NPI and address. The data do not have enough information to identify readmissions of the same patient at the same facility.

Number of discharges [A]	Number of Unique Patients [B]	Number of Facilities [C]
181,447 discharges	164,238 patients	1,158 SNFs

F. 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.

G. Regression Specification for Analyses of Past Acquisitions

I use the following DID regression specification for retrospective analyses of Jericho’s prior acquisitions in 2022, Bayshire’s prior acquisitions in 2021, and Skillserve’s prior acquisitions in 2021:

where for each facility in year t , let y_{it} be the metric of interest, α_i be the facility-specific fixed effect, γ_t be the year fixed effect, δ_{it} be an indicator that is equal to one if and only if facility i is t years from being acquired by Jericho, Bayshire, or Skillserve in year t . The coefficients on δ_{it} are the effects of Jericho’s, Bayshire’s, or Skillserve’s acquisitions.

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

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

I rely on two data sources for the DID analyses: SNF Medicare Compare data and SNF Medicare Cost Report data.¹²² The following table summarizes these data sources:

Metrics [A]	Data Source [B]	Years Covered [C]
------------------------	----------------------------	------------------------------

¹²² 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/>.

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

Health outcome	SNF Medicare Compare	2017–2025
Nursing care staffing	SNF Medicare Cost Report	2017–2024
Patient volume	SNF Medicare Cost Report	2017–2024
Case mix	SNF Medicare Cost Report and SNF Medicare Compare	2017–2024 and 2017–2025

SNF Medicare Cost Report

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

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

The SNF Medicare Cost Report data are released once a year. Different SNFs in the same year’s SNF Medicare 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 2017 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 case mix. On the other hand, the expected value measures patient health outcomes if the SNF’s patients were treated by a SNF with “average” quality.¹²³ Consequently, I use the adjusted values as SNF health outcome metrics and I use the expected values as SNF case mix 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:¹²⁴

Reporting Month [A]	Measurement Period [B]
December 2018	January 1, 2017 to December 31, 2017
September 2019	January 1, 2018 to December 31, 2018
November 2020	January 1, 2019 to December 31, 2019
September 2021	January 1, 2020 to December 31, 2020
September 2022	January 1, 2021 to December 31, 2021
September 2023	January 1, 2022 to December 31, 2022
September 2024	January 1, 2023 to December 31, 2023
September 2025	January 1, 2024 to December 31, 2024
March 2026	July 1, 2024 to June 30, 2025

¹²³ “Nursing Home Care Compare Claims-Based Quality Measure Technical Specifications,” *Centers for Medicare & Medicaid Services*, July 2025, available at <https://www.cms.gov/files/zip/mds-qm-users-manual-v18-0-effective-1-1-2026-associated-user-manuals.zip>.

¹²⁴ Metric values measured for the full calendar year 2025 are not available. Therefore, I use metric values measured from July 1, 2024 to June 30, 2025 as metric values for calendar year 2025.