Financial and Quality Metrics of A Large, Publicly Traded U.S. Nursing Home Chain in the Age of Covid-19

International Journal of Health Services
2022, Vol. 52(2) 212–224

DOI: 10.1177/00207314221077649
journals.sagepub.com/home/joh
SAGE

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Abstract

Nursing homes faced serious challenges with large COVID-19 resident infection rates and deaths during the pandemic. This descriptive case study examined the structure, operations, strategies, care outcomes, and owners of The Ensign Group Inc. the second largest U.S. for-profit chain, between 2007 and 2021. Ensign, as a holding company, has a complex organizational structure that uses more than 430 corporate entities to manage its 228 nursing homes and senior living facilities. With mostly Medicare and Medicaid revenues and favorable government COVID-19 relief, Ensign grew rapidly, even during the pandemic, to $2.5 billion (all amounts in U.S. Dollars) in revenues with a market capitalization of $4.5 billion and strong profits and financial metrics in 2020 to 2021. The company used real estate purchasing, debt financing, and spin-off companies, and tax arbitrage to optimize shareholder value. Before and during the pandemic, its 198 nursing homes had low registered nurse and total nurse staffing levels and regulatory violations with below-average ratings, and they had high COVID-19 infection rates during the pandemic. Ensign's small board, executives, and institutional investors protected and enhanced shareholder interests rather than ensuring that its nursing homes met professional standards and regulatory requirements.

Keywords

nursing home chain, financial metrics, quality, publicly-traded, staffing, COVID-19, for-profit

Nursing home (NH) residents are highly vulnerable and need extensive nursing care because most are older with chronic illnesses, medical conditions, and cognitive impairments.[1] Widespread quality problems and failure to comply with government regulations have been longstanding concerns in U.S. nursing homes (NHs).[2–4] One-third of Medicare NH residents were found to experience adverse events, resulting in harm or death, during their short stays.[5] Residents are frequently readmitted to the hospital for common and preventable problems.[6] Other problems include: abuse and sexual assaults, overuse of psychotropic medication, inadequate emergency provisions, pressure ulcers, falls with injuries, weight loss, dehydration, pain, medication errors, and infections,[7,8] with evidence that these problems are underreported.[9,10] NHs were poorly prepared for the COVID-19 pandemic, during which more than 722,000 NH residents and 673,000 staff had infections and approximately 140,000 residents and 2000 staff had died by November 2021.[11]

Approximately 70% of U.S. NHs are operated by for-profit corporations and 58% are operated by corporate chains, with an increase in investor-owned regional and national chains over time.[12] Some chains became publicly traded companies in the 1980s (eg, HCR Manor Care, Beverly Enterprises, Genesis), whereas others remained private companies or owned by private equity investors.[13] Several of the largest chains had quality and/or financial problems that led to government actions and bankruptcy in the early 2000s, and some chains were restructured or sold.[14] By 2020, only four NHs chains were publicly listed companies, and two of those (Diversicare and Genesis) announced plans to shift to private ownership, leaving only The Ensign Group Inc. (Ensign) and Brookdale as publicly traded for-profit chains, along with several real estate investment trusts (REITs) that specialize in NHs.[15,16]

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Although the NH industry argued that many facilities were facing potential bankruptcy and closures related to the pandemic, little evidence for these claims has been found.[17,18] Before and during the pandemic, Ensign showed strong financial performance, with 2020 revenues of $2.5 billion (all amounts in U.S. Dollars) and a market capitalization of $4.5 billion.[19] Ensign was identified as the second largest NH chain (after Genesis) in terms of total NHs and beds in 2020.[20] Given its size and rapid growth, along with its profitability during the COVID-19 pandemic, this corporation merits a study to more fully understand its organization, structure, and financial success.

Background

More than 20 years ago, a study on appropriate NH staffing for the Centers for Medicare & Medicaid Services (CMS) in 2001 established the importance of having a minimum of 0.75 registered nurse (RN) hours per resident day (hprd), 0.55 licensed vocational or practical nurse (LVN/LPN) hprd, and 2.8 (to 3.0) certified nursing assistant (CNA) hprd, for a total of 4.1 nursing hprd to prevent harm and jeopardy for long-stay residents.[21] These standards have been endorsed by professional associations and experts.[22–25] Federal law requires staffing levels to be sufficient to meet resident care needs and to address resident acuity levels.[26] Experts recommend higher staffing for higher acuity residents, ranging from 5.6 to 6.8 total nursing hprd and 1.4 to 1.9 RN hprd.[27] CMS's Care Compare Five-Star Rating System evaluates the nurse staffing levels needed in each U.S. facility based on its resident acuity to provide public information and encourage staffing improvements.[8]

Despite evidence demonstrating the importance of nurse staffing levels, understaffing has been a longstanding problem in U.S. NHs. Based on the CMS 2001 recommended minimums, half of the NHs had low staffing and at least a quarter had dangerously low staffing in 2014.[28] In 2017 to 2018, 75% of NHs almost never met the CMS-expected RN staffing levels based on resident acuity, with wide variability in staffing levels and steep staffing declines on weekends and holidays.[29]

For-profit NH companies generally have poorer quality indices and deficiencies (for violations of regulations) than nonprofit and government facilities.[30] Staffing levels are lower in for-profit NHs, where owners often cut nurse staffing, especially RN staffing, and reduce wages, benefits, and pensions to maximize profits.[31] For-profit NHs reported about 16% fewer staff than nonprofits, controlling for resident needs, in 2017.[32] Homes with the highest profit margins have been found to have the worst quality in the United States.[33]

Nursing home chains have more quality and compliance problems than other NHs. The largest for-profit chains have lower RN and total nurse staffing hours and more deficiencies than nonprofit facilities and government facilities.[31] Nonprofit NHs (compared to for-profits) have fewer 30-day hospitalizations and show greater improvements in mobility, pain, and functioning.[34] For-profit private equity buyouts of NHs show declines in resident health and care standards because of cuts in nursing staff compared to acquisitions by non-private equity corporate chains.[35]

For-profit NHs were associated with more quality-of-care problems related to COVID-19 infections. A California study showed that COVID death rates were higher in for-profit homes,[36] and another three-state study showed similar findings.[37] Another study found that chains had a higher probability of having COVID infections and that for-profit NHs had a probability of higher outbreak size.[38]

For-profit NH companies have developed increasingly complex corporate ownership structures, with some having seven or eight layers of companies.[39] By moving assets in a company separate from operating companies, NHs can lower taxes rates, shield parent companies from liability, reduce regulatory oversight, and hide profit margins.[31,40] Large for-profit NH chains may pursue profits and shareholder value by using strategies that include: (*a*) pursuing growth through debt-financed purchases and mergers; (*b*) separating assets from operating companies and creating separate, complex corporate structures; (*c*) maximizing revenues from government payers; (*d*) instituting strict controls on labor costs and staffing levels; and (*e*) viewing sanctions for fraud and poor quality as a cost of business.[14] In addition, companies can use tax arbitrage to profit from differences in the ways that various types of income, capital gains, and transactions are taxed.

Methodology

Specific Aims

The overall goal of this article is to illuminate the structure, operations, strategies, and care outcomes of Ensign over time and during the pandemic in 2002 to 2021. The first aim is to describe and examine Ensign's corporate structure, growth, and financial trends from its initial public offering in 2007 through 2020. The second aim is to examine Ensign's financial metrics in comparison to industry-wide measures for health-related publicly traded companies and its corporate strategies in 2020 to 2021. The third aim is to examine NH quality indicators, including staffing levels, government ratings of quality, COVID-19 infections and deaths during the pandemic, compared to average NHs in the 2020 to 2021 period, and government regulatory actions in the 2007 to 2020 period. The final aim is to describe the corporate board members, executives, and investors and their benefits and stocks between 2007 to 2020.

Study Design

A descriptive case-study design was selected to develop an in-depth and focused analysis of a high-growth, publicly

traded NH chain. We describe the organization, growth, financial indicators, and quality indicators over time, including contemporary events before and during the COVID-19 pandemic. Standard procedures were used to collect and analyze publicly available corporate and secondary data from government and private sources. Multiple data sources were assessed to identify the most reliable information available and to identify confirming and disconfirming evidence.[41] No human subjects were involved in the study.

Data Sources and Measures

To describe Ensign's organizational structure, provider ownership, real estate, and growth strategies over time, we used Ensign's own public reports to the U.S. Securities and Exchange Commission (SEC) from Ensign's SEC annual 10 K reports. We used standard financial measures from SEC 10 K reports from 2007 to 2020, including: facility revenues; net income (revenues minus expenses, taxes, and interest rates); depreciation (deductions of asset costs over its useful life); EBITDA (earnings before interest, taxes, depreciation, and amortization); earnings per share (net profit divided by the number of common shares outstanding); and share price (the price of a single share of stock).[42]

Standard financial metrics were used to compare Ensign to industry-wide, health-related publicly traded companies in 2000 and 2021. These measures included: (*a*) price per share, (*b*) the market-to-book ratio (price per share times the number of outstanding shares divided by shareholder equity), (*c*) price-to-earnings ratio (the market value price per share divided by the earnings per share), (*d*) the debt-to-equity ratio (total liabilities divided by shareholder equity), (*e*) the current ratio (current assets divided by current liabilities), and (*f*) the enterprise value (market capitalization, plus market value of debt minus cash and equivalents divided by the EBITDA) from Yahoo and Market Trends financial reports. For industry comparisons, we used data from CSIMarket, an independent digital financial media company.[43]

For quality measures, we used data from CMS for March 2020 prior to the pandemic and for October 2020 and May 2021, during the pandemic.[8] We obtained CMS data on the average number of beds, occupancy rates, and payroll-based journal staffing data for: registered nurses (RNs), licensed vocational or practical nurses (LVN/LPNs), certified nursing assistants (CNAs), and total nursing hours per resident day (hprd). The CMS Care Compare data included: average facility deficiencies, weighted deficiency scores, total staffing rating, RN staffing rating, facility survey rating, resident quality measure ratings, and overall facility quality rating. We also obtained cumulative CMS COVID-19 resident and staff infection and death rates from May 2020 through May 30, 2021.[11] Government regulatory actions against Ensign were obtained from the Office of the Inspector General (OIG) of the Department of Health and Human Services.

Finally, we collected data on Ensign's board members' and executives' stock shares and percent of ownership from SEC Schedule 14A proxy statements for 2008 to 2020. We also examined stock shares of beneficial owners, defined by the SEC as any entity or individual possessing 5% or more ownership of a public corporation, which requires SEC reports.

Analyses

For the financial analysis, we compiled data into tables to show the financial trends from 2007 through 2020. This analysis includes a variety of financial metrics, such as revenue net income, profitability, and share price from Ensign's income statements, balance sheets, and cash flow statements over time, and we compared these to Brookdale,[44] the other large, publicly traded NH chain in 2020. Ensign's financial metrics for its market capitalization, price to earnings, debt to equity, and other measures were compared to the industry average for other health-related, publicly traded companies in 2020 to 2021.

For facility quality, we calculated Ensign's average staffing and facility ratings in March 2020, October 2020, and May 2021 from CMS Care Compare data. Ensign staffing levels were compared to U.S. averages for the same period and to the staffing levels recommended by experts.[21,27] Deficiencies and facility ratings were compared to national averages for U.S. facilities. Cumulative CMS data on Ensign resident and staff COVID-19 infections and deaths rates were averaged through May 30, 2021, and compared with national averages. The OIG regulatory actions were described for the study period. Finally, we described the board members and executives in terms of their roles, experience, and family relationships. We also examined the percentages of Ensign shares held by executive officers, board members, and beneficial owners.

Results

Corporate Structure

The Ensign Group Inc. incorporated in Delaware and founded in 1999, is a "holding company with no direct operating assets, employees, or revenue" that became publicly traded in November 2007 (ENSG) (NASDAQ).[42] According to the company, the name Ensign is synonymous with a flag or a standard and refers to Ensign's goal of setting the standard by which all others are measured. The holding company has wholly-owned, independently-operated subsidiaries and facilities with their own management, employees, and assets that provide services.

Ensign's "Service Center" is a collection of wholly-owned subsidiaries, located in California, that

provide centralized accounting, payroll, human resources, information technology, legal, risk management, and other centralized services to its other operating subsidiaries through contractual relationships. In addition, Ensign has its own wholly-owned captive insurance subsidiary, called the "Captive," which provides some coverage to its operating subsidiaries.[19]

In 2020, Ensign reported owning 22 separate companies, including: Ensign Inc. (which owned 129 entities), Keystone Care limited liability corporation (LLC) (70 entities), Bandera Healthcare LLC (34 entities), Flagstone Healthcare South LLC (31 entities), Milestone Healthcare LLC (24 entities), Gateway Healthcare Inc. (23 entities), Pennant Healthcare LLC (21 entities), Endura Healthcare Inc. (19 entities), Flagstone Healthcare Central LLC (14 entities), Flagstone Healthcare North Inc. (7 entities), and other smaller companies. All except three companies were incorporated in Nevada, and these companies, in turn, owned a total of 409 legal entities (mostly LLCs), which owned and/or operated separate NH and senior care communities, many with different corporate names.

Provider Ownership

Ensign began with five NHs with 710 beds in 1999 and increased to 61 facilities with 6777 beds in 2007. Ensign also had 566 assisted and independent living units with 671 beds, for a grand total of 7448 beds (Table 1). Ensign reorganized its facilities into five separate portfolio companies in 2006.

In 2020, Ensign operated 228 total facilities with 25,426 beds (including 195 NHs with 23 172 beds in 13 states and 33 senior living communities) (Table 1). Of the total facilities, 164 were operated under long-term leases and 64 properties were owned (although 31 were leased to and operated by The Pennant Group). The 2018 to 2019 decline in beds (Table 1) occurred when Ensign spun off properties to The Pennant Group.

In spite of the COVID-19 pandemic in 2020 to 2021, Ensign increased its operating NHs to 240 facilities by June 2021. In 2020, Ensign's senior living communities had their own ancillary operations, including digital x-ray, ultrasound, electrocardiograms, laboratory services, subacute services, and patient transportation.

Real Estate

In 2013, most of Ensign's real estate was spun off into a newly created corporation called CareTrust REIT, a real estate investment trust, structured as an "umbrella REIT" or "UPREIT".[45] An UPREIT is a unique REIT structure that allows property owners to exchange their property for share ownership in the UPREIT. In June 2014, Ensign completed the separation of the REIT into an independent, publicly traded company (NASDAQ) with the distribution of all the outstanding shares of common CareTrust REIT stock to Ensign stockholders on a pro rata basis that was tax-free for directors and stockholders.

In 2020, CareTrust REIT's real estate portfolio consisted of 218 NHs, multiservice campuses, and assisted living facilities with 22 466 beds and units located in 28 states, with most properties located in California, Texas, Louisiana, Idaho, and Arizona. Of the total properties, it owned 157 NH facilities with 16 238 beds, most of which were leased to Ensign subsidiaries on a triple-net long-term basis, which requires each NH to pay for building maintenance, insurance, and property taxes. CareTrust REIT reported revenues of $178 million and $1.6 billion in assets in 2020.

In 2016, Ensign spun off its home health, hospice, and senior living businesses to The Pennant Group. It was incorporated in Delaware in 2019 as a separate publicly traded company through a tax-free distribution of outstanding common stock shares to Ensign stockholders on a pro rata basis.[46] By 2020, The Pennant Group Inc. had 76 home health and hospice agencies and 54 senior living services with 4127 assisted living, independent, and memory care programs in 14 states. Its total revenues were $391 million, with about 70% of its home health and hospice revenues from government sources and 73% of senior living revenues from private pay.

In its 2021 third-quarter financial report, Ensign announced the formation of a "captive REIT," which was a legal entity for holding real estate owned by the company rather than spinning it out into a separate corporation. By bundling properties into a captive REIT, the company may receive special tax breaks.[47]

Ensign Group used the triple-net lease arrangements for its own properties with its subsidiary facilities and generated $61.3 million in rental revenues and $55 million from depreciation of its buildings (see Table 1). Its buildings ranged in age from 3 to 57 years, with an average of 35 years in 2020.

Growth Strategies

In contrast to some other NH chains that sell off property and manage property for REITs, Ensign has spun off some properties while growing its own property assets. Ensign's reports stated that it continued to purchase both underperforming and performing post-acute care operations, even during the pandemic. Ensign's stated growth strategies are based on: identifying and developing future leaders, organizing and operating its subsidiaries into portfolio companies with their own leaders who can build relationships with local stakeholders in communities, increasing the overall percentage of higher-acuity residents, focusing on organizational growth and operating efficiencies, expanding and renovating existing operations, and strategically investing in and integrating other post-acute businesses.

Financial Growth

Ensign has demonstrated robust growth in revenues and other financial metrics prior to and after spinning off a large proportion of its property. Table 1 shows that since 2007, Ensign's annual revenues increased from $410 million to $2.4 billion in 2020. Nearly all of Ensign's revenues

Table 1. Ensign Annual Financial Performance Indicators for 2007 to 2020.

Year	No. SNF & Other Facilities	No. of NH & Other Facility Beds	Total Revenues [a]	Medicare, Medicaid, Managed Care Revenues[a] (% of Revenues)	Net Income [b]	Depreciation [b]	EBITDA [ac]	Earnings Per Share[d]	Share Price [d]
2007	61	7105	$0.41	$0.36 (86.4)	$20.19	$7	$0.04	$0.68	$3.71
2008	63	7324	$0.47	$0.41 (86.6)	$27.51	$9	$0.06	$0.67	$3.39
2009	77	8948	$0.54	$0.47 (80.3)	$32.48	$14	$0.07	$0.78	$3.54
2010	82	9539	$0.65	$0.57 (87.0)	$40.53	$17	$0.09	$0.96	$4.49
2011	102	11 702	$0.76	$0.65 (86.0)	$47.68	$24	$0.12	$1.10	$5.23
2012	108	12 198	$0.82	$70 (85.2)	$40.52	$31	$0.11	$0.93	$7.22
2013	119	13 204	$0.90	$0.76 (83.6)	$24.04	$35	$0.09	$0.54	$10.22
2014	136	14 725	$1.02	$0.83 (83.2)	$35.59	$27	$0.10	$0.78	$16.72
2015	186	19 653	$1.34	$1.12 (83.5)	$55.43	$29	$0.12	$1.06	$19.13
2016	210	22 174	$1.65	$1.40 (84.6)	$49.99	$40	$0.13	$0.96	$16.03
2017	230	23 881	$1.59	$1.35 (84.8)	$40.48	$43	$0.09	$0.77	$20.24
2018	244	25 279	$1.75	$1.48 (84.5)	$92.36	$45	$0.13	$1.70	$37.85
2019	223	24 779	$2.04	$1.80 (88.2)	$110.53	$52	$0.18	$1.97	$42.79
2020	228	25 426	$2.40	$2.20 (91.6)	$170.36	$55	$0.28	$3.06	$60.75

Source: Securities and Exchange Commission (SEC). The Ensign Group. Form 10-K Annual Report, 2007– 2020.
[a]Billions,
[b]Millions.
[c]Earnings before interest, taxes, depreciation, and amortization.
[d]Price at the close of trade on November 1, 2, or 3 of each year. Ensign stock closed at $81.95 on November 10, 2021.

(95.2%) were generated from its NHs, while 4.1% of revenues were from senior living operations, mobile diagnostics, and other ancillary operations. Most of Ensign's NH revenues were from Medicare, Medicaid, and Medicare and Medicaid managed care in 2020. Overall, 86.4% of total revenues were from government sources in 2007, which increased to 91.6% in 2020. Of its NH subsidiaries, 19 had U.S. Housing and Urban Development (HUD) mortgage insurance loan guarantees, for a total about $114 million at the end of 2020, which reduced its loan costs.

Ensign, with approximately 24 000 employees,[48] reported that 77.6% of revenues were spent on services and operational expenses, including administrative and property costs; 5.4% on rent; 7.0% on general administrative expenses; and 2.3% on depreciation and amortization. It paid 1.9% in taxes and had a net income of 7.1% in 2020.

Table 1 shows Ensign's net income increased from $20.2 million to $170.4 million during the 2007 to 2020 period. Its EBITDA increased from $40 million to $280 million, and earnings per share grew from $0.68 to $3.06 dollars per share. Ensign's stock also climbed dramatically from $3.71 per share to $81.95 in November 2021. Overall, its financial metrics have steadily increased despite the economic vicissitudes of the U.S. economy during the severe economic crisis of 2008 and the 2020 to 2021 pandemic.

Financial Comparisons

In comparison to Brookdale, the other large, publicly traded NH company, Brookdale had more revenues—$1.8 billion in 2007—compared to $0.4 billion for Ensign and higher overall revenues in 2020 ($3.5 billion compared to $2.4 billion for Ensign) (no table shown).[44] Brookdale revenues, however, declined from $4.06 billion in 2019 to $3.5 billion in 2020, while Ensign showed a steady increase in revenues. Brookdale's EBITDA was higher than Ensign's in 2007, but by 2020, Ensign slightly surpassed Brookdale. Share prices for Ensign soared (from $3.71 in 2007 to $60.75 in 2020), while Brookdale showed a dramatic decline in its share prices (from $34.09 in 2007 to $3.08 in 2020). Ensign showed better financial fundamentals than Brookdale over the period.

The financial indicators in Table 2 show that Ensign Group shares are not overpriced. Ensign's market-to-book ratio was similar to the health-related industry average in 2020. The Ensign price-to-earnings ratio of 24.94 in 2020 was lower than the industry and its debt-to-equity ratio was lower than the industry average.[43] Ensign's current ratio of 1.23 in 2020 was also lower than the industry average. Finally, the Ensign enterprise values divided by the EBITDA were more than twice the industry average in 2020 and 2021.

Financial Impact of COVID-19 Pandemic

COVID-19 resulted in a reduction in U.S. NH occupancy rates and in Ensign's facility occupancy rates, which dropped 5.7% (to 73.5%) between 2019 and 2020[19] (Table 3). Despite the occupancy decline, Ensign's total NH beds increased by 2.4% and patient days by 3% over

2019. Ensign's Medicare average daily rates increased by 8.9% ($607 to $661), managed care rates increased by 7% ($458 to $491), Medicaid rates increased by 5.8% ($226 to $231), and total rates for all payers by 10.5% ($313 to $346) between 2019 and 2020. Ensign's facility revenues increased by 18.3%, in part because its resident acuity increased: Medicare and managed care revenues increased by 18.3%, Medicaid custodial by 12.3%, and Medicaid skilled by 12.8%, while private pay decreased by 2.6% between 2019 and 2020.

Table 2. Ensign Financial Value Measures Compared with Industry-Wide Health-Related Publicly Traded Companies in 2020.

FINANCIAL MEASURES	ENSIGN GROUP 12/31/2020	INDUSTRY 12/31/2020	ENSIGN GROUP 10/29/2021	INDUSTRY 10/29/2021
Price per Share	72.78	NA	$78.01	NA
Market to Book[a]	4.8	5.0	4.40	7.16
Price to Earnings	24.94	44.61	23.01	38.55
Debt to Equity (MRQ)	.12	.74	.14	.07
Current Ratio	1.23	1.66	1.38	1.44
Enterprise Value to EBITDA	18.32	9.37	17.10	8.97

[a]Market Capitalization on December 31, 2020 = $3.94 billion; October 29, 2021 = $4.6 billion and 55.1 million shares outstanding. https://ycharts.com/companies/ENSG/market_cap.

Sources:.

Ensign.

Price per Share: https://finance.yahoo.com/quote/ENSG/history?p=ENSG.

Market to Book: https://www.macrotrends.net/stocks/charts/ENSG/ensign/price-book.

Price to Earnings: https://www.macrotrends.net/stocks/charts/ENSG/ensign/pe-ratio.

Debt to Equity: thttps://www.macrotrends.net/stocks/charts/ENSG/ensign/debt-equity-ratio.

Current Ratio: https://www.macrotrends.net/stocks/charts/ENSG/ensign/current-ratio.

Enterprise Value to EBITDA: https://finance.yahoo.com/quote/ENSG/key-statistics/.

Health Care Industry Sector.

Price per Share: N/A.

Market to Book: https://csimarket.com/Industry/industry_valuation_ttm.php?pb&s=800.

Price to Earnings: https://csimarket.com/Industry/industry_valuation_ttm.php?pe&s=800.

Debt to Equity: https://csimarket.com/Industry/industry_Financial_Strength_Ratios.php?s=800.

Current Ratio: https://csimarket.com/Industry/industry_Financial_Strength_Ratios.php?s=800.

Enterprise Value to EBITDA: https://www.statista.com/statistics/1 030 072/enterprise-value-to-ebitda-in-the-health-and-pharmaceuticals-sector-in-united-states/.

Like many other U.S. NHs, Ensign received COVID-19 legislative and regulatory relief. Its 2020 relief included: $10.4 million in savings from the temporary suspension of the Medicare sequestration; $141.7 million and $5.1 million from the CARES Act, which was returned by Ensign; $45.4 million in state funding from the Federal Medical Assistance Percentage program; savings from the temporary suspension of certain coverage criteria, documentation, and care requirements; $102 million from the Medicare accelerated and Advance payment program, which was partially repaid; and a deferral of employer payroll taxes.

Facility Staffing and Quality Measures

CMS data showed Ensign with 198 NHs with 21 770 beds in March 2020 and May 2021 (Table 3). Its average facility had 110 beds, slightly higher than the U.S. average, and its occupancy rates were slightly lower than the national average. Ensign's 3.69 total nurse staffing hprd was 95% of the national average in March 2020. Although its total nursing hprd increased slightly in May 2021, its total staffing hprd was 94% of the national average in May 2021. Ensign's RN staffing was 88% lower than the national average prior to the pandemic and dropped to 84% in May 2021.

Ensign's CNA staffing levels were 2.15 to 2.19 hprd during 2020 to 2021 compared to a minimum recommended level by experts of 2.8 CNA hprd (78% of recommended). Its RN staffing levels were 0.61 to 0.65 hprd compared to a minimum recommended level of 0.75 for the lowest acuity (or 81-87% of recommended).[21] Overall, Ensign staffing ratings were below the national average (2.8 stars out of 5 for total and RN staffing in 2021) (Table 3).

Ensign reported a high percentage of short-stay Medicare and managed care residents, suggesting higher than average resident acuity. For higher acuity levels, experts recommend CNA staffing of 3.2 to 3.6 hprd and RN staffing of 1.03 to 1.85 hprd.[27] Ensign was saving a substantial amount by keeping its staffing levels below the national average and below the levels recommended by experts.

Ensign had a slightly higher number of deficiencies and weighted deficiency scores than the U.S. average, both before and after the pandemic (Table 3). Its facility survey rating was below average (2.79-2.81), but about the same as the national average. Because Ensign reported higher ratings than the national average on its self-reported resident quality measures (which can be inflated), it raised its CMS overall rating to slightly higher than the national average.

CMS data showed that Ensign facilities reported a cumulative total of 13 694 COVID-19 resident infections and suspected infections, 1749 COVID-19 resident deaths, and a total of 5603 resident deaths by May 30, 2021. Ensign's mean resident infection rates (69 residents per facility) were higher than the national average per facility, and

Table 3. Ensign Nursing Home Staffing and Quality Compared to U.S. Nursing Homes, 2020 to 2021.

	March 1, 2020		October 1, 2020		May 1, 2021	
	Ensign	U.S.	Ensign	U.S.	Ensign	U.S.
	N = 198	N = 15 446	N = 198	N = 15 350	N = 198	N = 15 315
Facility Characteristics [a]						
Average Number of Beds	110	106	110	106	110	106
Occupancy Rate	76.3%	80.8%	71.1%	72.8%	68.6%	69.5%
Staffing Levels						
CNA Staffing hprd	2.15	2.31	2.16	2.38	2.19	2.37
LPN/LVN Staffing hprd	0.92	0.87	0.96	0.92	0.99	0.95
RN Staffing hprd	0.61	0.69	0.63	0.75	0.65	0.77
Total Nurse Staffing hprd	3.69	3.87	3.75	4.05	3.82	4.08
Regulatory Violations [a]						
Average Deficiencies	8.28	8.23	8.54	8.34	9.32	8.28
Weighted Deficiency Scores[c]	63.93	61.42	65.09	61.26	68.48	64.10
CMS Care Compare Rating [a]						
CMS Total Staffing Rating	2.62	2.90	2.77	3.23	2.82	3.14
CMS RN Staffing Rating	2.65	2.90	2.79	3.23	2.82	3.12
CMS Survey Rating	2.81	2.81	2.79	2.81	2.79	2.80
CMS Quality Rating[d]	4.37	3.63	4.45	3.74	4.48	3.7
CMS Overall Rating[d]	3.31	3.13	3.42	3.28	3.42	3.22
COVID-19 Data [b]					N = 198	N = 15 303
Resident Infections –Total [e]					13 694	848 464
Resident Infections – Mean per facility (& range)[e]					69.2 (0-465)	55.4
Resident COVID-19 Deaths – Total					1749	132 326
Resident COVID-19 Deaths –Mean per facility (& range)					8.8 (0-54)	8.7
Resident Total Deaths – Total					5603	502 455
Resident Total Deaths – Mean per facility (& range)					28.3 (0-94)	32.1
Staff Infections – Total [e]					9718	775 525
Staff Infections – Mean per facility (and range)[e]					49.1 (3-173)	50.7
Staff Deaths – Total					24	1929
Staff Deans – Mean per facility					.12	.13

Sources:
[a]CMS nursing home care compare website data;
[b]CMS COVID-19 nursing home website data.
[c]Weighted over three survey cycles.
[d]Overall rating may be increased by self-reported quality measures.
[e]COVID-19 confirmed and suspected infections and deaths cumulative through May 30, 2021.

COVID-19 death rates were about the same as the national average (Table 3).

Regulatory Actions by the Office of the Inspector General

In 2013, Ensign reached a $48 million settlement agreement with the U.S. Department of Justice, which charged that six California NHs billed for therapy that was not needed or not provided.[49] Ensign was accused of improperly incentivizing therapists to increase treatments to meet revenue targets and keeping residents longer than necessary. Without admitting wrongdoing, Ensign agreed to a five-year corporate integrity agreement with the OIG that required: a compliance officer and a compliance committee for oversight, a code of conduct, written policies and procedures, educational and training initiatives, an audit program, a confidential disclosure program of potential compliance violations, screening measures for ineligible persons, and oversight by the board of directors. Ensign also reached other settlements with the OIG over the employment of persons excluded from federal participation, including one for $80 000 in 2018.[50]

In 2018, Ensign reported receiving a demand from the U.S. Department of Justice civil investigative unit for

information to determine whether 10 California NHs violated the False Claims Act and/or the Anti-Kickback Statute in relationships with medical directors, advisory board participants, or other referral sources from 2011 to 2018.

Company Board Members and Executives

Table 4 shows board member and executive stock shares over time. Ensign split its stock in 2015 from 25.5 million to 50.2 million (at $24 per share). In 2020, the board members and executives owned 3.4 million shares of stock (about 6% of total) worth about $282 million ($82 per share in November 2021).

Roy Christensen, founder and chairman of the Ensign board from 1999 to 2019 and chief executive officer (CEO) from 1999 to 2006, died in November 2021. Prior to founding Ensign, he was highly experienced with NH chains as the former founder, chairman, and CEO of Beverly Enterprises, GranCare Inc., and Covenant Care. He previously taught at Brigham Young University.[51]

Christopher Christensen, son of Roy, co-founded and served as Ensign's president in 1999. He was made CEO in 2006 and executive chairman and chair of the board in 2019. Prior to that, he was acting chief operating officer (COO) of Covenant Care Inc. and was educated at Brigham Young University. Ensign's seven other board members included: Lee A. Daniels, a professor at Brigham Young University and previous CEO/managing partner of Daniels Capital LLC, and Barry Port, CEO and director of Ensign since 2019. Total executive compensation was more than $62 million and board compensation was about $1.4 million in 2020.

Some of Ensign board members have been tied to the Christensens through family and connections with Brigham Young University. In 2008, board members included: Gregory Stapley (brother-in-law of John Albrechtsen) as vice president and general counsel, John Albrechtsen (nephew of Roy Christensen), Covey Christensen (son of Roy Christensen), and other directors of Ensign's portfolio companies.[52] Christopher Christensen serves on the board of directors of The Pennant Group, where he held 2.5% of stock in 2020.[53] Gregory Stapley was an Ensign cofounder and executive vice president; he founded and has served as chairman of the board and CEO of the CareTrust REIT Inc. since 2013.[54]

Beneficial Owners

Table 4 shows that following the initial public offering, Ensign ownership shifted from the founders and initial executives to major institutional investors, which is typical of publicly traded corporations. Three entities—BlackRock, Wasatch Advisors, and Vanguard—were beneficial owners of Ensign's 19.9 million shares in 2020. Moreover, the top 10 institutional investment firms owned 54.3% of Ensign's shares, and about 90% was owned by institutional investors at the end of 2020 (no table shown).[51] BlackRock also owned 19.8% and Vanguard held 15.4% of the stock in CareTrust REIT Inc. in 2020.[54] The Pennant Group Inc.'s beneficial owners included T. Rowe Price Associates Inc. (14.8%), BlackRock Inc. (13.5%), Wasatch Advisors Inc. (12.3%), and The Vanguard Group (9.8%).[53] Thus, the corporate stock in the three financially interrelated companies was concentrated in a small group of individuals and beneficial owners.

Discussion

Ensign grew from five NHs with 710 beds in 1999 to 195 facilities with 23 172 beds in 2020. Although the company diversified to own assisted living, senior housing, home health and hospice, and ancillary services over time, 95% of its total revenues were from its NHs, and 91.6% of its revenues were from Medicare and Medicaid in 2020. Ensign NHs heavily relied on government funding to provide stable, inflation-adjusted revenues over time.

Ensign, established as a holding company, developed a complex corporate structure with 22 portfolio companies that in turn owned 409 separate companies that, in turn, operate 228 facilities with separate facility property owners. Each nursing facility paid the rent on all buildings and maintenance, insurance, and property taxes under a master lease arrangement with the property company. Ensign charged depreciation and expenses for its properties. The complexity of its organizational structure to manage about 228 facilities appears designed to shield the company from liability and regulatory oversight, obscure its high profits, and keep taxes low, as shown in previous studies of large, for-profit chains.[14,39,40]

Ensign's corporate strategies included purchasing underperforming and performing NHs, even during the pandemic. The facilities were debt-financed, and costs were further reduced by using some HUD mortgage loan guarantees. In the early stages of facility loans, depreciation write-offs and capital cost reimbursement can exceed the payment on loans. After loan payments exceed the benefits from tax advantages, it is advantageous to sell the property or spin it off into a REIT, as Ensign did when it established CareTrust REIT. Over time, Ensign can continue the strategy of transferring property companies into CareTrust REIT and establishing its own captive REIT as well as transferring entities into its second publicly traded company—The Pennant Group—which owns and operates health and hospice agencies along with senior living services and ancillary service companies. Ensign successfully used tax arbitrage to profit from differences in the ways various types of income, capital gains, properties, and transactions are taxed.

Ensign's financial engineering resulted in remarkable financial growth and profits, with $2.4 billion in annual revenues in 2020 and rapid growth in share prices (from $3.71 to

Table 4. Ensign Stock Ownership by Board, Executives, and Beneficial Owners, 2008 to 2020.

Year	Total Shares Outstanding	Shares of Board and Executives	% Shares of Board and Executives	Number of Beneficial Owners	Shares of Beneficial Owners	% Shares of Beneficial Owners
2008	20,535 280	12,526 631	60.1	3(1)	4,931,661	23.7
2009	20,582 780	8,171,424	39.1	1(2)	1,765,590	8.6
2010	20,731 532	6,497,620	31.2	2(3)	2,512,313	12.1
2011	20,897 738	4,728,514	22.6	1(4)	1,102,100	5.3
2012	21,905 486	4,215,397	19.2	2(5)	2,310,407	10.6
2013	22,082 420	2,595,571	11.8	3(6)	4,789,567	21.7
2014	22,425 728	2,383,405	10.6	4(7)	6,553,457	29.2
2015[a]	25,598 673	2,078,563	8.1	4(8)	7,005,211	27.3
2016	50,204 945	3,362,173	6.5	4(9)	17,713 132	35.4
2017	51,069 510	3,147,921	6.2	4(10)	20,056 775	39.3
2018	51,761 686	3,071,663	6.0	3(11)	16,955 618	33.3
2019	52,954 867	3,407,297	6.7	5(12)	20,090 724	39.3
2020	54,953 285	3,434,136	6.2	3(13)	19,916 749	36.2

Source: U.S. SEC, Schedule 14A, Proxy Statement, The Ensign Group, Inc. 2008 to 2020. Starting with:.
https://investor.ensigngroup.net/sec-filings/sec-filing/def-14a/0000892569-08-000681.
[a] = Stock split in 2015.
(1) Ensign Group Investments, LLC; Wells Fargo & Company (5.1%); Wellington Management Company (5.5%).
(2) Terri M. Christensen (1,765,590-8.6%).
(3) Terri M. Christensen (1,312,133-6.3%); Heartland Advisors, Inc (1,200,180-5.8%).
(4) Heartland Advisors, Inc. (1,102,100-5.3%).
(5) Heartland Advisors, Inc. (1,089,620-5.0%); BlackRock Inc. (1,220,787-5.6%).
(6) Fidelity Investments Inc., LLC (2,046,500-9.3%); Wasatch Advisors Inc. (1,370,578-6.2%); BlackRock Inc. (1,372,489-6.2%).
(7) Fidelity Investments Inc., LLC (1,983,700-8.8%); BlackRock Inc. (1,738,979-7.8%); Wasatch Advisors Inc. (1,551,556-6.9%); The Vanguard Group (1,279,222-5.7%).
(8) Fidelity Investments Inc., LLC (2,105,900-8.2%); BlackRock Inc. (1,859,809-7.3%); Wasatch Advisors Inc. (1,646,221-6.4%); The Vanguard Group (1,393,281-5.4%).
(9) Fidelity Investments Inc., LLC (4,116,542-8.2%); BlackRock Inc. (4,755,799-9.5%); Wasatch Advisors Inc. (5,150,413-10.3%); The Vanguard Group (3,690,378-7.4%).
(10) Fidelity Investments Inc., LLC (3,977,279-7.8%); BlackRock Inc. (5,458,950-10.7%); Wasatch Advisors Inc. (6,492,272-12.7%); The Vanguard Group (4,128,274-8.1%).
(11) BlackRock Inc. (6,156,602-12.1%); Wasatch Advisors Inc. (6,273,450-12.3%); The Vanguard Group (4,525,566-8.9%).
(12) BlackRock Inc. (7,626,750-14.9%); The Vanguard Group (5,817,695-11.4%); Wasatch Advisors Inc. (3,866,554 −7.6%); T. Rowe Price Associates Inc. (2,779,725-5.4%).
(13) BlackRock Inc. (7,862,409-14.3%); Wasatch Advisors Inc. (6,057,256 −11.0%); The Vanguard Group (5,997,084-10.9%); T. Rowe Price (2,699,710 to 4.9%).

$81.95 by November 2021). Its profits and financial metrics were strong, and the company had a market capitalization of $4.6 billion with 55 million in outstanding shares in October 2021. Much of its financial success during the COVID-19 pandemic, despite lower resident occupancy rates, was the result of government regulatory relief and increases in Medicare and Medicaid payment rates.

Even though Ensign has remarkable financial resources to operate its NHs, its strategy has been to keep its staffing levels low to maximize profits, based on evidence of its low staffing prior to and during the 2020 to 2021 pandemic. In May 2021, Ensign's RN and total staffing were below the national average and below the level recommended by experts. Because Ensign had many Medicare short-term residents with high resident acuity needs, its staffing levels probably should have been much higher. Ensign's overall CMS total staffing and its RN staffing levels were rated as below average (less than 3 stars) in 2020 and 2021.

Even with the pandemic relief provided by government, Ensign's staffing levels did not increase substantially to provide care to its large number of COVID-19-infected residents and staff. It should be noted that SEC reports do not require reports on staffing levels and staff wages and benefits. Clearly, Ensign has maintained below-average staffing without regard to its CMS staffing ratings, the care needs of its residents, and the workloads of its nursing staff.

With the relatively low staffing levels, it was not surprising that Ensign facilities had slightly higher than average deficiencies in 2020 to 2021 and facility survey ratings below average. With its low staffing and below-average survey ratings prior to the pandemic, Ensign reported higher COVD-19 resident infection rates than the U.S. average facility, although its reported death rates were about the national average. Some research studies during the pandemic showed that NHs with higher staffing had fewer COVID-19 infections and deaths.[55–57] A study of cumulative resident COVID-19 infections and deaths by

January 2021 found NHs with 5-star ratings for overall quality, health inspections, and staffing had a lower incidence of infections and deaths than those with lower quality ratings.[58] Had Ensign met professional staffing and regulatory requirements before and during the pandemic, perhaps it could have better protected its residents and staff from COVID-19 infections and deaths.

Ensign's NHs were slightly larger than the national average bed size and its buildings were on average 35 years old. NH research has found that larger numbers of beds were a strong predictor of NH COVID-19 infection rates because of greater exposure to infected staff.[38,59,60] Nationally, most residents are living in older buildings and crowded rooms, with two to four beds and shared toileting, which is a risk for spreading infections and COVID-19.[59] The lack of privacy also results in unpleasant and undesirable living conditions, and many older facilities fail to meet regulatory standards for ventilation, fire, and life safety.[61] Some experts argue that small-home models are needed to ensure infection control and improve the quality of life.[62] Ensign, with its extensive NH properties and its REITs, has the financial resources to invest in upgrading its NHs to private rooms and to meet modern, small-home standards.

This study highlights the lack of CMS ownership transparency of large chains such as Ensign. Although CMS requires disclosure of all entities and individuals with 5% or more ownership interest in any NH, the complexity of multilayered corporate structures of large chains makes transparency difficult. CMS does not require reports of chain organizational structures, holding companies, property companies, and beneficial owners. Because of this, CMS ownership reports are limited and even misleading. CMS's regulatory attention is directed primarily to the lowest legal entity, which is the licensed facility. CMS needs to develop improved ownership reporting that takes into account complex organizational structures to inform the public, government regulators, and policymakers.

Ensign's primary beneficiaries are the interlocking triad of stock owners, board members, and beneficial owners. The corporate strategy is driven by tax arbitrage, debt financing, and trading in real estate to maximize shareholder value. The company's stock is concentrated among a small group of the founder's family, executives, board members, and institutional investors. Technically, and practically, beneficial owners control a major proportion of Ensign and are positioned to direct the company's activities, which are oriented toward cash flow and extraction of funds rather than directing resources toward resident care and employees.

Over the past several decades, managers of large pools of capital such as pension funds, university endowment funds, and sovereign wealth funds have looked to asset managers such as BlackRock Inc., Vanguard, and State Street (the Big Three) to invest their funds in the equities market. Along with this new corporate zeitgeist, the asset management industry, with the explosive growth of large pools of capital in pension, endowment, sovereign wealth, and other funds, has played an increasingly dominant role in capital markets—especially in equity markets where ultimate ownership resides.[63]

The financial power that institutional investors bring to corporate governance reinforces the agency theory of management and a philosophy that shareholder interests are the sole mission of corporations, while their nursing homes provide mediocre care at best and deadly care at worst. By protecting and enhancing shareholder interests as the summum bonum of management, excess capital is accumulating and driving governance to benefit investors rather than ensuring that NHs meet professional standards and regulatory requirements.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

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