Ensign: Deceiving the Government at Estimated ~20% of Facilities

Multi-Billion Dollar Potential Liability, Margins and Acquisitions that Cannot be Sustained Without Significant Ongoing Misconduct

June 11, 2026

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Sections

Executive Summary

Muddy Waters is short Ensign (NASDAQ: ENSG, see Disclaimer). We conclude that Ensign engages in a systematic scheme at an estimated ~20% of Skilled Nursing Facilities (SNFs) to rent the licenses of Administrators who are not generally present at, nor actually managing, the facilities. Ensign enters into consulting agreements with these nominal Administrators that appear to cause Ensign to state the facilities have licensed Administrators when in fact these administrators are seldom on premise and do not substantively manage facilities. We believe this scheme, which could amount to fraud against states, Medicare, and Medicaid, is the pillar upon which Ensign's acquisition strategy and margins is built. Federal law requires each SNF have a licensed Administrator (the state sets the licensing requirement) who manages the facility to meet a Condition of Participation to be eligible to bill Medicare and Medicaid, which account for 69% of Ensign's revenue. The Administrator is legally responsible for facility operations, staffing, regulatory compliance, resident safety, and quality of care. Under the False Claims Act, if these practices have been in place for one year at ~20% of facilities, we estimate the violations carry theoretical sanctions in the billions of dollars. We estimate that without the license renting scheme and related practices, which we believe enable its acquisitions and result in unduly low expenditures, Ensign's EBITDAR margins would compress by ~210 bps and its growth would be limited to the ~2% rate of its peers. We estimate that compliance – exclusive of any sanctions – would reduce Ensign's 2027 EBIT by ~35% vs consensus.

We sent investigators to 57 of Ensign's 379 facilities across eight states. We found red flags consistent with rented licenses at 12 of these facilities, which was 21% of the facilities visited. MW has obtained a "Consulting Agreement" reportedly used to rent an Administrator's license. Eight former employees have detailed how the scheme operates, which makes clear to us that these practices are intended to deceive regulators. The Centers for Medicare & Medicaid Services appears unaware that ENSG is systematically engaging in this behavior, which is likely due to the numerous brands under which Ensign operates its SNFs. In 2023 and 2024, CMS has issued reports showing unlicensed operators running four facilities that belong to Ensign, illustrating that CMS has likely not yet connected the dots.

Hunterbrook Media on June 8th issued a report exposing low nursing levels, dangerous practices, and overbilling for therapy at Ensign facilities. Our research independently corroborates the evidence of billing for therapeutic services that were never rendered and staffing. We believe that all these practices result from the unique Management by Peer-Pressure model that Ensign runs, which we understand leads to ~60% annual Administrator turnover (including acquired facilities).

Management by Peer-Pressure

Administrator turnover is driven by Ensign's "Cluster" model and the extreme financial pressures it exerts on the – often young – OMs / Administrators. Facilities are placed into a Cluster of four buildings. Administrators' bonuses are partly dependent on the profitability of their Cluster, and losses at one facility can reduce bonus payments to Administrators at other facilities in the Cluster. Similar to the reality game show "Survivor", Administrators within a Cluster can vote underperforming OMs / Administrators out of the company. Former employees describe a company that deliberately generally avoids hiring experienced or licensed Administrators. Instead, it reportedly hires recent college graduates without meaningful healthcare experience, trains them in-house (calling each an "Administrator-in-Training"), and then places them as de facto Administrators (called "Operations Managers") in facilities with rented Administrator licenses while they earn their own licenses should they last long enough. This peer-pressure based management model, we feel, is at the heart of the abuses Hunterbrook and we have found. We think it further unhealthy that facility Directors of Nursing also receive facility profitability-linked bonuses.

Unlicensed Administrators are not Speeding Ticket Violations

The potential for material, even crippling, penalties against ENSG seems far greater than in prior well-known "regulatory shorts". Each of a former DOJ prosecutor and former OIG special agent emphasized the gravity of this apparent conduct, emphasizing that as we presented it in a hypothetical fact pattern, the conduct likely amounts to fraud, particularly if there's evidence of concealment. They emphasized that what we described were not minor paperwork violations; and, noted that enforcement is more likely when the misconduct involves a vulnerable patient population and a licensing requirement intended to protect the health and safety of the population.

Sections

1. Executive Summary
2. **Growth Built on Rented Licenses and Deceiving the Government**
3. Margins Built on Perverse Incentives and Resident Harm
4. DOJ Recidivism Risk and Reports of Phantom Therapy Billing
5. Aggregated Impact: Acquisitions Flatline, Margins Compress, and False Claims Act Exposure

The License-Rental Scheme:
Why It Exists, How It Works, The Evidence, and Impact

Ensign has been able to grow at 11% per year via acquisition in part due to the use of unlicensed operators to manage skilled nursing facilities while paying licensed Administrators a monthly retainer of ~ $2,000 plus $600 per site visit to hang their license on the wall. We view this “license rental scheme” as a deliberate attempt to fool regulators into believing facilities are being operated by a licensed Administrator.

We believe this violates a material condition of Medicare and Medicaid participation under 42 CFR § 483.70(d)(2) and reimbursements to these facilities could constitute “False Claims” under the False Claims Act under 31 U.S.C. § 3729. We further believe the license-rental scheme is the foundation of Ensign’s acquisition strategy. Absent the scheme, Ensign’s acquisition engine would likely slow from ~11% annual growth to peer-level growth of ~ 2%, resulting in materially fewer acquisitions and significantly lower future EBIT growth.

Why the Scheme is in Place

- Ensign acquires facilities faster than it can staff buildings with licensed Administrators
- Reported ~60% Administrator turnover + peer "vote-off-the-island" culture keeps tenure short
- Ensign usually does not hire experienced Administrators; prefers internal AIT program to staff facilities

How the Scheme Operates

- Unlicensed operator runs the building day-to-day
- Licensed Administrator is paid ~$2,000/month plus ~$600 per visit to lend their license to the facility; not involved in day-to-day management; usually has another job
- Facility bills Medicare/Medicaid as if properly licensed; possibly constituting False Claims

Evidence

- A copy of the contract Ensign uses to rent licenses
- Former-employee interviews
- CMS surveys
- PI site visits to 57 Ensign facilities

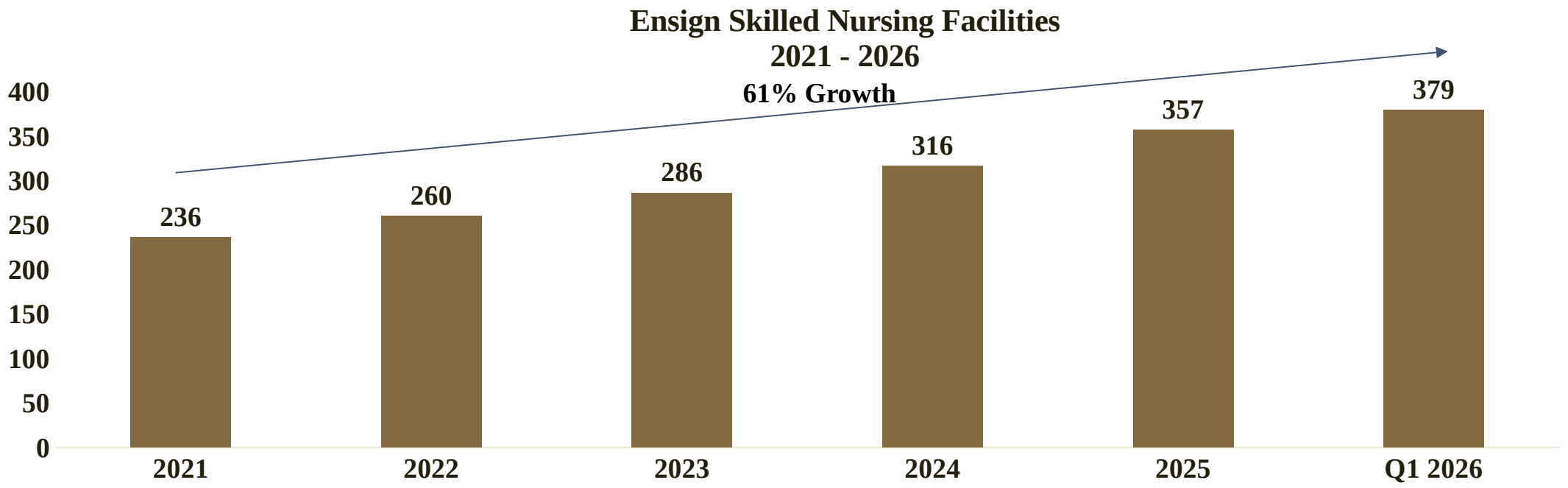
Potential Financial and Operational Impact

- ~20% of facilities are likely managed by unlicensed operators
- The scheme drives the M&A flywheel; absent it, deal pace falls from ~40 to ~7 acquisitions per year
- Significantly lower future EBIT growth
- ~$7B potential False Claims Act exposure

Sources: Ensign “license rental” contract; interviews with former employees; CMS Reports; PI site visits

Ensign Needed To “Rent” Licenses In Order To Grow Rapidly

Ensign’s model is straightforward: Acquire underperforming skilled nursing facilities and install its own Administrators to run them. From 2021 to 2026, Ensign grew SNF facilities at ~11% annually, while NHC grew only ~1.6% annually over the same period. PACS became public in 2024, and grew facilities from 314 to 321 from 2024 to 2025, or ~2.2%. Former employees described ~60% annual Administrator turnover at Ensign, with many terminated within their first year for failing to meet financial targets. This combination of rapid acquisition growth and high Administrator turnover created a challenge that required Ensign to rent licenses.



Note 1: Skilled Nursing Facilities include Skilled Nursing Operations and Campus Operations. Per Ensign 10-K disclosure. Campus Operations are facilities that offer both skilled nursing and senior living services and therefore generate SNF Medicare/Medicaid claims; stand-alone Senior Living Communities are excluded. Campus Operations grew from 22 (FY2021) to 33 (Q1 2026).
Note 2: PACS became public in April 2024, providing insufficient history for a five-year comparison. PACS grew from 314 facilities in 2024 to 321 facilities in 2025.
Sources: Ensign Group 10-K (FY2021–FY2025); Ensign Group Q1 2026 10-Q; National HealthCare Corporation 10-K (FY2021–FY2025); Interviews with former Ensign employees conducted from 2025 to 2026

How Ensign's "License Rental" Scheme Works

Step 1 Install an Unlicensed Operator	Step 2 Rent a License	Step 3 Activate the "Paper Administrator" for Inspections
Ensign acquires a building, fires the incumbent administrator, installs an unlicensed employee from its Administrator In Training (AIT) program, and assigns them the title of "Operations Manager," to run the skilled nursing facility's day-to-day operations	A cluster leader pays a licensed Administrator ~$2,000/month plus ~$600 per visit to hang their license over the building. This "Paper Administrator" typically holds another job outside skilled nursing and has no role in actual facility operations.	When CMS or a state regulator arrives, the Operations Manager calls the Paper Administrator, who rushes to the facility and presents themselves to inspectors as the Administrator responsible for operations, concealing that an unlicensed employee is running the facility's day-to-day operations.

"The first call that [the Ops Manager] is making is to [the person whose license is on the building] saying, 'Hey, state just showed up,' and that person is dropping whatever he or she is doing and hightailing it to the building to say, 'Hey, I'm the Administrator here…' and they kind of put on a show of, 'I'm the Administrator of record here,' and usually the state doesn't dig into that too much."

Former Ensign Administrator

Sources: Interviews with former Ensign employees conducted from 2025 to 2026

Federal Law Requires the Administrator To Be Licensed & Actually Manage the Facility

To participate in and bill Medicare and Medicaid, which account for ~69% of Ensign's total service revenue, a skilled nursing facility must have an Administrator who:

1. Is licensed by the state
2. Is responsible for management of the facility; AND
3. Reports to and is accountable to the governing body.

Ensign's scheme appears to violate requirements #1 and #2 in an estimated ~20% of facilities: The person actually running the facility is not licensed by the state (#1), and the licensed individual on record does not manage it (#2). Certifying compliance in order to bill Medicare and Medicaid while failing to meet these requirements potentially renders each claim false under the False Claims Act.

The controlling question is federal, not state. The number of hours an administrator works, and other state-specific licensure rules, are not the standard at issue; the federal condition of participation is. Where an unlicensed operator performs the Administrator's core management functions while the licensed Administrator's role is nominal, the Administrator is not "responsible for management of the facility" as federal law requires. And where CMS surveyors observe exactly that, they document it under F0837, as they have at the facilities shown in Proof Point 3.

Federal Regulation: 42 CFR § 483.70(d)(2)

(2) The governing body appoints the administrator who is—

(i) Licensed by the State, where licensing is required;

(ii) Responsible for management of the facility; and

(iii) Reports to and is accountable to the governing body.

Ensign's Scheme Appears to Violate Requirements #1 and #2.

- **Day to Day Operations:** Operational decisions are made by an unlicensed Operations Manager, not the Administrator whose license is being rented.
- **Critical Responsibilities**: The unlicensed operator controls nurse and therapist staffing, labor budgeting, and resident-safety oversight, the functions that define management of the facility, and the same decisions that drive the labor and cost outcomes at the center of this report.
- **"Responsible for Management":** is a federal standard that CMS enforces through its survey process. Across 2023–2024, CMS cited four Ensign facilities under Tag F0837: in each, surveyors determined the facility failed to have an administrator who was both licensed and responsible for management of the facility. (See Proof Point 3.)

Sources: Ensign Q1 2026 10-Q (Revenue by Payor); Interviews with former Ensign employees conducted from 2025 to 2026; 42 CFR Part 483, Subpart B; 42 CFR § 483.70(d)(2); CMS Appendix PP

Ensign's License Rental Scheme Appears to Create Direct False Claims Act Exposure

Under federal law, a skilled nursing facility must have a state-licensed Administrator actively managing operations to participate in and bill Medicare and Medicaid, which account for ~69% of Ensign's total service revenue. Facilities that are non-compliant are not eligible for reimbursement, and knowingly billing federal programs while out of compliance can trigger liability under the False Claims Act. We believe Ensign's practice of knowingly renting Administrator licenses seemingly to create the appearance of compliance could constitute knowingly using a false record or statement material to a false or fraudulent claim under 31 U.S.C. § 3729(a)(1)(B).

Statutory Authority (Congress): Establishes Conditions of Participation for skilled nursing facilities.

- **42 U.S.C. § 1396r and 42 U.S.C. § 1395i-3:** Establishes Medicaid and Medicare Conditions of Participation for skilled nursing facilities

Regulatory Requirement (HHS/CMS): Establishes the Administrator must be responsible for and manage the facility's operations, not merely listed on paper.

- **42 CFR Part 483, Subpart B:** Conditions of Participation for Long-Term Care Facilities.
- **42 CFR § 483.70(d)(2):** Requires the governing body to appoint a State-licensed Administrator responsible for facility management

CMS Administrative Enforcement: Governs survey, certification, and enforcement procedures for noncompliance with Conditions of Participation.

- **42 CFR Part 488:** Establishes civil monetary penalties, denial of payment, and termination from the Medicare and Medicaid programs.

False Claims Act Liability: Imposes civil liability for knowingly submitting false or fraudulent claims for payment to the United States.

- **31 U.S.C. § 3729(a)(1)(A)–(B)):** Prohibits knowingly submitting a false or fraudulent claim for payment to the government, as well as knowingly making or using a false record or statement that is material to such a claim. Provides for treble damages and statutory civil penalties, adjusted for inflation.

42 CFR § 483.70(d)(2)

(2) The governing body appoints the administrator who is—

(i) Licensed by the State, where licensing is required;

(ii) Responsible for management of the facility; and

(iii) Reports to and is accountable to the governing body.

31 U.S.C. § 3729(a)(1)(A)–(B)

(a) LIABILITY FOR CERTAIN ACTS.—

(1) IN GENERAL.—Subject to paragraph (2), any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

31 U.S.C. § 3729(a)(1)(g)

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410[1]), plus 3 times the amount of damages which the Government sustains because of the act of that person.

Sources: Ensign Group Q1 2026 10-Q; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3; 42 CFR Part 483, Subpart B; 42 CFR § 483.70(d)(2); 42 CFR Part 488; 31 U.S.C. § 3729(a)(1)(A)–(B))

Ensign's "Vote Off the Island" Culture Creates a Constant Need for Rented Licenses

The license-rental scheme is not just present at new acquisitions; it is also present at legacy facilities. Ensign generally does not hire experienced Administrators, preferring instead to rely on its internal Administrator-in-Training (AIT) pipeline. At the same time, Ensign's compensation and incentive structure continuously churns Administrators out of the system. Former employees described ~60–65% annual Administrator turnover at Ensign, driven by aggressive financial targets and a profit-sharing system that financially rewards Administrators for removing underperforming peers.

Administrators earn 10–15% of facility-level EBIT and also participate in a four-building cluster profit-sharing pool. An underperforming Administrator hurts peers twice: weak building performance reduces cluster-level payouts for all Administrators, while losses can trigger clawbacks that reduce compensation even for Administrators running their own buildings successfully. In effect, one poor performer directly reduces the compensation of multiple peers.

Former employees described this dynamic as a "vote off the island" culture in which Administrators “vote out” underperforming Administrators who are hurting the clusters bonus. This culture of "voting peers off the island" appears unique to Ensign and was not described to us by former employees of PACS, Cottonwood, or Brookdale. The result is high Administrator turnover and a constant need for replacement Administrators across Ensign's portfolio.

The same economics also explain why Ensign does not retain a licensed Administrator while training an unlicensed replacement. Doing so would dilute both building-level and cluster-level profit sharing while the incumbent Administrator is already underperforming. Combined with Ensign's reliance on unlicensed AITs rather than experienced outside hires, this creates an ongoing need for rented licenses.

“On average, they would receive about 10% based on profit, and their stretch goals were more like 15%... and usually it'd be another 10% [at the cluster level] on top of that 15%, so ***they could essentially take home 25% of profit sharing.***

Former Assistant Vice President of HR

“If they had one building in that cluster that just fell apart… the cluster would also have a negative hit. So ***if they had a building in their cluster that was struggling, those other administrators, even if their own buildings were doing well, their incentive would have a deduction*** *because of the results of that other building.”*

Former Assistant Vice President of HR

Sources: Interviews with former Ensign employees conducted from 2025 to 2026

Former DOJ Prosecutor and OIG Special Agent Believe Actions Could Constitute Fraud

We separately spoke with two former senior federal healthcare fraud enforcement officials regarding a hypothetical fact pattern mirroring Ensign's alleged administrator "license-rental" structure. The first was a former HHS-OIG Special Agent with 25 years investigating healthcare fraud. The second was a former DOJ Assistant U.S. Attorney with 31 years of federal experience, including 12 years prosecuting False Claims Act cases.

Both independently concluded the conduct described could constitute healthcare and False Claims Act violations because maintaining a functioning licensed Administrator is a material condition of participation in Medicare and Medicaid. In their view, the Administrator is the individual ultimately responsible for regulatory compliance, resident safety, staffing adequacy, and quality of care within the facility. After hearing the hypothetical mirroring Ensign, the Special Agent immediately listed the statutes he would have charged them with violating: 31 U.S.C. §3729, 18 U.S.C. §1347, 18 U.S.C. §1035, and 18 U.S.C. §1516.

Both experts further stated that claims submitted during periods of knowing noncompliance could potentially constitute false claims under the implied certification framework established in *Universal Health Services v. Escobar*. They also stated that evidence suggesting efforts to conceal the true operating structure, while continuing to bill federal healthcare programs, could support allegations of intentional fraud rather than negligence or administrative oversight.

*"**In Escobar, the Supreme court found that yes, there is such a thing as an implied false certification or a false implied certification**. And that it can be a basis for recovery. And so far that **sounds like what we have here**."*

Former Assistant U.S. Attorney, Department of Justice

*"Not only [would it be] a false certification, but [if] **there's actually further attempts to hide this, which [would] really show[s] an intent to defraud** rather than just mere negligence or oversight."*

Former Assistant U.S. Attorney, Department of Justice

*"[If] they put in writing that Joe Blow is the administrator, and we got direct proof that Joe Blow isn't. Oh, and **we got Joe Blow's bank records showing these $2,000 monthly payments to him and not any regular compensation that would marry up to a W-2 wage employee or a 1099… There's your case, man. There's your case**."*

Former Special Agent at HHS OIG responding to our hypothetical

Note: Former AUSA reaction based on a hypothetical fact pattern. No regulatory finding has been made.
Sources: Call with former DOJ AUSA, February 2026; Call with former HHS-OIG Special Agent, February 2026

Four Independent Evidence Sources Corroborate Ensign's License Rental Scheme

We identified four independent evidence sources supporting the existence of an Administrator license rental structure across Ensign facilities: (i) a copy of the contract Ensign apparently uses to arrange Administrator license rentals while unlicensed operators run day-to-day facility operations, (ii) interviews with former Ensign employees across multiple states and roles, (iii) CMS survey reports documenting unlicensed operators running facilities, and (iv) unannounced private investigator site visits conducted across 15% of all Ensign facilities in eight states.

Taken together, we believe this evidence makes clear these practices are systematic and widespread, rather than isolated.

1. The Contract

- $2K per month plus $600 per site visit
- Contract pays ~$24K for the year
- PACS pays full-time Administrators $120K–$140K annually

2. Employee Interviews

- 16 former employees interviewed
- Employees worked across nine states
- Multiple roles corroborated same scheme

3. CMS Reports

- Four CMS reports documented unlicensed operators
- Unlicensed Ops Managers admitted running facilities
- Licensed Administrators absent or off-site

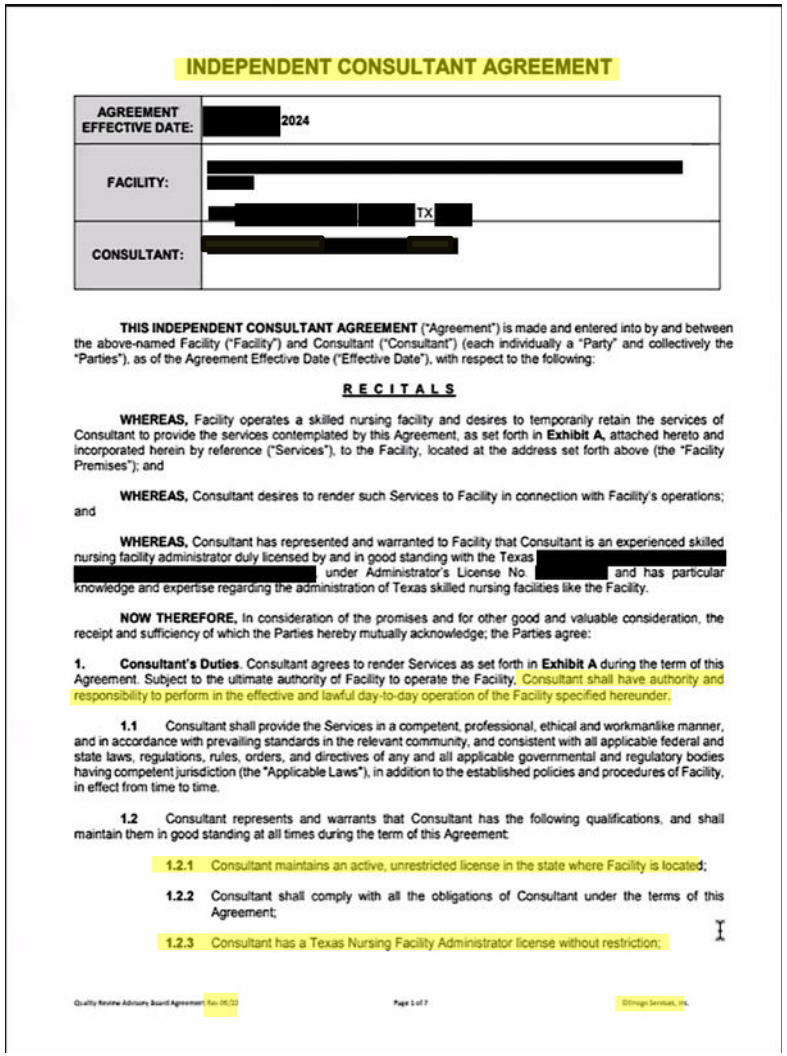
4. P.I. Site Visits

- 57 unannounced site visits conducted
- Eight states visited across ~15% of ENSG facilities
- 21% of facilities exhibited red flags consistent with license rental arrangements

Sources: Ensign contract; interviews with former employees; CMS Reports; P.I site visits

Proof Point 1:

The Contract Ensign Apparently Uses To Arrange Administrator License Rentals



INDEPENDENT CONSULTANT AGREEMENT

AGREEMENT EFFECTIVE DATE:	[redacted] 2024
FACILITY:	[redacted] TX [redacted]
CONSULTANT:	[redacted]

THIS INDEPENDENT CONSULTANT AGREEMENT ("Agreement") is made and entered into by and between the above-named Facility ("Facility") and Consultant ("Consultant") (each individually a "Party" and collectively the "Parties"), as of the Agreement Effective Date ("Effective Date"), with respect to the following:

RECITALS

WHEREAS, Facility operates a skilled nursing facility and desires to temporarily retain the services of Consultant to provide the services contemplated by this Agreement, as set forth in **Exhibit A**, attached hereto and incorporated herein by reference ("Services"), to the Facility, located at the address set forth above (the "Facility Premises"); and

WHEREAS, Consultant desires to render such Services to Facility in connection with Facility's operations; and

WHEREAS, Consultant has represented and warranted to Facility that Consultant is an experienced skilled nursing facility administrator duly licensed by and in good standing with the Texas [redacted] under Administrator's License No. [redacted] and has particular knowledge and expertise regarding the administration of Texas skilled nursing facilities like the Facility.

NOW THEREFORE, In consideration of the promises and for other good and valuable consideration, the receipt and sufficiency of which the Parties hereby mutually acknowledge; the Parties agree:

1. **Consultant's Duties**. Consultant agrees to render Services as set forth in **Exhibit A** during the term of this Agreement. Subject to the ultimate authority of Facility to operate the Facility, Consultant shall have authority and responsibility to perform in the effective and lawful day-to-day operation of the Facility specified hereunder.

1.1 Consultant shall provide the Services in a competent, professional, ethical and workmanlike manner, and in accordance with prevailing standards in the relevant community, and consistent with all applicable federal and state laws, regulations, rules, orders, and directives of any and all applicable governmental and regulatory bodies having competent jurisdiction (the "Applicable Laws"), in addition to the established policies and procedures of Facility, in effect from time to time.

1.2 Consultant represents and warrants that Consultant has the following qualifications, and shall maintain them in good standing at all times during the term of this Agreement:

1.2.1 Consultant maintains an active, unrestricted license in the state where Facility is located;

1.2.2 Consultant shall comply with all the obligations of Consultant under the terms of this Agreement;

1.2.3 Consultant has a Texas Nursing Facility Administrator license without restriction;

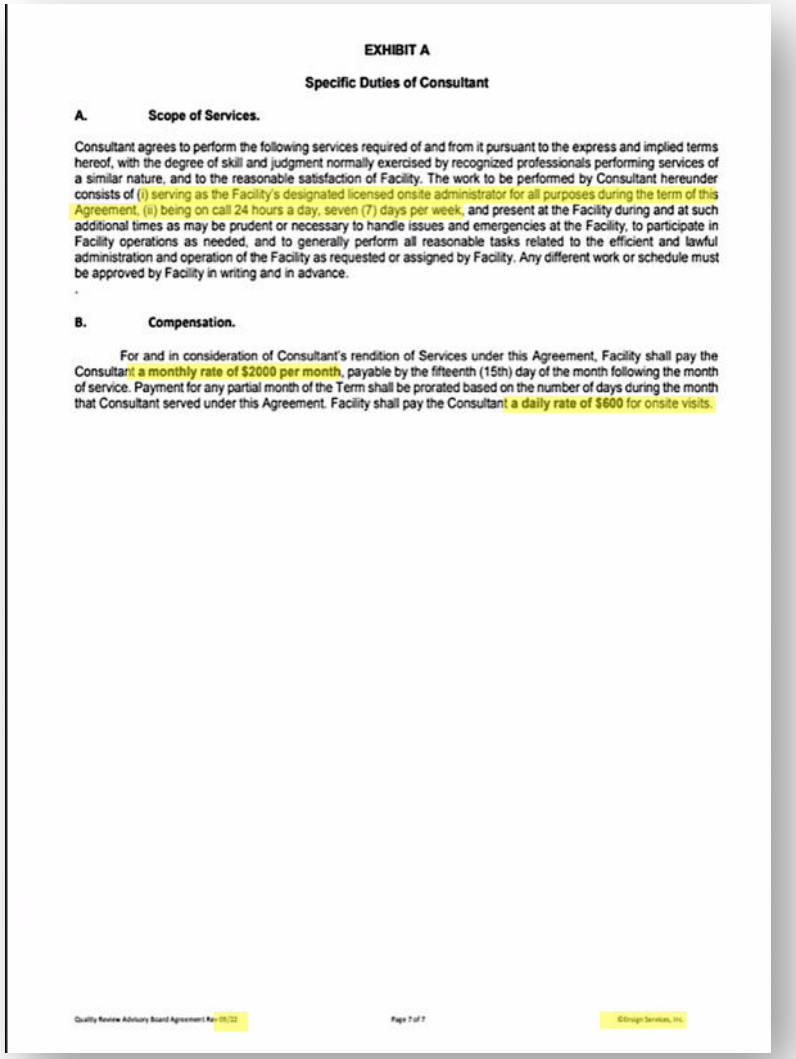


EXHIBIT A

Specific Duties of Consultant

A. Scope of Services.

Consultant agrees to perform the following services required of and from it pursuant to the express and implied terms hereof, with the degree of skill and judgment normally exercised by recognized professionals performing services of a similar nature, and to the reasonable satisfaction of Facility. The work to be performed by Consultant hereunder consists of (i) serving as the Facility's designated licensed onsite administrator for all purposes during the term of this Agreement, (ii) being on call 24 hours a day, seven (7) days per week, and present at the Facility during and at such additional times as may be prudent or necessary to handle issues and emergencies at the Facility, to participate in Facility operations as needed, and to generally perform all reasonable tasks related to the efficient and lawful administration and operation of the Facility as requested or assigned by Facility. Any different work or schedule must be approved by Facility in writing and in advance.

B. Compensation.

For and in consideration of Consultant's rendition of Services under this Agreement, Facility shall pay the Consultant a monthly rate of $2000 per month, payable by the fifteenth (15th) day of the month following the month of service. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. Facility shall pay the Consultant a daily rate of $600 for onsite visits.

Contract Overview

- **Contract Structure:** Titled as a consulting engagement, not an employment contract; an Administrator is usually a salaried employee.
- **$2,000 Monthly Retainer:** Fixed monthly payment paid regardless of services rendered or hours worked, distinct from typical Administrator salary structure.
- **$600 Per On-Site Day:** Per-visit compensation; a structure suited to episodic engagement rather than continuous facility management.
- **Ensign Services Template:** Drafted on Ensign Services, Inc. letterhead with revision number ("Rev 08/22") at footer, indicating a version-controlled corporate template used across facilities.
- **No Preceptor Role:** Acting as a preceptor to an AIT appears not to be contemplated by the agreement.

Proof Point 1:

PACS Pays Real Administrators $140K; Ensign's License Rental Pays $24K

The contract Ensign apparently uses to arrange Administrator license rentals pays just $2,000 per month ($24K annually), plus $600 per facility visit. It seems unreasonable that a licensed nursing home Administrator legally responsible for managing a skilled nursing facility would work on-site full-time for $24K per year. By comparison, PACS publicly advertises Administrator salaries of $120K–$140K annually for real full-time Administrators.

EXHIBIT A

Specific Duties of Consultant

A. Scope of Services.

Consultant agrees to perform the following services required of and from it pursuant to the express and implied terms hereof, with the degree of skill and judgment normally exercised by recognized professionals performing services of a similar nature, and to the reasonable satisfaction of Facility. The work to be performed by Consultant hereunder consists of (i) serving as the Facility's designated licensed onsite administrator for all purposes during the term of this Agreement, (ii) being on call 24 hours a day, seven (7) days per week, and present at the Facility during and at such additional times as may be prudent or necessary to handle issues and emergencies at the Facility, to participate in Facility operations as needed, and to generally perform all reasonable tasks related to the efficient and lawful administration and operation of the Facility as requested or assigned by Facility. Any different work or schedule must be approved by Facility in writing and in advance.

B. Compensation.

For and in consideration of Consultant's rendition of Services under this Agreement, Facility shall pay the Consultant a monthly rate of $2000 per month, payable by the fifteenth (15th) day of the month following the month of service. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. Facility shall pay the Consultant a daily rate of $600 for onsite visits.

Administrator

Apply

Ability to apply concepts such as fractions, percentages, ratios and proportions to practical situations.

Reasoning Ability
Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

Certificates, Licenses, Registrations
To perform this job successfully, an individual must be proficient in the Microsoft Suite products.
Must maintain licensing credentials for an Administrator.

Physical Demands
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
The employee must occasionally lift and/or move up to 25 pounds. Prolonged use of a desk top or laptop computer. While performing the duties of this job, the employee is regularly required to sit, stand; walk and talk, read or hear. Frequent use of all office related equipment to include; copier/scanner/fax, telephone, and calculator.
Travel by auto or airline will be required.

Work Environment
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
The noise level in the work environment is usually low to moderate.

Salary Range: $120,000 - $140,000 annual

Additional Information
Note: Nothing in this job specification restricts management's right to assign or reassign duties and responsibilities to this job at any time. Critical features of this job are described under various headings above. They may be subject to change at any time due to reasonable accommodation or other reasons. The above statements are strictly intended to describe the general nature and level of the work being performed. They are not intended to be construed as a complete list of all responsibilities, duties, and skills required of employees in this position.

PACS is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, protected veteran status, or any other legally protected status.

Sources: Screenshot of PACS job posting from PACS website on May 15, 2026. Job Application hyperlinked here

Proof Point 2:
Interviews with Former Ensign Employees

We spoke with eight former Ensign employees who were either Administrators or Office Managers and worked at the company between 2008 and 2025; all of them left between 2019 and 2025, with most leaving in 2024 and 2025. Interviewees stated the Administrator license rental scheme is present in at least nine states, including TX, CA, UT, AZ, ID, KS, IA, CO and NV. One former employee stated the practice also extends to Ensign's ancillary businesses, including dialysis and mobile X-ray services, which require separate licenses. Former employees said the scheme was deliberate to deceive regulators; when CMS showed up or an inspection was scheduled, the Operations Manager actually running the facility would text the person whose license hung on the wall so they could come in purport to be the licensed Administrator running day-to-day operations, creating the appearance of compliance. The quotes below are a sample of interviews with three former employees.

*"**I saw firsthand the fake licenses being hung up on the wall in Utah, Arizona, California, and Idaho**. Ensign would use an AIT [Ops Manager] to run the place and someone else's license over the building."*

Former Ensign Business Manager

*"**My market leader told me to pay someone $3K a month plus $400 per visit to hang their license on the wall so I could run the building**. It turned out that person was his own father-in-law. When I tried to push back, the market leader shut me down."*

Former Ensign Administrator

*"It's not just the facilities, **Ensign has ancillary** businesses like Dialysis, X-Ray, and pharmacy, those need a separate license…**they use someone else's license there too."***

Former Ensign Business Manager

*"**He wasn't even an Ensign employee; I'd just call him when the state was coming."***

Former Ensign Administrator

*"**My Cluster leader told me, 'I have my uncle who can put the license on the building.'"***

Former Ensign Administrator

*"In my building we paid a guy $2K a month just to hang his license on the wall, **he never set foot in the building**."*

Former Ensign Administrator

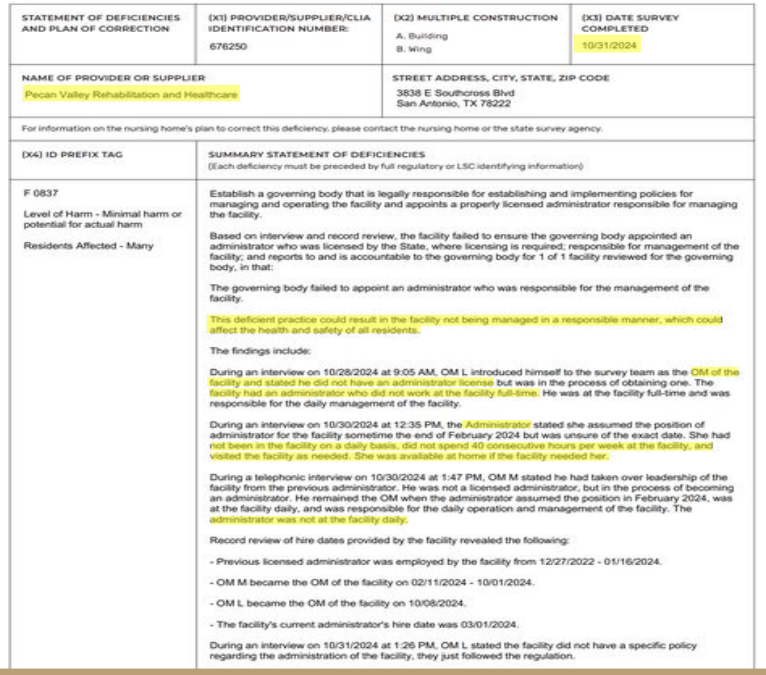
*"Probably **one in four facilities** are doing this license rental agreement today in Texas."*

Former Ensign Administrator

Sources: Interviews with former Ensign employees 2025 to 2026

Proof Point 3: CMS Surveys (1/2)

CMS conducts routine site inspections at skilled nursing facilities and over the past two years, four separate Ensign facilities were documented for unlicensed personnel managing day-to-day operations while licensed Administrators were absent and not actively managing the facility. CMS does not have prosecutorial authority; enforcement authority rests with HHS OIG and the Department of Justice. After speaking with a Former Deputy Director of CMS's Center for Clinical Standards and Quality, we were told that because these facilities operate under separate local names without Ensign branding, surveyors cannot easily identify the broader pattern. The four reports below are publicly available in the CMS database but are effectively buried within millions of pages of survey records.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676250	A. Building B. Wing	10/31/2024

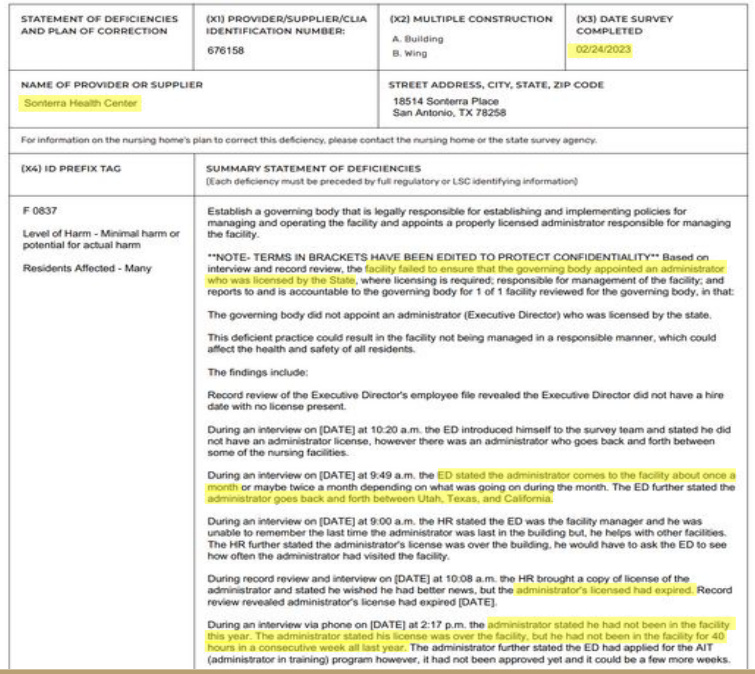
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Valley Rehabilitation and Healthcare	3838 E Southcross Blvd San Antonio, TX 78222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and record review, the facility failed to ensure the governing body appointed an administrator who was licensed by the State, where licensing is required; responsible for management of the facility; and reports to and is accountable to the governing body for 1 of 1 facility reviewed for the governing body, in that: The governing body failed to appoint an administrator who was responsible for the management of the facility. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. The findings include: During an interview on 10/28/2024 at 9:05 AM, OM L introduced himself to the survey team as the OM of the facility and stated he did not have an administrator license but was in the process of obtaining one. The facility had an administrator who did not work at the facility full-time. He was at the facility full-time and was responsible for the daily management of the facility. During an interview on 10/30/2024 at 12:35 PM, the Administrator stated she assumed the position of administrator for the facility sometime the end of February 2024 but was unsure of the exact date. She had not been in the facility on a daily basis, did not spend 40 consecutive hours per week at the facility, and visited the facility as needed. She was available at home if the facility needed her. During a telephonic interview on 10/30/2024 at 1:47 PM, OM M stated he had taken over leadership of the facility from the previous administrator. He was not a licensed administrator, but in the process of becoming an administrator. He remained the OM when the administrator assumed the position in February 2024, was at the facility daily, and was responsible for the daily operation and management of the facility. The administrator was not at the facility daily. Record review of hire dates provided by the facility revealed the following: - Previous licensed administrator was employed by the facility from 12/27/2022 - 01/16/2024. - OM M became the OM of the facility on 02/11/2024 - 10/01/2024. - OM L became the OM of the facility on 10/08/2024. - The facility's current administrator's hire date was 03/01/2024. During an interview on 10/31/2024 at 1:26 PM, OM L stated the facility did not have a specific policy regarding the administration of the facility, they just followed the regulation.

Report date and link: October 31, 2024

- Ops Manager admitted to running facility's day-to-day operations
- Licensed Administrator admitted she was **not on site daily and was "available" from home**



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676158	A. Building B. Wing	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sonterra Health Center	18514 Sonterra Place San Antonio, TX 78258

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the governing body appointed an administrator who was licensed by the State, where licensing is required; responsible for management of the facility; and reports to and is accountable to the governing body for 1 of 1 facility reviewed for the governing body, in that: The governing body did not appoint an administrator (Executive Director) who was licensed by the state. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. The findings include: Record review of the Executive Director's employee file revealed the Executive Director did not have a hire date with no license present. During an interview on [DATE] at 10:20 a.m. the ED introduced himself to the survey team and stated he did not have an administrator license, however there was an administrator who goes back and forth between some of the nursing facilities. During an interview on [DATE] at 9:49 a.m. the ED stated the administrator comes to the facility about once a month or maybe twice a month depending on what was going on during the month. The ED further stated the administrator goes back and forth between Utah, Texas, and California. During an interview on [DATE] at 9:00 a.m. the HR stated the ED was the facility manager and he was unable to remember the last time the administrator was last in the building but, he helps with other facilities. The HR further stated the administrator's license was over the building, he would have to ask the ED to see how often the administrator had visited the facility. During record review and interview on [DATE] at 10:08 a.m. the HR brought a copy of license of the administrator and stated he wished he had better news, but the administrator's licensed had expired. Record review revealed administrator's license had expired [DATE]. During an interview via phone on [DATE] at 2:17 p.m. the administrator stated he had not been in the facility this year. The administrator stated his license was over the facility, but he had not been in the facility for 40 hours in a consecutive week all last year. The administrator further stated the ED had applied for the AIT (administrator in training) program however, it had not been approved yet and it could be a few more weeks.

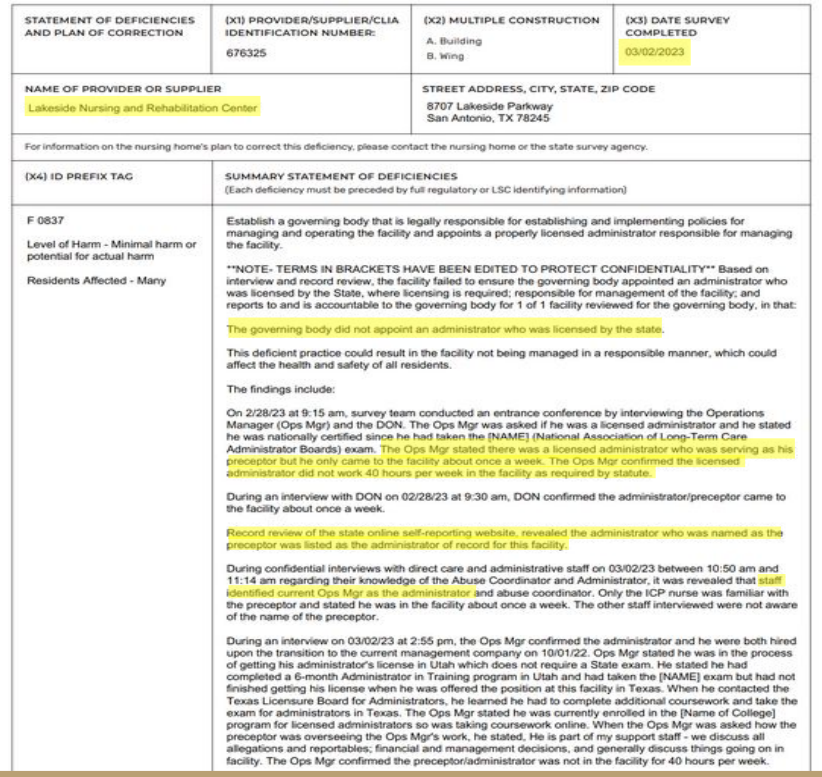
Report date and link: February 24, 2023

- Executive Director managed facility day-to-day operations
- **Administrator worked across facilities in Texas, Utah, and California**; admitted he was not at facility at any point in that year

Sources: CMS Surveys 2023 to 2024; Interview with Former Deputy Director, CMS Center for Clinical Standards and Quality

Proof Point 3: CMS Surveys (2/2)

CMS surveys continued from previous page, showing the same Administrator license rental pattern at two additional facilities. Across all four facilities, CMS surveyors independently identified an unlicensed Operations Manager running daily operations while a licensed Administrator appeared sporadically, if at all.



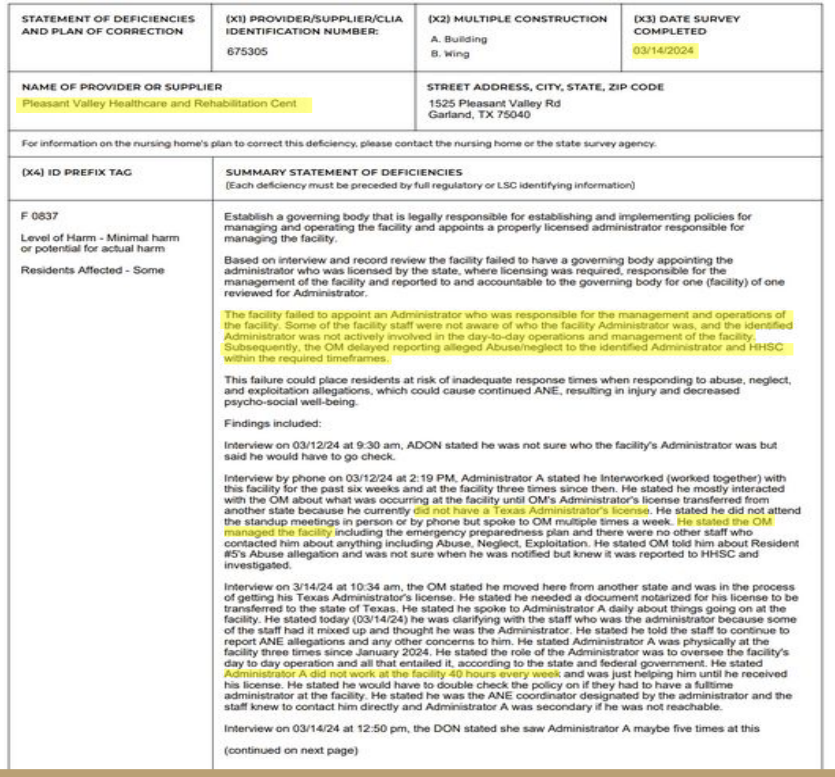
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676325	A. Building B. Wing	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Nursing and Rehabilitation Center	8707 Lakeside Parkway San Antonio, TX 78245

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the governing body appointed an administrator who was licensed by the State, where licensing is required; responsible for management of the facility; and reports to and is accountable to the governing body for 1 of 1 facility reviewed for the governing body, in that: The governing body did not appoint an administrator who was licensed by the state. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. The findings include: On 2/28/23 at 9:15 am, survey team conducted an entrance conference by interviewing the Operations Manager (Ops Mgr) and the DON. The Ops Mgr was asked if he was a licensed administrator and he stated he was nationally certified since he had taken the [NAME] (National Association of Long-Term Care Administrator Boards) exam. The Ops Mgr stated there was a licensed administrator who was serving as his preceptor but he only came to the facility about once a week. The Ops Mgr confirmed the licensed administrator did not work 40 hours per week in the facility as required by statute. During an interview with DON on 02/28/23 at 9:30 am, DON confirmed the administrator/preceptor came to the facility about once a week. Record review of the state online self-reporting website, revealed the administrator who was named as the preceptor was listed as the administrator of record for this facility. During confidential interviews with direct care and administrative staff on 03/02/23 between 10:50 am and 11:14 am regarding their knowledge of the Abuse Coordinator and Administrator, it was revealed that staff identified current Ops Mgr as the administrator and abuse coordinator. Only the ICP nurse was familiar with the preceptor and stated he was in the facility about once a week. The other staff interviewed were not aware of the name of the preceptor. During an interview on 03/02/23 at 2:55 pm, the Ops Mgr confirmed the administrator and he were both hired upon the transition to the current management company on 10/01/22. Ops Mgr stated he was in the process of getting his administrator's license in Utah which does not require a State exam. He stated he had completed a 6-month Administrator in Training program in Utah and had taken the [NAME] exam but had not finished getting his license when he was offered the position at this facility in Texas. When he contacted the Texas Licensure Board for Administrators, he learned he had to complete additional coursework and take the exam for administrators in Texas. The Ops Mgr stated he was currently enrolled in the [Name of College] program for licensed administrators so was taking coursework online. When the Ops Mgr was asked how the preceptor was overseeing the Ops Mgr's work, he stated, He is part of my support staff - we discuss all allegations and reportables; financial and management decisions, and generally discuss things going on in facility. The Ops Mgr confirmed the preceptor/administrator was not in the facility for 40 hours per week.

Report date and link: March 2, 2023
- Staff **identified Ops Manager** as Administrator
- Ops Manager **admitted Administrator did not work 40 hours per week** and was present **~1 day per week**



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675305	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Healthcare and Rehabilitation Cent	1525 Pleasant Valley Rd Garland, TX 75040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and record review the facility failed to have a governing body appointing the administrator who was licensed by the state, where licensing was required, responsible for the management of the facility and reported to and accountable to the governing body for one (facility) of one reviewed for Administrator. The facility failed to appoint an Administrator who was responsible for the management and operations of the facility. Some of the facility staff were not aware of who the facility Administrator was, and the identified Administrator was not actively involved in the day-to-day operations and management of the facility. Subsequently, the OM delayed reporting alleged Abuse/neglect to the identified Administrator and HHSC within the required timeframes. This failure could place residents at risk of inadequate response times when responding to abuse, neglect, and exploitation allegations, which could cause continued ANE, resulting in injury and decreased psycho-social well-being. Findings included: Interview on 03/12/24 at 9:30 am, ADON stated he was not sure who the facility's Administrator was but said he would have to go check. Interview by phone on 03/12/24 at 2:19 PM, Administrator A stated he Interworked (worked together) with this facility for the past six weeks and at the facility three times since then. He stated he mostly interacted with the OM about what was occurring at the facility until OM's Administrator's license transferred from another state because he currently did not have a Texas Administrator's license. He stated he did not attend the standup meetings in person or by phone but spoke to OM multiple times a week. He stated the OM managed the facility including the emergency preparedness plan and there were no other staff who contacted him about anything including Abuse, Neglect, Exploitation. He stated OM told him about Resident #5's Abuse allegation and was not sure when he was notified but knew it was reported to HHSC and investigated. Interview on 3/14/24 at 10:34 am, the OM stated he moved here from another state and was in the process of getting his Texas Administrator's license. He stated he needed a document notarized for his license to be transferred to the state of Texas. He stated he spoke to Administrator A daily about things going on at the facility. He stated today (03/14/24) he was clarifying with the staff who was the administrator because some of the staff had it mixed up and thought he was the Administrator. He stated he told the staff to continue to report ANE allegations and any other concerns to him. He stated Administrator A was physically at the facility three times since January 2024. He stated the role of the Administrator was to oversee the facility's day to day operation and all that entailed it, according to the state and federal government. He stated Administrator A did not work at the facility 40 hours every week and was just helping him until he received his license. He stated he would have to double check the policy on if they had to have a fulltime administrator at the facility. He stated he was the ANE coordinator designated by the administrator and the staff knew to contact him directly and Administrator A was secondary if he was not reachable. Interview on 03/14/24 at 12:50 pm, the DON stated she saw Administrator A maybe five times at this (continued on next page)

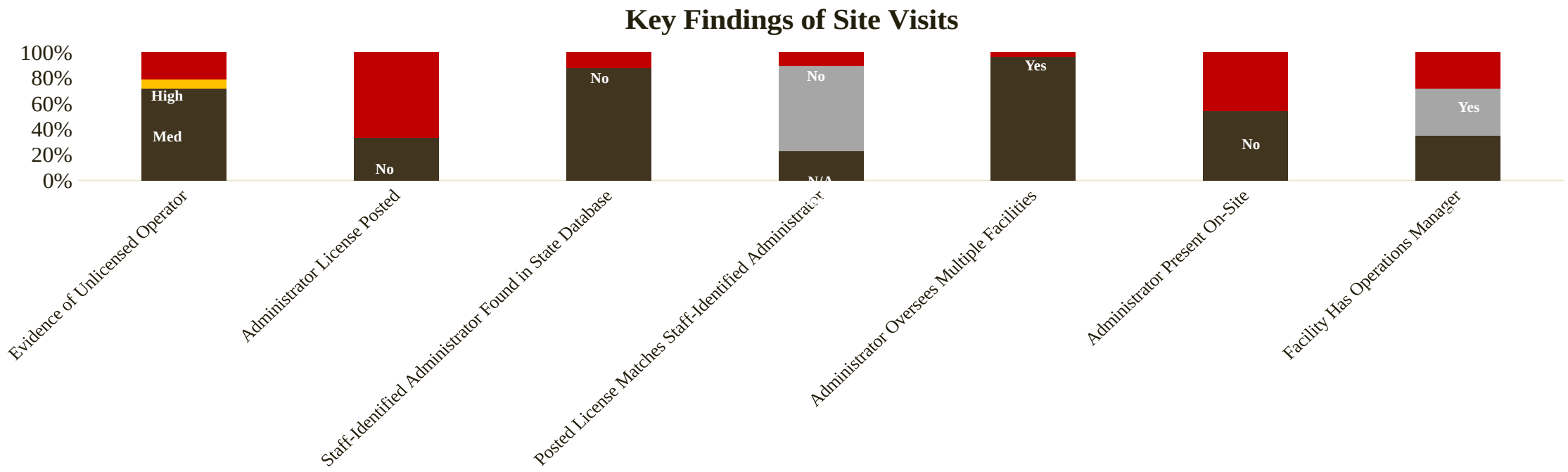
Report date and link: March 14, 2024
- Ops Manager ran the facility's day-to-day operations
- Ops Manager failed to timely report alleged sexual abuse, illustrating the **resident-safety consequences when an unlicensed person manages a facility**

Sources: CMS Surveys 2023 to 2024; Interview with Former Deputy Director, CMS Center for Clinical Standards and Quality

Proof Point 4: Site Visits Conducted by Private Investigators

We retained an independent private investigator team to conduct 57 unannounced site visits across eight states (AZ, CA, IA, ID, KS, NV, TX, and UT), representing ~15% of all Ensign facilities. Former Ensign employees told us the specific red flags to assess whether a facility was engaging in a license rental scheme, including: (i) a mismatch between the individual identified by staff as the Administrator and the name on the posted license, (ii) the presence of an operations manager or AIT at the facility, and (iii) Administrators overseeing multiple facilities.

We believe 21% of facilities visited are likely being operated by individuals who do not hold an active Administrator license; these facilities span seven states (KS did not have any red flags). The following slides present screenshots from the private investigator team's findings at facilities we identified as likely engaging in this license rental scheme. A summary of the full site visit log are in Appendix 1.



Note: Staff-identified Administrator refers to the individual facility staff stated was the Administrator during unannounced site visit conducted by an independent investigator.

Proof Point 4: Private Investigator Visits Show Red Flags at 12 of 57 Facilities (1/4)

12 of 57 facilities visited by private investigators (21%) exhibited red flags consistent with administrator license rental arrangements. These 12 facilities span seven states; the pattern is not isolated. Staff identified Administrators who are unlicensed, who left the facility years ago, or who operate across multiple facilities in violation of state law. Below are excerpts from those 12 private investigator site visit reports.

[redacted]

[redacted] AZ

[redacted]

[redacted] AZ, [redacted]

Upon entry, investigator observed a small waiting area and a reception desk. Investigator was taken on a tour by [redacted] Director of Admissions. The facility was clean and well maintained. Per Ms. [redacted] they will be undergoing some remodeling soon.

On the wall beyond the reception desk were the facility's licenses. Among them was a Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers with the name of [redacted] with an expiration date of [redacted] 2025.

However, according to Ms. [redacted] the facility Administrator is [redacted] who also serves as the Operations Manager. [redacted] is present at the facility Monday through Friday from 9am to 5pm., according to Ms. [redacted] She stated that they have not updated the administrator's license yet. Investigator was able to meet Mr. [redacted] while on site.

Later on, research of the Arizona Nursing Care Institution Administrators website did not identify a license for [redacted] in the database (see below).

Staff-identified Administrator does not have a license in state database

[redacted]

Address: [redacted] UT [redacted]
Phone: [redacted]

On [redacted] 2026, [redacted], investigator visited [redacted]

Investigator was directed to [redacted] admissions coordinator. [redacted] agreed to answer questions and provide a short tour of the facility.

The administrator license was not observed in the lobby or reception area during the visit.

[redacted] stated that the facility's Licensed Administrator was [redacted] Staff indicated that the administrator was not present during the visit. The administrator was not personally observed and no direct interaction occurred during the visit.

[redacted] said that the facility did not have a separate Operations Manager during the interaction but said the .

When asked whether the administrator splits time between multiple facilities, staff did not indicate that the administrator covers other facilities.

The Utah Department of Health & Human Services (DHHS) (https://dlbc.utah.gov/wp-content/uploads/Nursing_Homes.xlsx) listed the facility Administrator as [redacted]

The Utah Department of Professional Licensing listed [redacted] of [redacted] Utah, as a licensed Health Facility Administrator. He has been licensed since [redacted] 2019, and his license expires on [redacted] 2027. He has no discipline on his license. [redacted] is about [redacted] Utah.

Despite this, [redacted] profile [redacted] states that he left [redacted] in [redacted] After that, he worked at [redacted] Healthcare, an Ensign affiliate, until [redacted] Since [redacted] states that he is [redacted] of [redacted] a Nursing home in [redacted] Utah.

Staff identified Administrator who left facility three years ago

[redacted]

[redacted] Idaho

At [redacted] 2026, the investigator arrived at [redacted] located at [redacted] Idaho.

The investigator entered the facility and was greeted by the front desk staff and redirected to meet with [redacted] the community liaison. The investigator was told that the Administrator was temporarily unavailable but is normally on-site Monday through Friday. The administrator's office door was closed and appeared dark.

[redacted] provided the investigator with a tour of the entire facility, where the investigator noted the facility appeared above average in cleanliness, and no obvious red flags were found throughout the tour of the facility.

The investigator did not locate the Administrator's License or Facility license during the tour of the facility.

Staff later provided the name of the facility Administrator as [redacted] According to the Idaho Department of Professional Licenses (DOPL), neither [redacted] (or anyone else named [redacted] is a licensed Nursing Home Administrator in Idaho. https://edopl.idaho.gov/OnlineServices/_/#7

According to the Idaho Department of Health and Welfare, Division of Licensing, as of [redacted] 2025, the Administrator was [redacted] (See attached Letter) According to the DOPL, [redacted] has an active Nursing Home Administrator License [redacted] that expires on [redacted] 2026.

[redacted] profile [redacted] listed him as the Executive Director of [redacted] to the present.

Staff-identified Administrator does not have a license in state database

Note: Summary of the visit log of all 57 facilities can be found in Appendix 1, **Sources:** Private Investigator Site Visits for 57 Ensign locations in 2026

Proof Point 4: Private Investigator Visits Show Red Flags at 12 of 57 Facilities (2/4)

12 of 57 facilities visited by private investigators (21%) exhibited red flags consistent with administrator license rental arrangements. These 12 facilities span 7 states; the pattern is not isolated. Staff identified Administrators who are unlicensed, who left the facility years ago, or who operate across multiple facilities in violation of state law. Below are excerpts from those 12 private investigator site visit reports.

[redacted] 2026 [redacted]
[redacted] Center: [redacted] TX [redacted]

The investigator entered the facility and spoke with the receptionist who called an admissions counselor to give a tour. The investigator asked about the facility Administrator and was told that his name is [redacted] The tour guide stated he was not currently there, but he is there most days during working hours. She said sometimes he helps out at other rehab facilities but was vague about what these were. The investigator photographed numerous licenses/postings in the facility, but did not locate anything with Mr. [redacted] name. There was a printed paper hung in one of the glass cases that said:

"Licensed Nursing Facility Administrator
For Information regarding the Administrator
Contact DADS 512-231-5825"

The investigator called this number, but the line was disconnected. After research, the investigator discovered that DADS was abolished As of September 1, 2017, the Texas Department of Aging and Disability Services (DADS) was abolished. While many services available via DADS transitioned to the Department of Health and Human Services (HHS), the SAIL program was discontinued. This page is maintained strictly for historical purposes. It is suggested one contact their local Area Agency on Aging for services that used to be offered via SAIL. (payingforseniorcare.com)

The investigator did locate [redacted] (Number [redacted] issued for a [redacted] as a nursing facility administrator on [redacted] 2025, that expires on [redacted] 2027. (https://tulip.hhs.texas.gov/TULIP/s/public-search)

Database research identified dozens of [redacted] living in the [redacted] area. As a result, [redacted] identity could not be confirmed.

Administrator works multiple facilities in apparent violation of Texas 40-hour rule 26 TAC § 554.1902)

[redacted]
Address: [redacted] UT [redacted]
Phone: [redacted]

On [redacted] investigator visited the [redacted] in [redacted] Utah around [redacted]

Upon entering the facility, the investigator was connected with [redacted] an admissions assistant. She member present during the visit and provided investigator with a brief tour.

When asked about an Administrator, [redacted] said [redacted] was the facility's administrator. She said [redacted] had been present earlier but left the facility prior to the visit. [redacted] said that administrator is typically at the facility all week long and does not work at other facilities.

The reception area was staffed. The facility appeared totally operational during the visit. However, the administrator was not personally observed and no meeting occurred during the visit. Also no administrator license was observed posted in the lobby or reception area.

[redacted] business card listed her title as "Community Liaison." Research with the Utah Division of Professional Licensing did not find a Health Facility Administrator license for [redacted]

The Utah Department of Health & Human Services (DHHS) (https://dlbc.utah.gov/wp-content/uploads/Nursing_Homes.xlsx) listed the facility Administrator as Mr. [redacted]

The Utah Department of Professional Licensing listed [redacted] age [redacted] of [redacted] Utah as a licensed Health Facility Administrator. He has been licensed since [redacted] and his license expires on [redacted] 2027. [redacted] is about [redacted] m [redacted] Utah.

Staff-identified Administrator does not have a license in state database

[redacted] Rd
[redacted] TX [redacted]

Investigator arrived at [redacted] entrance to the facility was locked. After a few minutes of knocking, the door was opened by a female employee who asked if the investigator had an appointment.

The employee, a woman, allowed the investigator entrance and handed him a clipboard and was told to fill it out. Investigator did not see any postings stating naming the Administrator of the facility.

Investigator was soon after introduced to the Administrator by the woman who answered the door. Administrator introduced himself simply as [redacted] and also introduced [redacted] as the Admissions Director. Later, another employee clarified that he was [redacted]

The investigator requested a short tour. [redacted] responded with "yes, I will gladly show you around, I'm acting office manager, and feel free to ask any questions." Investigator proceeded to ask [redacted] 1) if he was at the facility all day and 2) does he have more than one facility he oversees. [redacted] did not answer the questions. He simply brushed it off and stated " let us know if you have any other questions."

Investigator was shown dining area, vacant living quarters, and therapy location and was informed they offer long and short term therapy and care. Afterwards, investigator was escorted to the front door.

Investigator said, "Thank you for your time, I hope you and [redacted] don't have to work too hard, I can't imagine having to work more than 40 hours a week." [redacted] stated, " My only day off is Monday, but he's not here as often as we need him to be." It was unclear if she was implying that [redacted] is not on location 40 hours a week.

On [redacted] the investigator called the facility and asked for [redacted] The receptionist stated he was not in currently, and that he's "in and out a lot."

As detailed below, [redacted] is a licensed Nursing Home Administrator. His license expires on [redacted] 2026.

Administrator dodged multi-facility questions; Office Manager stated insufficient on-site presence 26 TAC § 554.1902

Note: Summary of the visit log of all 57 facilities can be found in Appendix 1**, Sources:** Private Investigator Site Visits for 57 Ensign locations in 2026; 26 TAC § 554.1902

Proof Point 4: Private Investigator Visits Show Red Flags at 12 of 57 Facilities (3/4)

12 of 57 facilities visited by private investigators (21%) exhibited red flags consistent with administrator license rental arrangements. These 12 facilities span 7 states; the pattern is not isolated. Staff identified Administrators who are unlicensed, who left the facility years ago, or who operate across multiple facilities in violation of state law. Below are excerpts from those 12 private investigator site visit reports.

[redacted]
Address: [redacted] UT [redacted]
Phone: [redacted]

On [redacted] investigator visite[redacted]

The investigator was introduced to [redacted] – Marketing Director. A business card and facility brochure were provided during the visit and tour. [redacted] was able to identify the administrator by name as [redacted]

[redacted] stated the administrator was on site in a nearby office but was currently on the phone. The administrator was not personally observed and no direct interaction occurred during the visit. Staff indicated the administrator also serves as the facility Operations Manager. When asked whether the administrator splits time between multiple facilities, staff stated the administrator is on site daily and did not work at other facilities.

During a brief tour, investigator did not see an administrator license or facility license in the lobby or reception area. However, the reception area was staffed and operational. Residents and staff were present within the facility.

Research of the Utah Department of Professional Licensing did not identify a Health Facility Administrator's license for [redacted] According to his [redacted] profile [redacted]

The Utah Department of Health & Human Services (DHHS) (https://dlbc.utah.gov/wp-content/uploads/Nursing_Homes.xlsx) listed the facility Administrator as [redacted]

The Utah Department of Professional Licensing listed [redacted] of [redacted] Utah as a licensed Health Facility Administrator. He has been licensed since [redacted] 2019 and his license expires on [redacted] 2027. [redacted] is about [redacted] m [redacted] Utah.

[redacted] profile listed him as the Administrator [redacted]

Staff-identified Administrator does not have a license in state database

[redacted]

On [redacted] 2026, investigator visited [redacted] located at [redacted] Arizona [redacted] phone [redacted]

Upon entry, Investigator did not observe any facility licensing posted in the main waiting area near the reception desk. No staff member was present at the reception desk at the time of arrival. Investigator proceeded toward the restroom area and observed a bulletin board displaying various facility-related notices and information.

Investigator was subsequently provided a tour of the facility by [redacted] Admissions Coordinator. The facility was clean and well maintained.

Ms. [redacted] advised that the Administrator for [redacted] and the adjacent [redacted] and the Operations Manager is [redacted] Ms. [redacted] further stated that the facility also has an Administrator-in-Training, whose name she did not provide.

According to Ms. [redacted] Mr. [redacted] and Mr. [redacted] were attending an Ensign conference in Anaheim, California. When in town, they are reportedly on-site daily between 9am to 5pm, but rotate between multiple properties.

Photographs of the facility's posted licenses are included below. Several of the licenses appeared to be expired. Additionally, none of the licenses observed listed the name of the facility operator or administrator.

[redacted] is licensed by the Arizona Nursing Care Insititution Administrators and Assisted Living Facility Managers. His licenses are included below.

Single Administrator across two facilities; rotates between properties; AIT likely runs day to day at one of the facilities

[redacted]
[redacted] CA
Visited [redacted]
Visited [redacted]

1. I asked front desk for the administrator. The receptionist directed me to admissions office, but stated they were unavailable and in a meeting
2. According to the receptionist, [redacted] the case manager in charge of everything, was acting administrator. She did not provide her full name. The receptionist said that [redacted] the acting administrator, does not split time between facilities and is typically available Monday to Friday. She did not comment on the Administrator's hours.
3. Eventually, I was able to meet [redacted] who gave me a brief tour. [redacted] said the facility Administrator, named [redacted] was in the facility M-F but would not confirm her precise hours. She said she was out at the moment. The facility does not have an operations manager, she said.
4. There was a board in the lobby with various licenses posted. A Nursing Home Administrator license for [redacted] with start date [redacted] was posted on the board.

Notably, [redacted] lives in [redacted] California, which [redacted] away from the [redacted] in [redacted] This is likely one-hour or 90 minute commute each way through Los Angeles traffic.

An Investigator returned to [redacted] a month later was informed that [redacted] full name is [redacted] Unfortunately, we were not able to ascertain her date of birth or home address.

There are several [redacted] licensed as vocational nurses in LA County. There are also two [redacted] licensed as Certified Nursing Assistant in California. However, no one with the name [redacted] is a licensed Nursing Home Administrator in California.

Staff-identified Administrator does not have a license in state database

Note: Summary of the visit log of all 57 facilities can be found in Appendix 1**. Sources:** Private Investigator Site Visits for 57 Ensign locations in 2026; 26 TAC § 554.1902

Proof Point 4: Private Investigator Visits Show Red Flags at 12 of 57 Facilities (4/4)

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[redacted]
Address: [redacted] TX [redacted]
Phone [redacted]

[redacted] The investigator arrived at The [redacted] and met with the receptionist. She called someone to take the investigator on a tour of the facility, but they were unavailable and asked that the investigator call to make an appointment.

The investigator asked if the facility administrator was available and the receptionist called his office, but he also did not answer. She further said that she had not seen the Administrator today and stated that he manages three other facilities, one of them being in [redacted] TX.

The receptionist then handed the investigator a pamphlet for the facility and a business card for [redacted] Administrator, [redacted] Investigator phoned the number on the card which went to a voicemail recording for the office of [redacted] administrator for The [redacted] and Rehabilitation.

There were no facility licenses or Administrator licenses visible in the nursing home lobby and the investigator was not allowed past the reception area without an escort.

Investigator conducted research on the state website for Licensed Nursing Facility Administrator by the name of [redacted] but there were none. Investigator did identify a license for a [redacted] issued on [redacted] 2020, that expires on [redacted] 2027.

Administrator manages three facilities in apparent violation of Texas 40-hour rule (26 TAC § 554.1902)

[redacted] Nevada

On [redacted], an investigator visited the [redacted] Nevada [redacted]

Upon entering [redacted] main entrance, I was greeted by a WFA, who introduced herself to me as [redacted] who was later identified as [redacted] Facility Administrator.

[redacted] instructed me to have seat in the front lobby of the facility, and she would have [redacted] Director of Admissions assist me. At approximately 11:00 AM a WFA identified herself to me as [redacted] and offered to answer any questions I had concerning [redacted] offering to take me on a tour of the facility. [redacted] was accompanied by a BFA, who was job shadowing [redacted] as a new employee.

* Is the Administrator physically present on site and did I have the opportunity to meet the administrator and could staff identify the administrator ? Yes, as stated I was greeted by [redacted] who was identified as the Facility Administrator by [redacted]

* Was the Administrator's license (with their name) is clearly posted?

The Administrator's license was mounted on a bulletin board in the main patient hallway of the facility, along with other documents pertaining to [redacted] such as business license, etc. However, the name listed on the license as the Administrator was [redacted] [redacted] explained to me that [redacted] was the previous administrator and was on extended sick leave, and [redacted] was her replacement, however [redacted] license had not yet arrived. A picture of the license is included below.

Staff-identified Administrator does not have a license in state database

[redacted]
[redacted] Iowa, [redacted]
[redacted]

On [redacted] 2026 [redacted] I entered the [redacted] [redacted] located at [redacted] Iowa, [redacted]

I entered the facility, was greeted by a female, [redacted] I asked to speak to the Operation Manager or Administrator. As I waited, I looked around the lobby and there was no certifications regarding the facility or the administrator. I even peaked in the office and still saw no licenses.

After a few minutes, a gentleman approached me by the name of [redacted] and identified himself as the administrator of the facility. We engaged in a brief discussion and I asked for a tour.

As we walked around the facility, [redacted] disclosed that he is from [redacted] Iowa, and commutes between their and here. He also mentioned that he grew up in this area and his father ran other facilities.

I commented that it is a lot of travel back-and-forth [redacted] He said that he stays up here all week and then goes home on the weekend. I asked him who operates runs the facility is there operational manager? He says yes we have managers who run the facility in case of his absence.

At that point, he suddenly appeared somewhat apprehensive and very nervous. I thanked him for his time and departed. Still, no facility or administrators licenses were observed anywhere by the front office or the entrance to the building or surrounding area.

According to the Iowa Department of Public Health, Bureau of Professional Licensure, [redacted] [redacted] is a license Nursing Home Administrator in Iowa. His license was issued on [redacted] 2010 and expires [redacted] 2027. He has no history of disciplinary action.

Administrator commutes long-distance; unlicensed managers likely run facility in his absence

Note: Summary of visit log of all 57 facilities can be found in Appendix 1**, Sources:** Private Investigator Site Visits for 57 Ensign locations in 2026; 26 TAC § 554.1902

Potential False Claims Act Exposure

Ensign operates 379 skilled nursing facilities. Former employees estimate that 20–25% of Texas facilities engage in administrator "license rental" arrangements and that the practice is live in at least eight out of 17 states. Based on our P.I. investigation of 57 facilities visited, we believe ~20% are operating without a licensed Administrator. Below we present a one-year statutory theoretical False Claims Act sensitivity analysis based on Q1 2026 reported operating data, assuming potential regulatory enforcement by HHS OIG and the DOJ. Government investigations typically review multiple prior years. They also typically settle for less than the statutory / theoretical maximums.

Key Facts from Q1 2026 Ensign 10-Q to inform sensitivity table

- 357 Skilled Nursing Facilities that contributed to revenue (excludes 22 recently acquired as they did not contribute meaningfully to revenue)
- 40,629 operational skilled nursing beds (38,549 + 2,080 skilled nursing beds from the May 1, 2026 Texas acquisition)
- 84% occupancy
- $5.33B Skilled Services Revenue (Q1 2026 skilled services segment revenue annualized: $1.33B × 4)
- 69% Government Fee-For-Service Revenue, $3.7B (Medicaid + Medicaid Skilled + Medicare FFS)
- ~$10.2M Annual Medicare and Medicaid Revenue per Skilled Nursing Facility ($3.7B divided by 357 SNFs)

Model Assumptions, Model reflects one year of exposure only

- 4,680 Medicaid claims per SNF annually, 90 patients on average (Former employees state they bill Medicaid weekly per resident (90 residents x 52 weeks))
- $14,308 FCA penalty per institutional claim (conservative; minimum is $14,308 and maximum is $28,619 per claim)
- Statutory treble damages (3× Government FFS revenue deemed non-reimbursable)

% of SNFs Implicated	Facilities	Treble Damages (3× Gov't FFS Revenue)	False Claims Act Penalties	Total Theoretical Exposure
5%	18	$551M	$1.2B	**$1.7B**
10%	36	$1.1B	$2.4B	**$3.5B**
15%	54	$1.6B	$3.6B	**$5.2B**
20%	71	$2.2B	$4.8B	**$7.1B**

Note: Full model mechanics provided in Appendix 4; model reflects FCA exposure associated with administrator license-rental arrangements only and excludes any potential FCA exposure related to therapy billing practices.
Sources: ENSG Q1 2026 10-Q (filed April 30, 2026); Interviews with former Ensign employees; Interview with former HHS OIG Special Agent (February 2026); DOJ Adjustments to FCA Penalties

Sections

1. Executive Summary
2. Growth Built on Rented Licenses and Deceiving the Government
3. **Margins Built on Perverse Incentives and Resident Harm**
4. DOJ Recidivism Risk and Reports of Phantom Therapy Billing
5. Aggregated Impact: Acquisitions Flatline, Margins Compress, and False Claims Act Exposure

The Margin Premium:
Why It Exists, How It Works, The Evidence, and Impact

On a three-year basis, Ensign's EBITDAR margin exceeds PACS by ~160 basis points. While Ensign benefits from using unlicensed operators who are paid less than licensed Administrators, we do not believe that salary difference explains the margin premium. The more significant driver is that Ensign staffs nursing hours below both PACS and the national average despite serving higher-acuity residents.

We believe this is driven by two factors: (i) profit-sharing incentives that financially benefit Administrators and Directors of Nursing for reducing nursing labor expense and (ii) Ensign's use of inexperienced and, in many cases, unlicensed operators who are less likely to challenge staffing reductions.

The understaffing of nurses likely contributes to the 85% more severe-harm incidents per occupied bed than PACS. If Ensign staffed at the same level as PACS (the national average), we estimate it would reduce margins at ENSG by ~210 bps. Ensign should arguably be staffing above PACS, given that Ensign's residents are more acute.

Why the Margin Premium Exists

- Ensign's EBITDAR margin runs ~160 bps above PACS
- Nursing labor is the largest cost in a skilled nursing facility

How the Margin Premium Is Created

- Profit-sharing incentives financially benefit Administrators and Directors of Nursing for reducing nursing labor costs
- Inexperienced and unlicensed operators are less likely to challenge staffing reductions

Evidence

- Ensign staffs below PACS and the national average despite serving higher-acuity residents
- Ensign averages 3.7 nurse hours per resident per day vs. 3.9 at PACS and nationally
- Ensign records 85% more severe-harm citations per occupied bed than PACS

Financial and Operational Impact

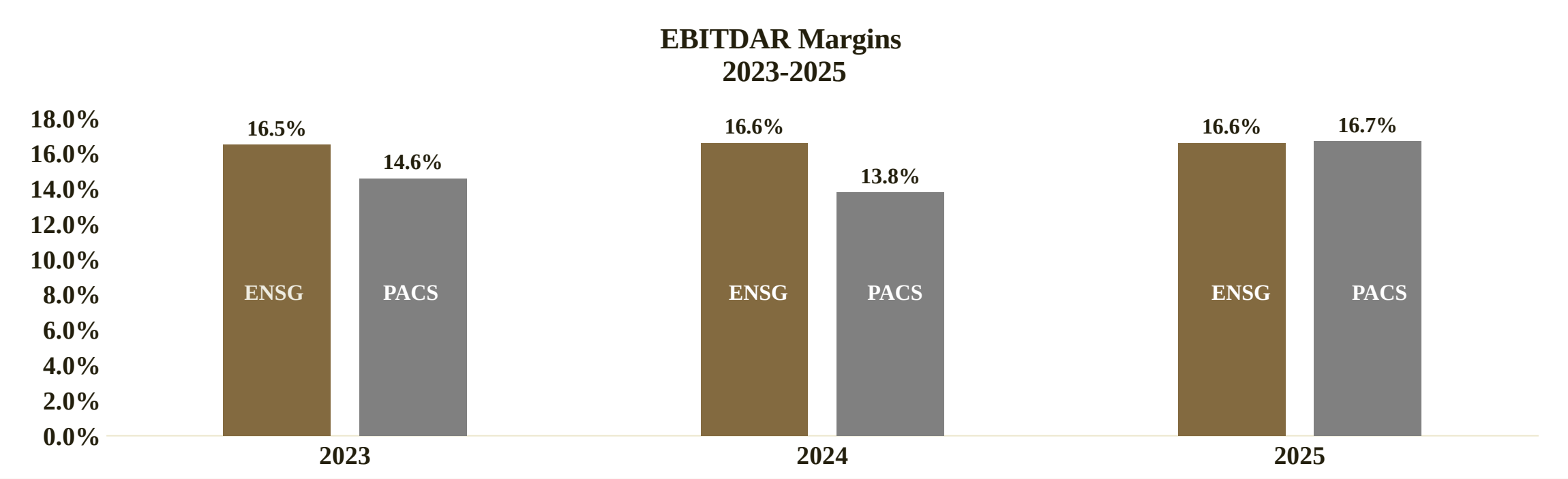
- Staffing to PACS and national-average levels would reduce EBITDAR margin by ~210 bps

Sources: Interviews with former employees; Ensign 10-K filings, 2023–2025; Ensign 2026 10-Q; PACS 10-K filings, 2024–2025; ProPublica Nursing Home Inspect affiliate data for The Ensign Group and PACS Affiliate Data

Ensign's Margin Premium Does Not Reflect Superior Operations

Ensign's EBITDAR margin has averaged ~160 bps above PACS over 2023–2025. We believe this premium reflects systematic understaffing, not operational excellence. Ensign staffs nursing below both PACS and the national average (3.7 vs. 3.9 nurse hours per resident per day) and compensates Administrators and Directors of Nursing on individual-building and cluster-level profit, a structure that directly incentivizes understaffing.

In 2025, PACS beat Ensign's EBITDAR margin while staffing ~0.2 HPRD higher. Normalized to a 3.9 HPRD staffing level, Ensign's EBITDAR margin seemingly would fall below PACS, suggesting its margin advantage is driven by lower staffing rather than superior operations.



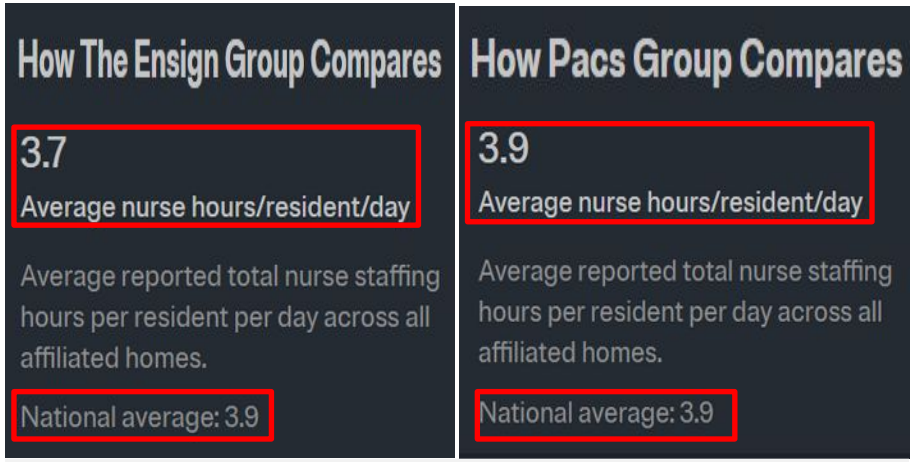
Note: NHC, the only other publicly traded pure-play SNF operator, is excluded because it reports neither EBITDAR nor EBITDA. See Appendix 3 for full methodology and calculations.
Sources: Company 10-K filings for Ensign 2023–2025; PACS 10-K filings, 2024–2025

Ensign Staffs Below PACS Despite Serving Sicker Patients, Driving ~210 bps of Margin

Ensign staffs 3.7 nurse hours per resident per day; PACS staffs 3.9, matching the national average of 3.9.

Across Ensign's ~32,000 occupied beds, 0.2 HPRD over 365 days is ~2.3 million nursing hours not staffed per year. At a fully loaded nursing cost of ~$45/hour, that is ~$106M in annual labor savings, ~ 210 bps of EBITDAR margin.

Acuity does not explain the gap; it makes it worse. Acuity is simply a measure of how sick residents are and how much nursing care they require. Skilled mix (the percentage of patient-days classified as skilled nursing) is the industry's standard proxy for acuity. Ensign's skilled mix exceeded PACS in both years, meaning Ensign cared for sicker patients who should require more nursing hours. Ensign should therefore be staffing above PACS, not below it.



Ensign staffs fewer nurse hours per resident per day than PACS and the national average, leading to 210 bps in margin.

Ensign Patient Acuity

	Year Ended December 31,	
	2025	2024
Percentage of Skilled Nursing Days:		
Medicare	11.6 %	11.4 %
Managed care	13.5	13.4
Other skilled	5.6	5.1
SKILLED MIX	30.7	29.9

PACS Patient Acuity

	2025	2024
Total Facility Results		(Dollars in t
Skilled nursing services revenue	$ 5,178,456	$ 4,014,412
Skilled mix by revenue	48.8 %	50.3 %
Skilled mix by nursing patient days	28.7 %	29.2 %

According to each company's 2025 10K, Ensign has more skilled mix than PACS (30.7% vs. 28.7%), meaning it should be staffing more nurse hours per resident per day than PACS. Skilled mix by revenue reflects Medicare's higher per-diem and 100-day cap, not acuity.

Note: See Appendix 3 for full methodology and calculations
Sources: Company 10-K filings for Ensign, 2023–2025; PACS 10-K filings, 2024–2025; ProPublica Nursing Home Inspect affiliate data for The Ensign Group, PACS Affiliate Data, and NHC Affiliate Data

Ensign's Incentives Drive Lower Nursing Hours

Ensign pays its Administrators and Directors of Nursing ~10%-15% of building profit and 10% of cluster-level profit. Because nursing is the largest controllable cost in a skilled nursing facility, this creates a direct incentive to cut nursing hours. Every dollar of nursing labor cut drops straight to facility profit, which flows into both the building-level and cluster-level profit shares that Administrators and Directors of Nursing are paid on.

Compounding this incentive structure, many of the individuals Ensign hires into its AIT program and promotes into Administrator roles are poorly positioned to challenge staffing reductions. They are often recent college graduates or recruits drawn from local community networks, frequently with no SNF experience and, in some cases, no healthcare experience at all. The result is an operator base less likely to resist pressure to reduce headcount when doing so directly increases their own compensation.

Combined, we believe these dynamics drive nursing hours structurally below peers. Ensign staffs at just 3.7 nurse hours per resident day versus 3.9 at PACS.

*"**Nursing is going to be the bulk of your wages**. So that's the first one to look to if you're trying to get profitability in line."*

Former Ensign Administrator

*"**The Directors of Nursing had a very similar incentive program as the Administrators**."*

Former Assistant Vice President of Human Resources

*"**The bonus is 15% of net proceeds, so if you cut hard enough, you can make serious money fast."***

Former Ensign Administrator

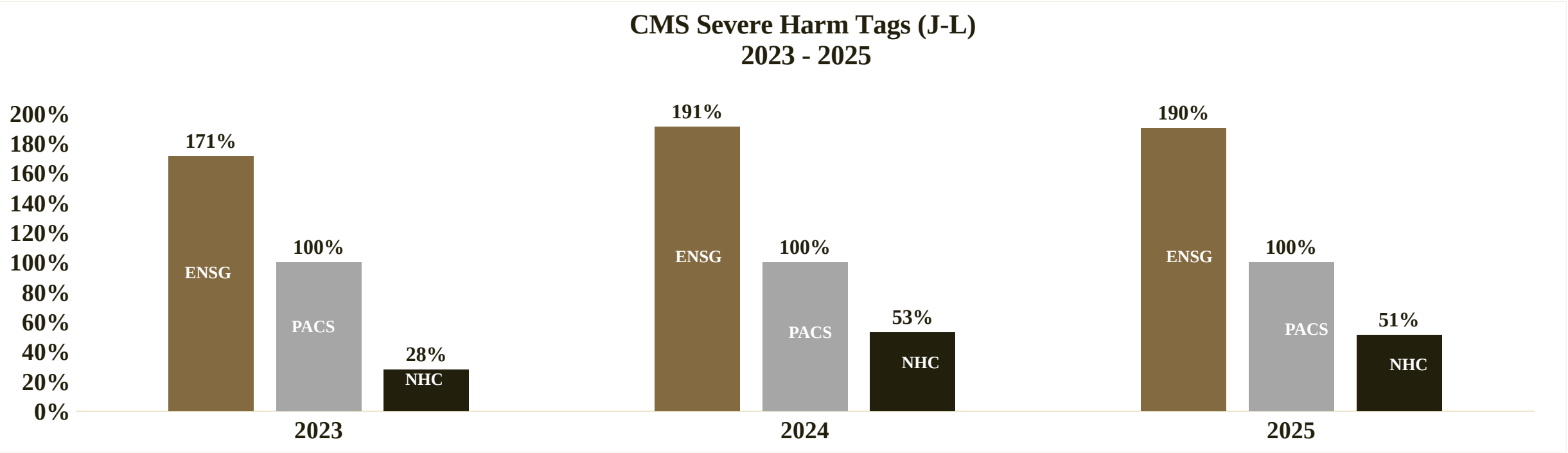
Sources: Interviews with former Ensign employees

We Believe Unlicensed Administrators & Perverse Incentives Explain Ensign's Higher Severe Harm to Residents

We believe Ensign's use of unlicensed Administrators to run facilities, combined with its perverse Management by Peer Pressure financial incentives for Administrators and Directors of Nursing, results in fewer nurse hours and drives a 210bps EBITDAR uplift. Unfortunately, this also leads to significantly more severe harm for residents.

CMS tags range from A-L. Our analysis focuses on J-L tags, the most serious CMS deficiencies. These are immediate-jeopardy deficiencies, where a facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death.

Our analysis examined severe harm tags on a per-occupied-bed basis over the past three years. In each year, Ensign was materially higher than peers, averaging nearly 2x PACS and at least 3.6x NHC on a per-occupied-bed basis. We indexed PACS to 100 in each year because CMS data indicates PACS is in line with the national average for nursing hours per resident per day.



Note: See Appendix 5 for full methodology and calculations; Severe harm rate indexed to PACS = 100

Sources: Company 10-K filings for Ensign and NHC, 2023–2025; PACS 10-K filings, 2024–2025; All as of June 4th 2026 ProPublica, ENSG J-L Tags; ProPublica, PACS J-L Tags; ProPublica, NHC J-L Tags;

Sections

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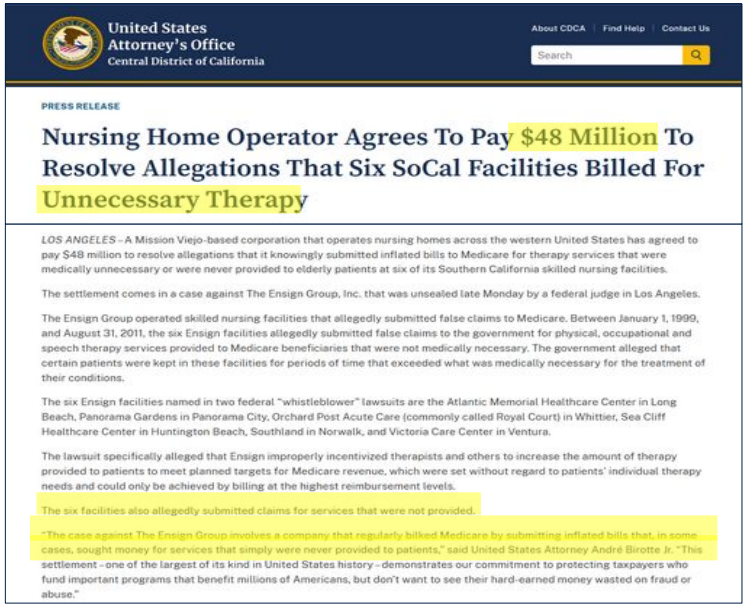
Ensign Paid ~$95M Since 2013 to Resolve Two Federal Healthcare Fraud Cases, Yet Former Employees Describe Similar Practices

Based on interviews with former Ensign therapists and a former Assistant Vice President, we identified the same billing practices that formed the basis of Ensign's 2013 settlement. Interviewees across multiple states reported therapy minutes billed but not delivered, inflated session documentation, and therapists completing documentation off the clock to meet productivity targets.

Ensign has a history of settling federal healthcare fraud allegations. In 2013 and 2024, the company paid approximately $95 million without admitting guilt to resolve two separate federal healthcare fraud cases. The first was a $48 million settlement involving allegations that facilities billed Medicare for therapy that was not provided, medically unnecessary, or inflated in billing records. The second was a $47.3 million settlement involving alleged kickbacks.

In the previous sections, we showed that Ensign's acquisition growth is built on using unlicensed operators while its margins are built on lower nursing staffing levels associated with higher rates of severe resident harm. Taken together, we do not believe these are isolated incidents, but evidence of a recurring willingness to cross regulatory, legal, and ethical lines when doing so benefits growth, profitability, or both.



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PRESS RELEASE

Nursing Home Operator Agrees To Pay $48 Million To Resolve Allegations That Six SoCal Facilities Billed For Unnecessary Therapy

LOS ANGELES – A Mission Viejo-based corporation that operates nursing homes across the western United States has agreed to pay $48 million to resolve allegations that it knowingly submitted inflated bills to Medicare for therapy services that were medically unnecessary or were never provided to elderly patients at six of its Southern California skilled nursing facilities.

The settlement comes in a case against The Ensign Group, Inc. that was unsealed late Monday by a federal judge in Los Angeles.

The Ensign Group operated skilled nursing facilities that allegedly submitted false claims to Medicare. Between January 1, 1999, and August 31, 2011, the six Ensign facilities allegedly submitted false claims to the government for physical, occupational and speech therapy services provided to Medicare beneficiaries that were not medically necessary. The government alleged that certain patients were kept in these facilities for periods of time that exceeded what was medically necessary for the treatment of their conditions.

The six Ensign facilities named in two federal "whistleblower" lawsuits are the Atlantic Memorial Healthcare Center in Long Beach, Panorama Gardens in Panorama City, Orchard Post Acute Care (commonly called Royal Court) in Whittier, Sea Cliff Healthcare Center in Huntington Beach, Southland in Norwalk, and Victoria Care Center in Ventura.

The lawsuit specifically alleged that Ensign improperly incentivized therapists and others to increase the amount of therapy provided to patients to meet planned targets for Medicare revenue, which were set without regard to patients' individual therapy needs and could only be achieved by billing at the highest reimbursement levels.

The six facilities also allegedly submitted claims for services that were not provided.

"The case against The Ensign Group involves a company that regularly billed Medicare by submitting inflated bills that, in some cases, sought money for services that simply were never provided to patients," said United States Attorney André Birotte Jr. "This settlement – one of the largest of its kind in United States history – demonstrates our commitment to protecting taxpayers who fund important programs that benefit millions of Americans, but don't want to see their hard-earned money wasted on fraud or abuse."

Ensign Pays Over $47 Million to Settle Claims in Whistleblower Suit Alleging Fraud and Kickbacks

BOSTON, Sept. 2, 2025 /PRNewswire/ -- Whistleblower Law Collaborative LLC, Hirst Law Group, P.C., and Bird, Marella, Rhow, Lincenberg, Drooks, & Nessim, LLP announced today a settlement of over $47.3 million in a whistleblower case against The Ensign Group, Inc., and Ensign Services, Inc. ("Ensign"). The settled claims, brought in a lawsuit filed by a whistleblower in 2015, resolve allegations that Ensign knowingly engaged in fraud perpetrated against Medicare, Medicaid, and other government health care programs.

The complaint, filed as a *qui tam* suit under the federal and California False Claims Acts (FCAs), alleged that nationwide Ensign knowingly paid kickbacks to physicians for referrals of patients to Ensign's skilled nursing facilities (SNFs) in violations of the FCAs, the federal and California Anti-Kickback Statutes, and the federal Stark self-referral law. The complaint also alleged that Ensign violated a previous Corporate Integrity Agreement (CIA) that Ensign signed with the Department of Health and Human Services (HHS) in 2013 as part of an earlier False Claims Act case settled by the company.

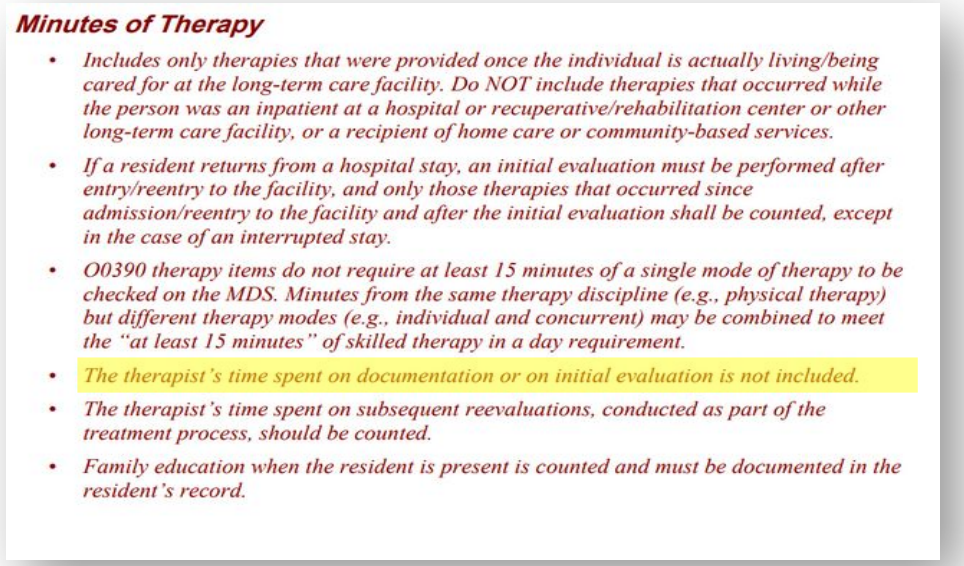
Sources: Department of Justice Press Release (2013); PR Newswire Ensign Settlement (2025); Interviews with former Ensign employees conducted in 2025 and 2026

CMS Makes It Clear What Can and Cannot Be Billed

Billing for therapy minutes not delivered, misclassifying group or concurrent sessions as individual treatment, or inflating documentation to support higher billing renders claims false. Based on interviews with former employees, we believe Ensign's productivity targets and incentive structures create pressure for therapists to engage in these practices.

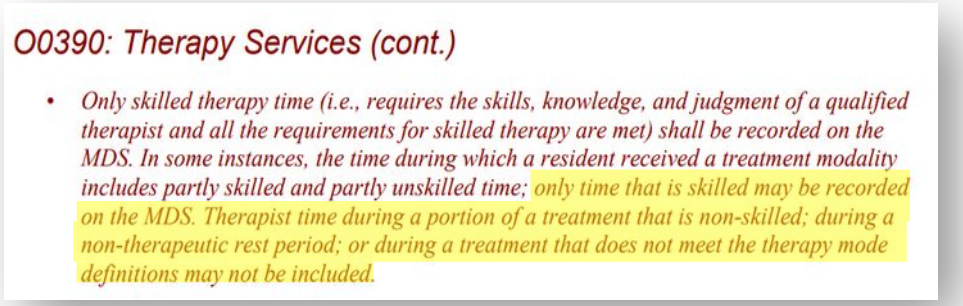
Medicare reimburses therapy provided in skilled nursing facilities through Medicare Part A and Part B. While the payment mechanics differ between the two programs, both require therapy minutes and treatment records to accurately reflect services actually provided to patients.

Across both systems, only skilled, medically necessary therapy that is actually provided to the patient is billable. Medicare explicitly excludes documentation, chart review, care coordination, travel, waiting, and any period where the patient is not actively receiving skilled treatment. Billing must reflect minutes actually delivered, not scheduled or estimated time. These rules come directly from CMS's Resident Assessment Instrument Manual (excerpted below).



Minutes of Therapy

- *Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.*
- *If a resident returns from a hospital stay, an initial evaluation must be performed after entry/reentry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted, except in the case of an interrupted stay.*
- *O0390 therapy items do not require at least 15 minutes of a single mode of therapy to be checked on the MDS. Minutes from the same therapy discipline (e.g., physical therapy) but different therapy modes (e.g., individual and concurrent) may be combined to meet the "at least 15 minutes" of skilled therapy in a day requirement.*
- *The therapist's time spent on documentation or on initial evaluation is not included.*
- *The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.*
- *Family education when the resident is present is counted and must be documented in the resident's record.*



O0390: Therapy Services (cont.)

- *Only skilled therapy time (i.e., requires the skills, knowledge, and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.*

Sources: Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.20.1, October 2025; 31 U.S.C. § 3729; 42 CFR §483.20(j)

Ensign’s 85% Productivity Target Creates Pressure to Inflate Billable Therapy Time

Ensign operates therapy in-house in its skilled nursing facilities. Each building employs three licensed disciplines; physical therapist (PT), occupational therapist (OT), and speech-language pathologist (SLP); therapy is primarily billed through Medicare Part A and Part B.

At the majority of buildings, Ensign sets a productivity standard of 85% for each therapy discipline. “Productivity” is defined as billable patient care time divided by total time clocked in, meaning therapists can only bill Medicare for direct, hands-on patient treatment.

On an eight-hour shift, a therapist is expected to bill 6 hours and 48 minutes of direct patient care, leaving only 72 minutes for all non-billable responsibilities; including documentation, chart review, care coordination, patient transport, and team meetings. Therapists reported seeing 7 to 15 patients per day, with documentation alone taking approximately 10 to 15 minutes per patient, implying 70 to 225 minutes of documentation daily, far exceeding the 72 minutes available for all non-billable tasks.

A former Assistant Vice President of HR stated that the 85% productivity target pressured therapists to bill for treatment not provided, bill individual sessions as group care, or complete documentation off the clock. She also noted that some facilities tie financial incentives to the productivity target, including incentives for Directors of Rehabilitation; a former Ensign therapist in Utah reported receiving a $1 per hour increase for exceeding an 80% productivity threshold.

*“**We would have an aggressive measurement of like, we want a therapy team to have 85% productivity.** That means 85% of the time that they're on the clock, they are providing treatment. **That would pressure the therapist to do things like either document for treatment that wasn't given, document for treatment maybe double bill treatment, like for multiple patients in a way that wasn't appropriate.** You absolutely can do group therapy, but it has to be done appropriately. **Or they would clock off to do their documentation. So that was, that was a pretty consistent issue that our, our team had to manage**.”*

Former Ensign Assistant Vice President of HR

Sources: Interviews with former Ensign employees conducted in 2025 and 2026

Multiple Former Employees Report Systematic Overbilling Across States

We spoke with six former Ensign employees about therapy and billing; four former therapists, one certified nursing assistant, and a former Assistant Vice President of HR. These employees worked across Arizona, Colorado, Texas, Utah, and South Carolina; the former Assistant Vice President of HR provided a corporate-level perspective as a business partner with visibility into broader operational practices. Five of the six reported observing billing practices that would constitute improper, possibly fraudulent, therapy billing under Medicare rules. Only the former therapist in South Carolina reported no issues observed during her tenure.

A former Ensign Physical Therapist in Colorado reported observing therapists billing for minutes not delivered and conducting joint OT and PT evaluations while each billed separately for a full hour. A former Ensign occupational therapist in Utah confirmed that joint OT/PT evaluations occurred at the facility, with each discipline billing separately for the encounter.

The former Ensign Certified Nursing Assistant in Arizona said therapists shortened scheduled therapy sessions while facilities billed Medicare for the full scheduled minutes.

The former Ensign speech-language pathologist in Texas stated that for a 30-minute scheduled session, therapists typically had only 18–20 minutes of direct or indirect patient contact, with the remainder spent on documentation, care planning, and communication with caregivers, billed at the full scheduled time. He also reported routinely completing documentation off the clock to preserve the 85% productivity target, effectively unpaid labor that benefited Ensign.

These observations span multiple roles, facilities, and states, indicating the reported practices are not confined to a single building or geography.

*"The reason why they were **billing for full 60 minutes when they were doing actually 45 minutes of patient care is because the rest of the 15 minutes they were spending doing chart reviews and making the plan of care**."*

Former Ensign Therapist in Colorado

*"**Let's say it's an hour therapy for that day. You know, they would either cut it short to 30 or 45 minutes or even less** because, they completed what they had to do and the patient was doing it or was doing fine. And so there was no reason for them to complete the full hour."*

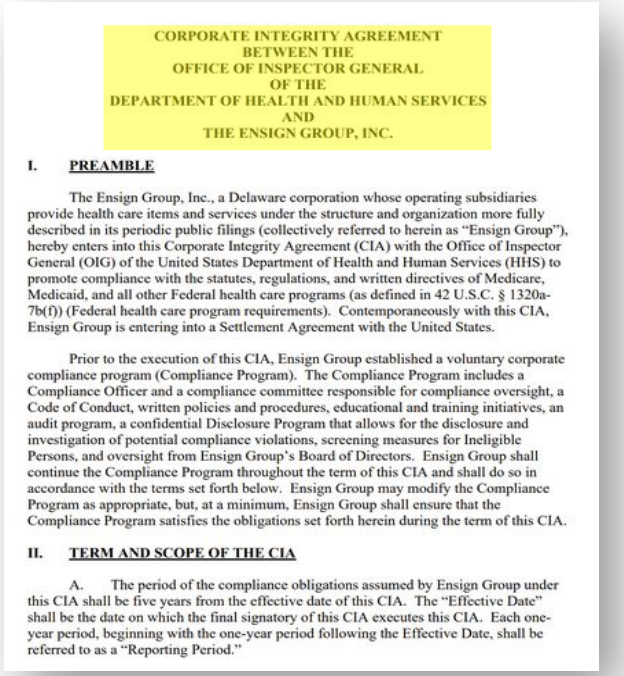
Former Ensign Certified Nursing Assistant in Arizona

Sources: Interviews with former Ensign employees conducted in 2025 and 2026

Repeat Conduct After Federal Oversight Raises Serious Control Concerns

Following the 2013 allegations that Ensign billed Medicare for therapy that was not provided, the company entered into a five-year Corporate Integrity Agreement that required targeted controls specifically designed to prevent improper therapy billing. These requirements included mandatory training for employees on accurate claims submission, improper billing practices, and what constitutes billable versus non-billable therapy services. The CIA also included direct oversight from senior management and the Board, including quarterly compliance reviews and annual certifications that the compliance program was effective.

4 out of 5 therapists and nurses we interviewed reported observing billing practices consistent with the improper therapy billing described above across four states. While the Corporate Integrity Agreement expired in 2018, we believe it is notable that former employees describe similar conduct years after Ensign completed five years of federal oversight specifically imposed in response to allegations of billing for therapy that was not provided.



CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
THE ENSIGN GROUP, INC.

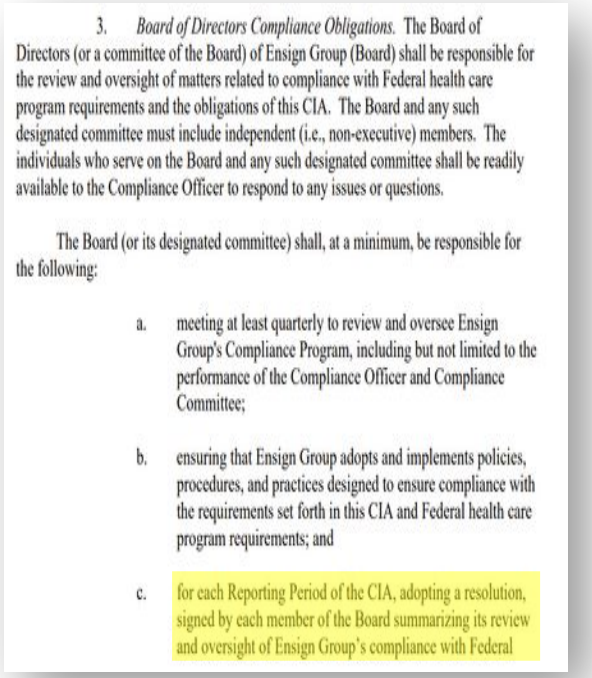
I. PREAMBLE

The Ensign Group, Inc., a Delaware corporation whose operating subsidiaries provide health care items and services under the structure and organization more fully described in its periodic public filings (collectively referred to herein as "Ensign Group"), hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Ensign Group is entering into a Settlement Agreement with the United States.

Prior to the execution of this CIA, Ensign Group established a voluntary corporate compliance program (Compliance Program). The Compliance Program includes a Compliance Officer and a compliance committee responsible for compliance oversight, a Code of Conduct, written policies and procedures, educational and training initiatives, an audit program, a confidential Disclosure Program that allows for the disclosure and investigation of potential compliance violations, screening measures for Ineligible Persons, and oversight from Ensign Group's Board of Directors. Ensign Group shall continue the Compliance Program throughout the term of this CIA and shall do so in accordance with the terms set forth below. Ensign Group may modify the Compliance Program as appropriate, but, at a minimum, Ensign Group shall ensure that the Compliance Program satisfies the obligations set forth herein during the term of this CIA.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by Ensign Group under this CIA shall be five years from the effective date of this CIA. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."



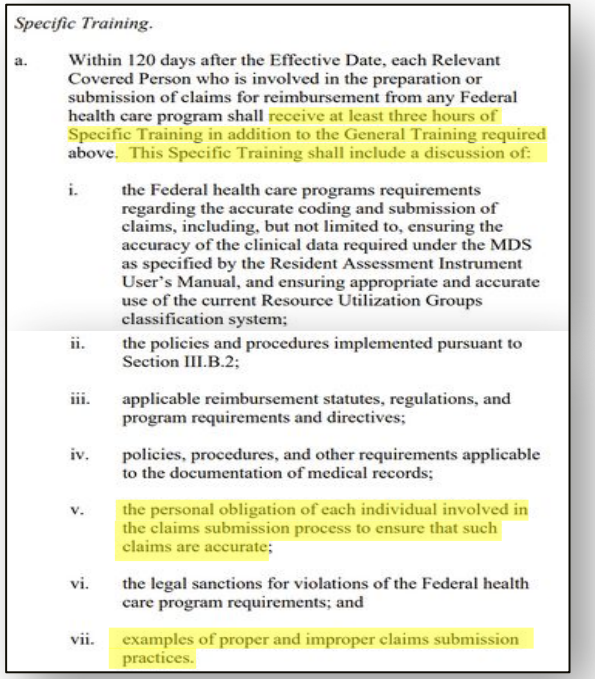
3. *Board of Directors Compliance Obligations.* The Board of Directors (or a committee of the Board) of Ensign Group (Board) shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA. The Board and any such designated committee must include independent (i.e., non-executive) members. The individuals who serve on the Board and any such designated committee shall be readily available to the Compliance Officer to respond to any issues or questions.

The Board (or its designated committee) shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee Ensign Group's Compliance Program, including but not limited to the performance of the Compliance Officer and Compliance Committee;

b. ensuring that Ensign Group adopts and implements policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and Federal health care program requirements; and

c. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board summarizing its review and oversight of Ensign Group's compliance with Federal



Specific Training.

a. Within 120 days after the Effective Date, each Relevant Covered Person who is involved in the preparation or submission of claims for reimbursement from any Federal health care program shall receive at least three hours of Specific Training in addition to the General Training required above. This Specific Training shall include a discussion of:

i. the Federal health care programs requirements regarding the accurate coding and submission of claims, including, but not limited to, ensuring the accuracy of the clinical data required under the MDS as specified by the Resident Assessment Instrument User's Manual, and ensuring appropriate and accurate use of the current Resource Utilization Groups classification system;

ii. the policies and procedures implemented pursuant to Section III.B.2;

iii. applicable reimbursement statutes, regulations, and program requirements and directives;

iv. policies, procedures, and other requirements applicable to the documentation of medical records;

v. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

vi. the legal sanctions for violations of the Federal health care program requirements; and

vii. examples of proper and improper claims submission practices.

Sources: Department of Justice Ensign Corporate Integrity Agreement; Interviews with former Ensign employees conducted in 2025 and 2026

An Investigation Could Expose Ensign to FCA Recidivism Risk and Unpaid Labor Claims

The consequences of the billing practices described by former employees are grounded in Ensign's enforcement history. In 2013, the Department of Justice alleged that Ensign facilities billed Medicare for therapy that was not provided and Ensign paid $48 million to resolve those allegations.

The conduct described by former employees mirrors the same category of conduct that formed the basis of Ensign's 2013 therapy billing settlement; any investigation would likely raise questions about potential recidivism. Unlike the 2013 case, which involved six facilities in one state, the conduct we identified spans multiple states and disciplines, potentially increasing both the scope of any investigation and the resulting damages. While Ensign does not disclose therapy-specific revenue, therapy services represent a core reimbursed activity within skilled nursing facilities, meaning even a partial clawback, settlement, or government investigation could have a material financial impact.

Separately, multiple former therapists described completing documentation off the clock to maintain productivity targets. If widespread, this practice could expose Ensign to significant wage-and-hour litigation for unpaid labor. Under 29 U.S.C. §216(b), employees may pursue collective actions for unpaid wages, and findings of willful violations can extend the recovery period from two years to three years while doubling damages through liquidated damages.

Taken together, the combination of potential FCA recidivism risk and labor-related liability creates a dual-front legal risk that could materially impact Ensign's financials and operations.

When asked about therapists billing for time that was not hands-on, billing group sessions as individual therapy, and billing scheduled minutes that exceeded actual treatment time, the former Ensign Assistant VP of HR said: *"**I did occasionally see it, but all of those things are examples of what would be considered fraudulent billing under Medicaid, Medicare."***

Former Ensign Assistant VP of HR

*"We would get therapists … who would like **clock off to do their documentation because they wanted to try to keep that, that productivity really high**."*

Former Ensign Assistant VP of HR

Sources: Interviews with former Ensign employees conducted in 2025 and 2026; 29 U.S. Code § 216

Sections

1. Executive Summary
2. Growth Built on Rented Licenses and Deceiving the Government
3. Margins Built on Perverse Incentives and Resident Harm
4. DOJ Recidivism Risk and Reports of Phantom Therapy Billing
5. **Aggregated Impact: Acquisitions Flatline, Margins Compress, and False Claims Act Exposure**

Three Independent Paths to Material Earnings Impairment

Throughout this report, we identified three issues that we believe underpin Ensign's financial performance: (i) administrator "license rental" arrangements that enabled acquisition-driven growth, (ii) nursing staffing levels below peer and national averages that inflated margins, and (iii) reported phantom therapy billing practices that point to a broader pattern of possibly fraudulent conduct against a backdrop of two prior fraud settlements. We believe these issues are key components of the operating model that enabled Ensign to significantly outgrow peers while generating industry-leading margins.

If Ensign is forced to discontinue these practices or operate under increased regulatory scrutiny, we believe investors face three independent earnings impairment paths: (i) dramatically slower acquisition growth and lost future run-rate earnings from missed acquisitions, (ii) margin compression as nurse staffing levels move toward peer benchmarks, and (iii) significant False Claims Act exposure tied to facilities operating without compliant licensed management.

1. Acquisition Material Slowdown

- Acquisition growth slows toward peer levels; ~2% growth instead of ~11%
- ~84 cumulative acquisitions missed by end of 2027
- ~$124M lost run-rate EBIT from missed acquisitions by 2027; equivalent to ~19% of consensus 2027 EBIT

2. Margin Compression

- Nursing hours increase from 3.7 to 3.9 per resident day; in line with PACS and the national average
- ~210 bps of EBITDAR margin erodes; equivalent to ~15% of enterprise value

3. False Claims Act Exposure

- Statutory FCA exposure from license-rental practices ranges from ~$1.7B–$7.1B
- Excludes potential exposure from alleged therapy billing practices
- Excludes operational disruption and reputational damage

Earnings Destruction Path 1: Acquisition Material Slowdown and Missed Run Rate

If Ensign were forced to stop using rented Administrator licenses today, we believe acquisition pace would normalize to that of its peers. The primary financial impact is not lower earnings at existing facilities, but rather the loss of future acquisition cohorts and the run-rate EBIT those facilities would have generated.

Ensign grew SNF facilities at ~11% annually from 2021 to 2025, while NHC grew ~1.6% annually over the same period. PACS grew facilities from 314 to 321 from 2024 to 2025, or ~2.2%. If Ensign can no longer use license rentals to rapidly staff facilities, acquisition cadence normalizes toward peer growth rates; implying ~7 acquisitions per year. Ensign would miss 29 acquisitions in 2026 and 55 acquisitions in 2027. On average, each SNF contributes $1.5M in EBIT, but newly acquired take 1-2 years to stabilize and only contribute modestly. The primary impact is to future run-rate earnings power, as these missed acquisitions represent an estimated ~$43M and ~$124M of incremental run-rate EBIT by 2027.

This analysis does not include the possibility that facilities operating without a licensed administrator immediately stop being paid by Medicare and Medicaid as Vice President Vance stated on May 13, the government is no longer doing “pay and chase” and instead is planning to stop payments tied to fraud immediately.

Operating Headwind	Methodology & Inputs	2026 Missed Cohort	2027 Cumulative Missed Cohort
Acquisition slowdown	~29 missed acquisitions in 2026 and ~55 missed acquisitions in 2027, implying ~84 cumulative missed acquisitions by 2027 if license-rental model stops. Portfolio blended EBIT/SNF of ~$1.5M already reflects facilities across different ramp and profitability stages. Implies ~$43M and ~$124M of lost future run-rate EBIT contribution from the 2026 and 2027 missed acquisition cohorts, respectively	**-$43M**	**-$124M**
Run-rate impact as % of consensus EBIT	Shown relative to consensus operating income for scale only; not a forecast of same-period EBIT decline.	**7%**	**19%**

Note: Full model mechanics and sensitivity inputs provided in Appendix 2 , **Sources:** ENSG Q1 2026 10-Q; Interviews with former Ensign employees; Bloomberg Consensus; UBS May 1 2026 Research; Vice President Vance Tweet on May 13, 2026 regarding fraud and payment stoppage.

Earnings Destruction Path 2: Margin Compression

We believe Ensign's 160bps margin advantage over PACS is driven by lower nursing staffing levels. Ensign serves higher-acuity residents yet staffs nurses at 3.7 hours per resident day, versus 3.9 at PACS and the national average. While a 0.2 hour daily difference appears modest, it compounds across more than 32,000 occupied beds into ~ 2.3 million fewer nursing hours annually. Applying a fully loaded nursing cost of $45 per hour implies ~ $106 million of annual labor savings. If Ensign staffed nurses at the same level as PACS and the national average, we estimate EBITDAR margins would decline by ~ 210bps.

Unfortunately, we believe Ensign's margin premium comes at the expense of resident care, as Ensign facilities received ~85% more severe-harm citations (CMS J-L tags) per occupied bed than PACS over the last three years.

Operating Headwind	Methodology & Inputs	EBITDAR Impact	Share of Reported EBITDAR
Lower nursing staffing relative to peers	ENSG provides 3.7 nursing hours per resident day versus 3.9 at PACS and the national average. The difference equates to ~73 annual nursing hours per occupied bed. Applying this staffing gap across ~32,381 occupied beds implies ~2.3 million additional nursing hours annually. At a fully loaded nursing cost of $45 per hour, estimated incremental labor expense is approximately $106M.	**-$106M**	**13.4%**
Margin impact	Shown relative to reported 2025 results. Revenue assumed unchanged.	**210 bps margin compression**	**-**

Note: See Appendix 3 for full methodology and calculations
Sources: Company 10-K filings for Ensign, 2023–2025; PACS 10-K filings, 2024–2025; ProPublica Nursing Home Inspect affiliate data for The Ensign Group; PACS Affiliate Data

Aggregated Impact: Ensign's Earnings Power Is Materially Overstated

Throughout this report, we identified three issues that we believe helped drive Ensign's growth and profitability: (i) administrator license-rental arrangements that accelerated acquisitions, (ii) nursing staffing levels below peer and national averages that inflated margins, and (iii) potential False Claims Act exposure associated with facilities billing Medicare and Medicaid without compliant licensed management.

The table below quantifies only the first two impacts. If Ensign can no longer rely on administrator license-rental arrangements, we believe acquisition growth would slow materially and future acquisition cohorts would be lost. If Ensign staffed nurses in line with PACS and the national average, we estimate EBITDAR margins would decline by approximately 210bps. Together, these two operating impacts represent ~35% of 2027 consensus EBIT.

This analysis excludes any potential False Claims Act liability, payment suspensions, operational disruption, reputational damage, and any exposure related to alleged therapy billing practices.

Earnings Power Impact	Value
Lost run-rate EBIT from missed acquisition cohorts	**-$124M**
Margin compression	**-$106M**
Combined earnings power impact	**-$230M**
Combined impact as % of 2027 consensus EBIT	**-35%**

Note: Newly acquired facilities typically require one to two years to reach normalized profitability. Accordingly, the acquisition-related impact should be viewed as lost future run-rate earnings power rather than an immediate-period earnings decline.
Sources: Bloomberg Consensus

Appendix

Appendix 1: Private Investigator Site Visits Across 57 Facilities

State	Facilities Visited
AZ	8
CA	10
IA	8
ID	5
KS	7
NV	2
TX	10
UT	7
Total	**57**

Sources: Site visits by independent private investigators

Appendix 2: Applying Cohort Acquisition Growth Rate

If Ensign were forced to stop using rented Administrator licenses today, we believe acquisition pace would normalize to peers and the true financial impact is in the form of missed acquisitions each year and that cohorts respective EBIT run rate.

SNF Growth

	2021	2022	2023	2024	2025	2026E	2027E
ENSG SNFs	236	260	286	316	357	411	472
Facilities Acquired		24	26	30	41	54	62
Growth		10%	10%	10%	13%	*15%*	*15%*

Sources of Truth

Input	Value	Source / Math
Q1 2026 Skilled Services revenue	$ 1,330,800,000	Q1 2026 10-Q Skilled Services revenue
Annualized Skilled Services revenue	$ 5,323,200,000	$1.3B × 4
Number of SNFs in Q1 2026	357	357 SNF facilities contributed to the 1.3B in Skilled Services Revenue
Revenue / SNF (portfolio blended)	$ 14,910,924	$5.3B / 357
EBIT margin	10%	UBS 2026E/2027E EBIT margin 9.9%/10.0%
EBIT / SNF (portfolio blended)	$ 1,491,092	$14.7M × 10.0%
Average residents / SNF	90	40,629 operational skilled nursing beds × 84% occupancy / 379 SNF-campus facilities
EBIT / resident	$ 16,568	$1.49M / 90
2026E Bloomberg consensus operating income	$ 586,330,000	Bloomberg consensus; UBS is $581M
2027E Bloomberg consensus operating income	$ 645,670,000	Bloomberg consensus; UBS is $647M
2026E Bloomberg adj. EPS	$ 7.55	Bloomberg consensus
2027E Bloomberg adj. EPS	$ 8.27	Bloomberg consensus

Acquisition Slowdown for 2026

Projected facilities to acquire	54	Based on historic growth and 22 facilities acquired in 5 months in 2026
YTD 2026 acquisitions through May	22	5 in Q1 + 17 announced with Q1 results
Remaining projected acquisitions	32	54 projected – 22 already acquired
Scenario acquisitions after model disruption	3	Assumes acquisition pace slows toward peers; NHC grew by 1.6% from 2021 to 2025 & PACSs grew by 7 facilities from 2024 to 2025
Acquisition shortfall	29	32 remaining – 3 scenario acquisitions
Portfolio blended EBIT / SNF	$ 1,491,092	Portfolio blended EBIT / SNF
Foregone EBIT contribution capacity	$ 42,570,689	29 × $1.49M
Bloomberg consensus operating income	$ 586,330,000	
Foregone EBIT as % of operating income	7%	

Acquisition Slowdown for 2027

Projected facilities to acquire	62	Based on historic growth, assumed 15% growth YoY
Scenario acquisitions	7	Assumes acquisition pace slows toward peers; NHC grew by 1.6% from 2021 to 2025 & PACSs grew by 7 facilities from 2024 to 2025
Acquisition shortfall	55	62 projected – 7 scenario acquisitions
Prior year cumulative acquisition shortfall	29	2026 facilities never acquired remain absent in 2027
Total cumulative acquisition shortfall	83	55 current year + 29 prior year
Portfolio blended EBIT / SNF	$ 1,491,092	Current ENSG portfolio EBIT divided by SNFs
Foregone EBIT contribution capacity	$123,958,242	84 × $1.49M
Bloomberg consensus operating income	$ 645,670,000	
Foregone EBIT as % of operating income	19%	

Total Impact

Input	2026E	2027E	Source / Math
Bloomberg Consensus EBIT	$ 586,330,000	$ 645,670,000	Bloomberg consensus
Foregone Future Run-Rate EBIT	($42,570,689)	($123,958,242)	
Run-Rate Impact as % of Consensus Operating	-7%	-19%	

Note: Run-rate EBIT impacts are shown relative to consensus operating income for sizing purposes and do not represent same-period EBIT declines; newly acquired facilities typically require 1–2 years to stabilize.

Sources: ENSG Q1 2026 10-Q; Bloomberg Consensus; UBS May 1, 2026, Research

Appendix 3: Margin Compression

If Ensign staffed nurses at PACS and national average levels, we estimate EBITDAR margins would compress by 210bps, implying approximately $1.5 billion of enterprise value downside, or 13% of current enterprise value

Peer Margin Analysis (2023–2025)

EBITDAR Margin Comparison

	2023	2024	2025	3-Yr Avg.	Source
ENSG Revenue	$ 3,729,360,000	$ 4,260,490,000	$ 5,057,840,000		ENSG 10K, 2023 - 2025
ENSG Adjusted EBITDAR	$ 616,854,000	$ 706,408,000	$ 841,662,000		ENSG 10K, 2023 - 2025
ENSG Adjusted EBITDAR Margin	16.5%	16.6%	16.6%	16.6%	
PACS Revenue	$ 3,111,490,000	$ 4,086,660,000	$ 5,287,890,000		PACS 10K, 2024 - 2025
PACS Adjusted EBITDAR	$ 454,197,000	$ 564,410,000	$ 883,931,000		PACS 10K, 2024 - 2025
PACS Adjusted EBITDAR Margin	14.6%	13.8%	16.7%	15.0%	

Total Beds

Total SNF Beds

	2023	2024	2025	Q1 2026	Source
ENSG	30,602	33,547	37,911	38,549	ENSG 10K, 2023 - 2025; 2026 10Q
PACS	22,950	32,016	32,854	32,757	PACS 10K, 2024 - 2025; 2026 10Q
NHC	8,726	8,732	10,341	10,323	NHC 10K, 2023 - 2025; 2026 10Q

SNF Occupancy Rate

	2023	2024	2025	Q1 2026	Source
ENSG	78.5%	80.5%	82.2%	84.0%	ENSG 10K, 2023 - 2025; 2026 10Q
PACS	90.9%	90.4%	89.1%	90.8%	PACS 10K, 2024 - 2025; 2026 10Q
NHC	87.9%	88.6%	89.7%	90.0%	NHC 10K, 2023 - 2025;; 2026 10Q

Estimated Occupied Beds

	2023	2024	2025	Q1 2026	Source
ENSG	24,023	27,005	31,163	32,381	Total SNF Beds * Occupancy Rate
PACS	20,862	28,942	29,273	29,743	Total SNF Beds * Occupancy Rate
NHC	7,670	7,737	9,276	9,291	Total SNF Beds * Occupancy Rate

Nursing Staffing Gap vs PACs and National Average

	Nursing Hours Per Resident Day	Days	Total Nursing Hours Per Resident Year	Additional Hours vs ENSG	Source
ENSG	3.7	365	1,351		ProPublica, ENSG Nursing Hours
PACS / National Average	3.9	365	1,424	73	ProPublica, PACS Nursing Hours

Estimated Annual Labor Savings from Lower Staffing

		Value
Additional nursing hours required per resident		73
Occupied beds		32,381
Incremental nursing hours required annually		2,363,825
Fully loaded nursing cost per hour	$	45.00
Incremental labor expense required	$	106,372,111

EBITDAR Impact if ENSG Staffed at National Average

		Reported 2025 Results
Revenue	$	5,057,840,000
EBITDAR	$	791,150,000
EBITDAR Margin		15.6%
EBITDAR Multiple		14
Enterprise Value	$	11,076,100,000
		Pro Forma at National Average Staffing Levels
Revenue	$	5,057,840,000
EBITDAR	$	684,777,889
EBITDAR Margin		13.5%
EBITDAR Multiple		14
Enterprise Value	$	9,586,890,452
		Margin Compression
EBITDAR Margin Reduction:		-2.10%

Implied Valuation Impact from Margin Normalization

		Reported 2025 Results
Revenue	$	5,057,840,000
EBITDAR	$	791,150,000
EBITDAR Margin		15.6%
EBITDAR Multiple		14
Enterprise Value	$	11,076,100,000
		At National Average Staffing Levels
Adjusted EBITDAR Margin		13.5%
Adjusted EBITDAR	$	684,777,889
EBITDAR Multiple		14
Enterprise Value	$	9,586,890,452
		Implied Valuation Impact
Enterprise Value Reduction	$	(1,489,209,548)
Implied EV Downside:		-13%

Sources: Company 10-K filings for Ensign and NHC, 2023–2025; PACS 10-K filings, 2024–2025; ProPublica, ENSG Nursing Hours; ProPublica, PACS Nursing Hours; ProPublica, NHC Nursing Hours.

Appendix 4: False Claims Act Damages Model (Treble + Per-Claim Penalties)

Sensitivity model for False Claims Act exposure assuming a range of facility participation rates in the alleged licensing-rental scheme over a one-year period. The 10% scenario is shown below.

Assumptions		
% of SNFs Implicated		10%
Estimated Annual Institutional Claims per SNF (Medicare + Medicaid) (90 residents per facility billed weekly for 52 weeks)		4,680
Assumed Statutory Penalty per False Claim	$	14,308
Facts from Q1 2026 10-Q		
Skilled Nursing Facilities (Q1 2026; excludes 22 recently acquired as they did not meaningfully contribute to revenue)		357
Operational SNF Beds (Q1 2026)		40,629
Average SNF Occupancy (Operational Beds)		84%
Skilled Services Revenue (Q1 2026 Annualized)		5,323,200,000
Government Fee-For-Service Revenue (Medicaid and Medicare) as a percentage		69%
Government Fee-For-Service Revenue (Medicaid and Medicare)	$	3,673,008,000
Math		
Average Revenue per SNF (Q1 2026 Annualized)	$	14,910,924
Average Government Program Revenue per SNF	$	10,288,538
False Claims Act Damages Model (Treble Multiplier Only)		
Number of Facilities Implicated		36
Average Government Program Revenue per SNF	$	10,288,538
Treble Damages Multiplier (3×)	$	30,865,613
Aggregate Treble Damages Exposure	$	1,101,902,400
Civil Penalty Model (Per-Claim Statutory Penalties)		
Number of Facilities Implicated		36
Estimated Annual Institutional Claims per SNF		4,680
Assumed Statutory Penalty per False Claim	$	14,308
Aggregate Civil Penalties Per-Claim Statutory	$	2,390,523,408
Estimated Aggregate False Claims Act Exposure		
Total Exposure from Treble and Claims	$	3,492,425,808

Appendix 5: CMS Severe Harm Tags

CMS tags range from A-L. Our analysis focuses on J-L tags, the most serious CMS deficiencies. These are deficiencies where CMS surveyors determined residents were actually harmed or placed in situations likely to cause serious injury, impairment, or death. Ensign was materially higher than peers, averaging nearly 2x PACS and more than 4x NHC on a per-occupied-bed basis. We indexed PACS to 100 in each year because CMS data indicates PACS is in line with the national average nursing hours per resident per day.

CMS J–L Severe Patient Harm Analysis

CMS J–L Severe Harm Tags by Year

	2023	2024	2025	3-Yr Total	Source
ENSG	57	100	63	220	ProPublica, ENSG J-L Tags
PACS	29	56	31	116	ProPublica, PACS J-L Tags
NHC	3	8	5	16	ProPublica, NHC J-L Tags

SNF Facility Count

	2023	2024	2025	Source
ENSG	286	316	357	ENSG 10K, 2023 - 2025
PACS	203	287	291	PACS 10K, 2024 - 2025
NHC	68	80	80	NHC 10K, 2023 - 2025

CMS J–L Severe Harm Tags per Facility

	2023	2024	2025	3-Yr Avg.	Source
ENSG	0.20	0.32	0.18	0.23	J-L Tags divided by SNF Facility Count
PACS	0.14	0.20	0.11	0.15	J-L Tags divided by SNF Facility Count
NHC	0.04	0.10	0.06	0.07	J-L Tags divided by SNF Facility Count

Total SNF Beds

	2023	2024	2025	Source
ENSG	30,602	33,547	37,911	ENSG 10K, 2023 - 2025
PACS	22,950	32,016	32,854	PACS 10K, 2024 - 2025
NHC	8,726	8,732	10,341	NHC 10K, 2023 - 2025

SNF Occupancy Rate

	2023	2024	2025	Source
ENSG	78.5%	80.5%	82.2%	ENSG 10K, 2023 - 2025
PACS	90.9%	90.4%	89.1%	PACS 10K, 2024 - 2025
NHC	87.9%	88.6%	89.7%	NHC 10K, 2023 - 2025

Estimated Occupied Beds

	2023	2024	2025	Source
ENSG	24,023	27,005	31,163	Total SNF Beds * Occupancy Rate
PACS	20,862	28,942	29,273	Total SNF Beds * Occupancy Rate
NHC	7,670	7,737	9,276	Total SNF Beds * Occupancy Rate

CMS J–L Severe Harm Tags per Occupied Bed

	2023	2024	2025	3-Yr Avg.	Source
ENSG	0.002373	0.003703	0.002022	0.002699	J-L Tags divided by Occupied Beds
PACS	0.001390	0.001935	0.001059	0.001461	J-L Tags divided by Occupied Beds
NHC	0.000391	0.001034	0.000539	0.000655	J-L Tags divided by Occupied Beds

Severe Harm Indexed to PACS

	2023	2024	2025	3-Yr Avg.	Source
ENSG	170.7%	191.4%	190.9%	184.7%	Index PACS to 100 as it the national average
PACS	100.0%	100.0%	100.0%	100.0%	Index PACS to 100 as it the national average
NHC	28.1%	53.4%	50.9%	44.8%	Index PACS to 100 as it the national average

Sources: Company 10-K filings for Ensign and NHC, 2023–2025; PACS 10-K filings, 2024–2025; As of June 4th 2026 ProPublica, ENSG J-L Tags; ProPublica, PACS J-L Tags; ProPublica, NHC J-L Tags;

Appendix 6: CMS Appendix PP Directs Surveyors to Interview the Administrator Personally Across Six Contexts

CMS Appendix PP, the federal surveyor guidance for nursing home inspections, directs surveyors to interview the Administrator personally across at least six distinct contexts, spanning abuse investigations, retaliation and crime reporting, governing body accountability, and facility closure.

CMS designed each of these protocols on the premise that the Administrator personally performs the role. A rented-license arrangement, in which an unlicensed Operations Manager performs the function and the licensed Administrator is absent in substance, is structurally incompatible with the six surveyor interview protocols.

F Tag	CMS Directs Surveyors to Interview Administrator On	PDF Page
F602	Misappropriation of resident property and exploitation	**103**
F603	Involuntary seclusion	**114**
F608	Allegations of facility retaliation against employees	**160**
F609	Reporting of suspected crimes against residents	**181**
F837	Governing body interview: administrator reports on management, accountability, audits, budgets, staffing, facility-wide assessment	**717**
F846	Facility closure plan implementation	**745**

Sources: Appendix PP – CMS Guidance to Surveyors

Appendix 7: List of All Expert Interviews

We interviewed a total of 19 people for this report and spoke with several of them multiple times for hours each. 7 were former Ensign Administrators, 4 were former Ensign Therapists, 2 were former Ensign Nurses, 1 was a former Ensign Assistant VP of HR, 1 was a former Ensign Office Manager, 1 was a former Assistant U.S. Attorney, 1 was a former Special Agent at HHS OIG, and 2 were former Deputy Directors at CMS.

Category	Code Name	Years worked at Ensign
Former Ensign Administrators	Former Ensign Administrator #1	2022 – 2024
	Former Ensign Administrator #2	2023 – 2025
	Former Ensign Administrator #3	2022 – 2023
	Former Ensign Administrator #4	2021 – 2022
	Former Ensign Administrator #5	2015 – 2018
	Former Ensign Administrator #6	2015 – 2019
	Former Ensign Administrator #7	2015 – 2024
Former Ensign Therapists	Former Ensign Physical Therapist #1	2024 – 2025
	Former Ensign Physical Therapist #2	2023 – 2024
	Former Ensign Speech Language Therapist	2021 – 2024
	Former Ensign Occupational Therapist	2023 – 2024
Former Ensign Nurses	Former Ensign Certified Nursing Assistant	2019 – 2022
	Former Ensign Director of Nursing Services	2023 – 2024
Former Ensign HR	Former Assistant Vice President of Human Resources	[redacted]
Former Ensign Office Manager	Former Ensign Business Office Manager	[redacted]
Former DOJ, HHS OIG, and CMS Regulators	Former Assistant U.S. Attorney at U.S. Attorneys Office	1994 – 2025: United States Attorney's Office
	Former Special Agent, HHS Office of Inspector General	1998 – 2023: Special Agent at HHS Office of Inspector General
	Former Deputy Director Centers for Medicare and Medicaid Services (CMS)	2005 – 2023: Centers for Medicare & Medicaid Services
	Former Deputy Director, Center for Clinical Standards and Quality	2005 – 2023: Centers for Medicare & Medicaid Services