Cost and Market Impact Review
ResCare, Inc. and National Mentor Holdings (Sevita)
Final Report

April 8, 2026

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"A healthier California where all receive equitable, affordable, and quality health care."

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I. Glossary and acronyms

Acronym	Term	Definition
ARF	Adult Residential Facility	A type of home and community-based service (HCBS) with individually tailored supports available in a provider-owned or controlled residential setting or a participant's own home that assist with the acquisition, retention, or improvement of skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs.
ADP	Adult Day Program	A type of HCBS with provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.
CalHHS	California Health and Human Services	California state agency overseeing departments providing a range of services related to health, income assistance, and social services.
DDS	California Department of Development Services	California state agency dedicated to oversight and services supporting Californians with intellectual and developmental disabilities and their family members.
CDSS	California Department of Social Services	California state agency that oversees and administers programs serving needy and vulnerable children and adults.
CDPH	California Department of Public Health	California state agency dedicated to optimizing the health and well-being of Californians. It is a regulatory and licensing authority for ICFs throughout California.

Acronym	Term	Definition
CMS	Center for Medicare & Medicaid Services	US federal agency responsible for administering government health insurance programs, certifying health care entities, and managing health care datasets.
DHCS	Department of Health Care Services	California state agency overseeing Medi-Cal and administering health care services to low-income individuals, children, seniors, and individuals with disabilities.
DD	Developmentally disabled	A range of conditions that affect physical and/or mental functioning, are manifested in childhood or adolescence, and are likely to continue indefinitely (common examples include intellectual disability, autism spectrum disorder, Down syndrome, and cerebral palsy).
DOJ	Department of Justice	US federal agency tasked with law enforcement, including civil and criminal antitrust enforcement.
FTC	Federal Trade Commission	US federal agency tasked with trade issues and consumer protection, including antitrust and competition issues.
HCBS	Home and Community-Based Services	Services for individuals with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders provided in a home setting (e.g., individual's home or group home) or community setting (e.g., day programs) rather than in an institution.
-	Intellectual disability	A set of neurodevelopmental conditions, developing in childhood, that affect cognitive functioning (learning, problem solving and judgment) and/or adaptive functioning (communication and social participation).
ICF/DD	Intermediate care facility/developmentally disabled	A facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

Acronym	Term	Definition
ICF/ DD-H	Intermediate care facility/developmentally disabled-habilitative	A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
ICF/ DD-N	Intermediate care facility/developmentally disabled-nursing	A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care.
ICF/ DD-CNC	Intermediate care facility/developmentally disabled-continuous nursing	The DD-CNC Waiver program provides 24-hour continuous skilled nursing care in home and community-based residential settings to persons with developmental disabilities who are medically fragile.
ICF/IDD	Intermediate care facility/intellectual or developmental disabilities	An umbrella term describing facilities that provide 24-hour personal care, habilitation, developmental, and supportive health services to individuals with intellectual or developmental disabilities.
-	Medicaid	A government program that provides health insurance, primarily to low-income individuals, children, and pregnant women.
-	Medi-Cal	California's state Medicaid program.
-	Residential Habilitation	As a dimension of ARF care, residential habilitation also includes personal care, protective oversight and supervision.

II. Introduction

About the Department of Health Care Access and Information

The Department of Health Care Access and Information (HCAI), formerly the Office of Statewide Health Planning and Development, was created in 1978 to provide the state with an enhanced understanding of the structure and function of its healthcare delivery systems. Since that time, HCAI's role has expanded to include delivery of services that promote equitable access to health care for all Californians.

HCAI is a leader in collecting data and disseminating information about California's health care infrastructure, promoting an equitably distributed health care workforce, and publishing valuable information about healthcare outcomes. HCAI also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's nonprofit health care facilities. HCAI works to improve affordability of health care costs including through spending targets and affordable generic drugs. These programmatic functions are advised by several boards and commissions.

About the Office of Health Care Affordability

In 2022, the California Health Care Quality and Affordability Act (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within HCAI. Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

The Act established OHCA as a core program within HCAI. OHCA has three primary responsibilities: (1) slow health care spending growth, (2) promote high-value health system performance, and (3) assess market consolidation that may impact market competition and consumer affordability. OHCA accomplishes these goals by collecting, analyzing, and publicly reporting data on total health care spending. OHCA also enforces spending targets that are established by the Health Care Affordability Board. While slowing spending growth, OHCA promotes high value health system performance by measuring quality, equity, adoption of alternative payment models, and by promoting investment in primary care, behavioral health, and workforce stability.

Finally, OHCA reviews and assesses market consolidation, market power, and other market failures through cost and market impact reviews (CMIRs) of mergers, acquisitions, or corporate affiliations. Consolidation in California's health care market is growing, with potential implications for cost, access, and affordability. In response, OHCA will monitor the impact of market consolidation on cost trends and will evaluate and review prospective transactions that could adversely impact competition and affordability in California's market.

Health care entities are required to provide OHCA with 90-day advance notice of material changes in ownership or governance. OHCA will decide whether to conduct a cost and market impact review or issue a waiver from the review. If the transaction or other material change is likely to have a significant impact on market competition, the state's ability to meet cost targets, or costs for purchasers and consumers, OHCA will conduct a CMIR. Upon completion of the review, OHCA will make its findings and issue a preliminary report. After allowing affected parties and the public to respond to the preliminary report, OHCA will issue a final report. The transaction that triggered the cost and market review may not be implemented until 60 days after OHCA issues its final report. Based on the results, OHCA will then work with other state agencies to address market consolidation as appropriate.

About This Report

On March 23, 2025, OHCA received a Material Change Notification of ResCare's transaction involving ResCare, Inc. (ResCare) and National Mentor Holdings, Inc. On November 4, 2025, OHCA informed ResCare of its determination to conduct a CMIR due to the following factors:

- The transaction may result in a negative impact on the availability or accessibility of health care services.
- The transaction may result in a negative impact on costs for payers or purchasers.
- The transaction may negatively impact the quality of health care services available to patients from the parties to the transaction.
- The transaction is part of a series of similar transactions by the health care entity or entities that furthers a trend toward consolidation.

The scope of the CMIR includes only those components of the transaction that impact Californians. Specifically, OHCA reviewed the transaction as it pertains to the following subsidiaries:

- Alternative Choices, Inc.
- J&J Care Centers, Inc.
- Normal Life of California, Inc.
- Res-Care California, Inc.
- Rockcreek, Inc.
- RSCR California, Inc.
- RSCR Inland, Inc.

On March 10, 2026, OHCA issued the preliminary report outlining its conclusions regarding the transaction's impact on health care costs, quality, accessibility, and market consolidation. To assist with the CMIR and author the preliminary report, OHCA engaged health care economic experts at Bates White, an economic consulting firm that specializes in providing advanced economic, financial, and econometric analyses to law firms, companies, and government agencies across a variety of industries. The Bates White team is comprised of Nitin Dua,[1] Saurav Karki,[2] Anirudh Jayanti,[3] and Michelle Lam.[4]

After issuing the preliminary report, OHCA held a public comment period for 10 business days. OHCA received one comment. This comment expressed support for OHCA's preliminary findings. The comment also expressed concerns regarding Sevita's quality-of-care issues and financial practices. OHCA did not make any

[1] Nitin Dua is a Partner and co-chairs the Antitrust and Competition Practice at Bates White. He has over 14 years of experience analyzing competition issues in healthcare and across a range of other industries. He specializes in antitrust analysis of mergers and monopolization issues and has extensive experience leading economic and statistical analyses in high-profile merger litigation on behalf of state and federal agencies as well as private entities. He has served as an economic expert in antitrust matters, including testifying in merger trials. Nitin received his PhD in economics from Florida State University.

[2] Saurav Karki is a Partner and specializes in providing consulting, economic, financial, and damages analysis. He advises government agencies, law firms, and industry clients on these issues in consulting engagements, arbitration proceedings, and litigation. As an expert in financial and damages analysis, Saurav has worked on breach of contract matters, bankruptcies, employment disputes, and regulatory investigations and has broad experience in industries that include alternative investments, financial institutions, pharmaceuticals, and technology. He has taught a graduate-level course in healthcare finance at Johns Hopkins University. Saurav is a Chartered Financial Analyst charterholder and received his MBA from Georgetown University.

[3] Anirudh Jayanti is a Manager and specializes in life sciences and healthcare matters, particularly as related to antitrust issues, providing clients with rigorous insights and tailored solutions that help them navigate high-stakes disputes. His casework spans areas such as monopolization, mergers, false marketing claims, patent disputes, and reimbursement disagreements, where he has analyzed key issues like market power, market definition, competitive effects, causation, and damages. Anirudh received his PhD in economics from the University of Michigan, Ann Arbor.

[4] Michelle Lam is a Senior Economist with extensive experience in healthcare antitrust for both private and government clients. She has conducted economic and statistical analyses of competition, market definition, and market power in the healthcare and technology industries. Michelle received her PhD in economics from the University of Michigan, Ann Arbor.

changes in response to public comment. The analysis and conclusions in this final report remain the same as those in the preliminary report released on March 10, 2026.

With the release of the final report on April 8, 2026, the parties may close the transaction subject to the CMIR on June 7, 2026, or thereafter.

III. Executive summary

ResCare, a subsidiary of BrightSpring Health Services, has filed a material change notice (MCN) to sell its subsidiaries and assets to National Mentor Holdings (NMH), the parent company of Sevita, for $835 million. The transaction would combine two large national providers of services for individuals with intellectual and developmental disabilities (IDD). The transaction involves multiple private-equity owners, with Centerbridge serving as the acquiring ultimate parent entity.

Both companies operate hundreds of intermediate care facilities for individuals with IDD (ICFs/IDD) and home- and community-based services (HCBS), including Adult Residential Facilities (ARFs) and Adult Day Programs (ADPs) across the United States. In California, ResCare operates 75 ICFs, 11 ARFs, and 6 ADPs, while Sevita operates 20 ICFs, 53 ARFs, and 54 ADPs. As part of its decision to allow the transaction to proceed, the Federal Trade Commission (FTC) has required Sevita to divest 128 ICFs in Indiana, Louisiana, and Texas due to concerns about reduced quality and choice.[5]

While Sevita and ResCare contend that the transaction will not harm competition—citing complementary geographic footprints, regulated Medi-Cal reimbursement rates, and anticipated operational efficiencies—the overlap in their services raises concerns about reduced competition for IDD services provided at ICFs and in community-based settings.

After its review of the MCN, the Office of Health Care Affordability (OHCA) determined that a Cost and Market Impact Review (CMIR) is required because the proposed transaction could reduce the availability and accessibility of services, increase costs for payers, diminish the quality of care, and contribute to ongoing

[5] https://www.ftc.gov/news-events/news/press-releases/2026/01/ftc-takes-action-prevent-anticompetitive-healthcare-services-merger.

consolidation in the health care market. This report analyzes the transaction's effect on costs, quality, access, labor, and market consolidation.

III.A. Landscape of IDD services in California

In California, adults with IDD can receive services through institutional, residential community-based, or non-residential community-based settings. Institutional care is typically provided by ICFs, which offer 24-hour residential and health care services, including skilled nursing, habilitation, and developmental supports, and are licensed by the California Department of Public Health (CDPH). There are multiple types of ICFs, which can vary based on the resident's needs for the level and continuity of nursing care. Individuals with IDD may also receive care outside of institutional settings through home- and community-based services. For example, Adult Residential Facilities (ARFs) provide housing and supervision along with assistance with skill development, activities of daily living, community inclusion, education, and social and leisure skill development. Adults with IDD may also receive non-residential, daytime services focused on skill development and community integration through Adult Day Programs (ADPs).

Services for individuals with IDD are coordinated through California's 21 nonprofit Regional Centers, which determine eligibility, develop individualized service plans, and contract with licensed providers. These Regional Centers play a central role in shaping service availability and location, as new facilities may require Regional Center-initiated requests for proposals and state licensure approvals, impacting both time and cost of entry. Unsolicited vendorizations may occur as well.[6] Within this landscape, ResCare and Sevita operate overlapping ICFs, ARFs, and ADPs in several Regional Center service areas, particularly in and around Los Angeles, the Inland Empire, Sacramento, and San Luis Obispo.

Funding for ICFs, ARFs, and ADPs primarily comes from Medi-Cal, California's Medicaid program. Historically, ICF services were reimbursed through fee-for-service Medicaid in some counties and managed care in others. As of 2024, all ICF residents (with the exception of ICF/DD-CN residents) were enrolled in Medi-Cal Managed Care Plans, with either minimum or minimum/maximum payment requirements tied to fee-for-service rates, depending on the county, at least through 2026 (leaving scope for rate negotiations in certain counties). ICF/DD-CNs are funded through the Medi-Cal 1915(c) Home and Community-Based Alternatives

[6] https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/.

(HCBA) Waiver with rates administratively set. ARFs and ADPs are funded through the Medi-Cal 1915(c) HCBS Developmental Disabilities (HCBS-DD) Waivers and 1915(i) HCBS-DD State Plan Amendment (SPA), with rates largely administratively set.

Section V provides additional detail on the landscape of IDD services in California.

III.B. Competition framework for analyzing the transaction impact

The proposed transaction could affect competition in California markets for services provided to individuals with IDD. Mergers can change market structure by reducing the number of providers or increasing concentration, which may weaken competitive pressures and lead to higher prices, reduced quality, or fewer choices.

To assess these potential competitive effects, this report applies standard antitrust principles and identifies “relevant markets” in which providers meaningfully compete. Relevant markets are defined based on the services that consumers view as close substitutes and the geographic areas they are willing to travel to access those services. Defining relevant markets allows assessing changes in market structure due to the transaction and examining changes in market shares and concentration that inform an analysis of competitive effects.

This report concludes that IDD services provided in Intermediate Care Facilities (ICFs), Adult Residential Facilities (ARFs), and Adult Day Programs (ADPs) constitute distinct product markets. Although both Sevita and ResCare operate across all three settings, their California portfolios differ, with ResCare primarily focused on ICFs and Sevita more heavily weighted toward ARFs and ADPs.

These three settings are not close substitutes for each other because they serve different clinical and functional needs, offer different levels of care, and are governed by regulatory requirements that limit substitution. In particular, Regional Centers develop individualized program plans that specify the level of care an individual requires and the setting that is suited for that level of care, reinforcing the distinction among ICF, ARF, and ADP markets.

Geographically, both Sevita and ResCare operate primarily in Southern California, with overlapping footprints in regions such as Los Angeles, the Inland Empire, and San Luis Obispo. Because travel burden, caregiver proximity, and Regional Center referral practices shape where individuals can practically receive services, the relevant geographic markets are narrower than statewide. The report therefore

evaluates competitive effects using Regional Center service areas as the primary geographic market for ICFs and ARFs. Because ADPs involve frequent travel and transportation logistics, the report primarily evaluates competitive effects using generally narrower county-level markets for ADPs. The report also analyzes the transaction using alternative geographies—specifically, Core Based Statistical Areas (CBSAs) for all three types of services, counties for ARFs, and Regional Centers for ADPs.

Section VI provides additional detail on the identification of relevant markets.

III.C. Likely impact of the transaction

This report finds that the transaction is unlikely to significantly increase costs associated with provision of IDD services at ICFs, ARFs, and ADPs in California. It also finds that the transaction is unlikely to reduce competition for workers at ICFs, ARFs, and ADPs. This is primarily because the parties' operational overlap is limited across most relevant product and geographic markets. However, despite limited competition and cost concerns, this report identifies risks related to quality and access following the change in ownership of ResCare facilities from BrightSpring to Sevita.

From a competition perspective, ResCare and Sevita do not overlap in any Regional Center for ICF services, and even under a hypothetical statewide market definition their combined share remains well below thresholds that raise competitive concerns.[7] Overlap in ARF services is limited to the Los Angeles County and Tri-Counties Regional Center areas, where combined market shares are small and concentration changes are minimal.[8]

Competition for ADP services is more localized, and county-level analysis identifies overlap in Sacramento, San Bernardino, and San Luis Obispo Counties. The share and concentration metrics in San Luis Obispo County technically meet thresholds that raise competitive concerns under a county-only screen. However, the competitive concerns are partially mitigated by the substantial distance between the parties' facilities. Taken together, the analysis suggests limited scope for the

[7] Regional Centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. California has 21 Regional Centers located throughout the state. The catchment area boundaries for the Regional Centers generally conform to county boundaries or groups of counties.

[8] Tri-Counties Regional Center catchment area includes San Luis Obispo, Santa Barbara, and Ventura Counties.

transaction to increase prices or materially reduce competitive alternatives. In addition, Medi-Cal reimbursement rules impose constraints to varying degrees on providers' ability to raise prices.

The report also finds no clear evidence that the transaction furthers an ongoing trend toward consolidation in California's ICF, ARF, or ADP markets. The parties' market shares have generally remained stable or declined over time.

Despite limited competition and cost concerns, the report identifies risks related to quality and access following the change in ownership. Sevita's quality track record is inconsistent across internal and public sources, with publicly available data indicating that Sevita facilities continue to face quality issues, including higher rates of substantiated complaints, deficiencies, and citations at its California ICFs compared with ResCare and other ICF providers. These concerns are reinforced by national reporting and enforcement actions involving Sevita's residential and day program facilities.

In addition, Sevita's historically aggressive financial practices—characterized by high leverage, debt-financed dividend recapitalizations, and relatively low interest-coverage ratios—raise the risk that financial pressures could limit future investment in staffing, training, and facility maintenance, or increase the likelihood of facility closures. While Sevita reports some recent improvements in quality metrics and financial leverage, the transaction is likely to increase the risk of reduced quality and access to IDD services.

Section VII provides additional detail on the impact analysis of the proposed transaction.

IV. Description of the transaction

Res-Care, Inc. (ResCare), a Kentucky corporation and wholly-owned subsidiary of BrightSpring Health Services, Inc. (BrightSpring), has filed a material change notice (MCN) with OHCA stating its intent to sell its subsidiaries, equities, and assets to National Mentor Holdings, Inc. (NMH) for $835 million.[9] The transaction has also been reviewed by the U.S. Federal Trade Commission (FTC), which determined that it would reduce the quality of care and limit options for individuals with intellectual and developmental disabilities. The FTC has required the acquirer to divest 128 facilities in Indiana, Louisiana, and Texas.[10]

ResCare "operates intermediate care facilities ('ICFs/IDD'), focusing on services for individuals with intellectual and developmental disabilities ('IDD') and other behaviorally complex populations with multiple chronic conditions and co-morbidities."[11] ResCare "also provides home and community-based health services ('HCBS') for individuals with IDD through the HCBS Medicaid waiver program, including residential services in community group homes . . . "[12] In addition, ResCare "offers several categories of support and ancillary services related to its HCBS programs . . . [including] Adult Day Services . . ."[13] In California, the types of "community group homes" and "Adult Day Services" offered by ResCare are known as Adult Residential Facilities (ARFs) and Adult Day Programs (ADPs), respectively.[14]

Not all ARFs and ADPs serve individuals with IDD. In this report, unless otherwise specified, the terms "ARF" and "ADP" refer only to facilities that serve individuals

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9 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 11–12.

10 https://www.ftc.gov/news-events/news/press-releases/2026/01/ftc-takes-action-prevent-anticompetitive-healthcare-services-merger ("Under the FTC's proposed consent order, Sevita will be required to divest 128 intermediate care facilities (ICFs), which provide IDD services, and other assets such as day-training programs. The divested facilities—which are in Indiana, Louisiana, and Texas—will be acquired by Dungarvin Group, Inc. (Dungarvin), an experienced and well-regarded operator of ICFs. The FTC's proposed consent order settles FTC charges that Sevita's acquisition of ResCare from BrightSpring would reduce the quality of care and options for ICF services for individuals with intellectual and development disabilities in certain markets within Indiana, Louisiana, and Texas.").

See also https://www.ftc.gov/system/files/ftc_gov/pdf/2510060SevitaDecisionOrder.pdf.

11 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 2.

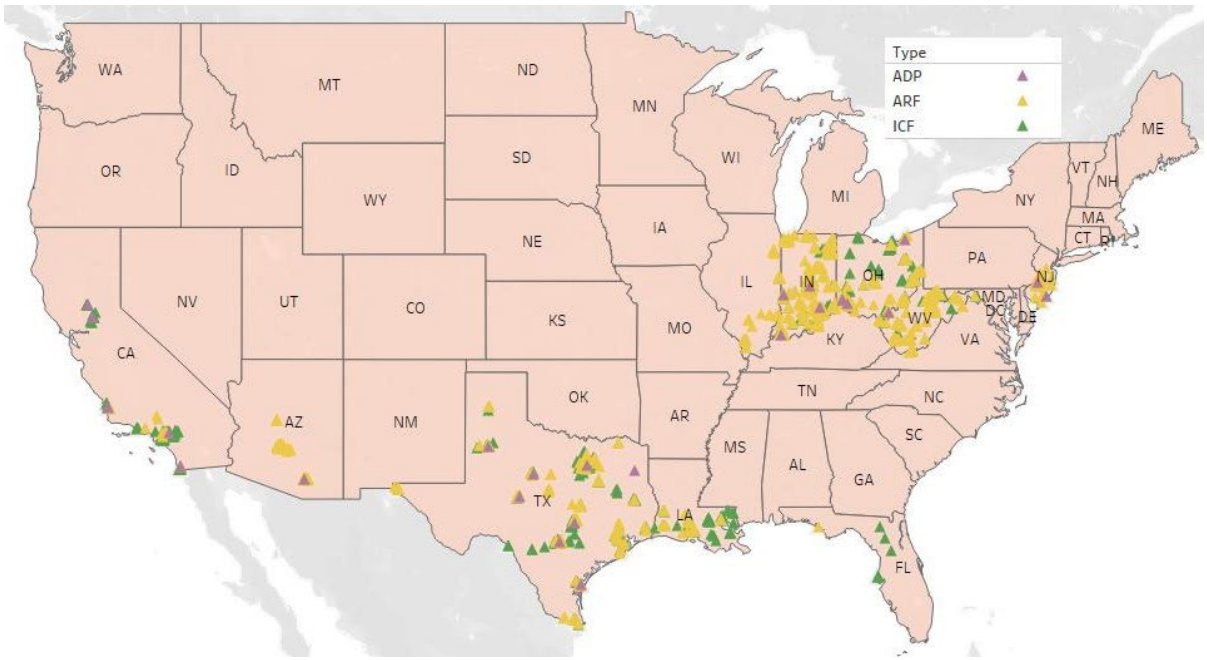
12 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 2.

13 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 3.

14 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 2–3. *See also* https://www.dds.ca.gov/wp-content/uploads/2024/01/CA-23-0036-APPROVED_Effective_1.1.2024-1.pdf and https://www.cdss.ca.gov/inforesources/community-care/ascp-centralized-application-units.

with IDD. Figure 1 shows ResCare's nationwide operations of ICFs, ARFs, and ADPs.

Figure 1. Across the United States, ResCare owns 486 ICFs, 1,142 ARFs, and 26 ADPs

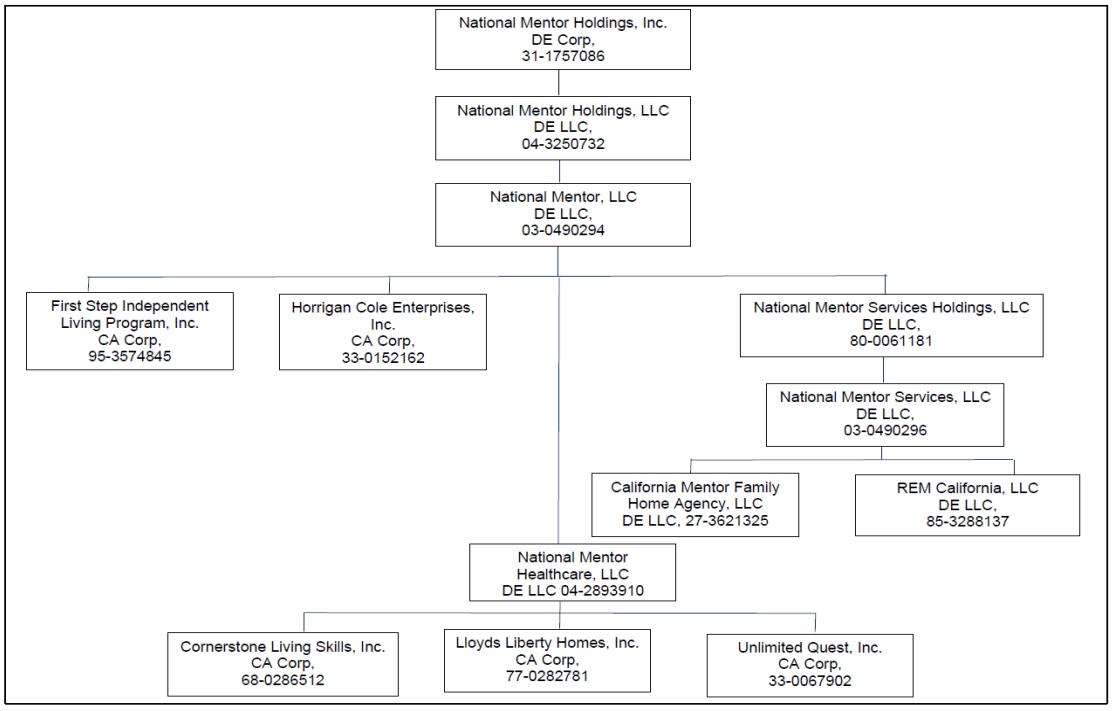


Source: BrightSpring facility location data.

NMH is a holding company whose subsidiaries include National Mentor Healthcare, LLC, and National Mentor Holdings, LLC. (Figure 2 shows NMH's organizational chart.) Like ResCare, NMH offers services to individuals with IDD through its ICFs and through HCBS, primarily under its brand name "Sevita."[15] In particular, Sevita also offers ARF and ADP services to individuals with IDD. 3 shows Sevita's nationwide operations of ICFs, ARFs, and ADPs.

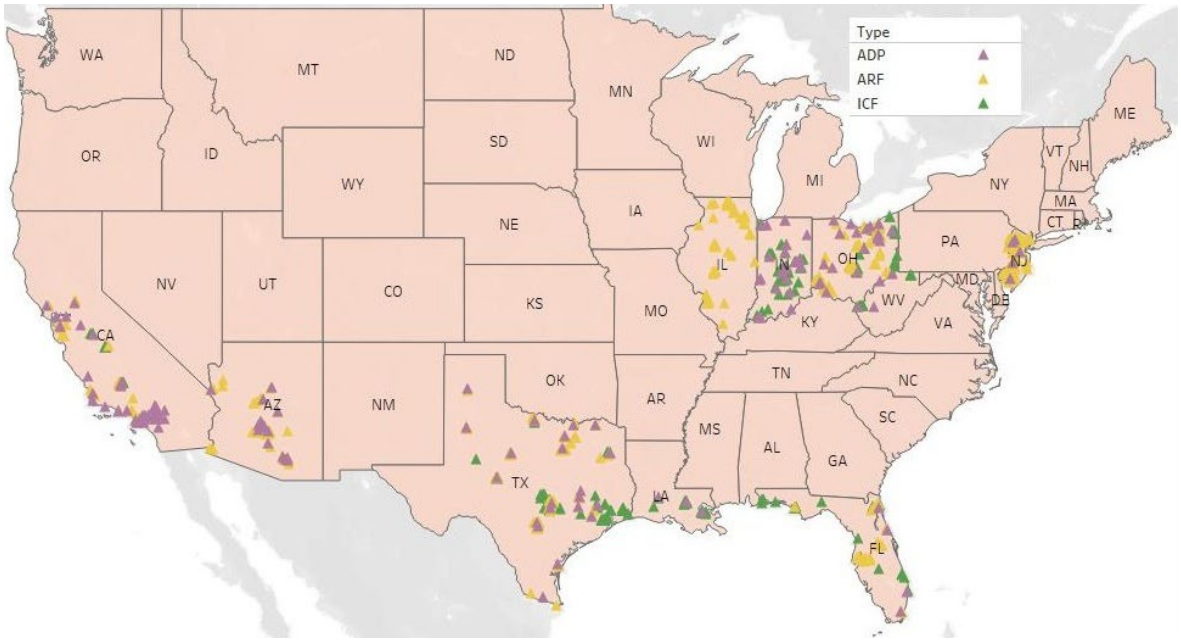
[15] https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 10.

Figure 2. National Mentor Holdings, Inc.'s organizational chart



Source: Sevita's organizational structure.

Figure 3. Across the United States, Sevita owns 249 ICFs, 797 ARFs, and 175 ADPs



Source: Sevita facility location data.

Under the proposed transaction, Sevita would acquire ResCare facilities that "provide HCBS to persons with IDD and operate ICFs/IDD."[16] The transaction would therefore combine two providers of ICF services and HCBS (including ARFs and ADPs) serving individuals with IDD. Because Sevita and ResCare offer overlapping services, the transaction has the potential to adversely affect competition in the provision of ICF and community-based services to individuals with IDD.

ResCare asserts that the transaction "will not result in negative competitive impacts, including in California" because (1) the parties "have geographically complementary options in the state, and there are numerous alternative ICFs/IDD providers[;]" and (2) the transaction "will not impact pricing because ICFs/IDD are reimbursed by California's Medi-Cal program in accordance with rates that are set using a cost reporting methodology outlined in the Medicaid State Plan."[17] (In this report, the term "parties" is used to refer to ResCare and Sevita collectively.) ResCare further states that Sevita "believes there is an opportunity to drive improved service delivery and operating performance by leveraging best practices across the two organizations."[18]

Private equity firms Centerbridge Partners,[19] Vistria Group,[20] Madison Dearborn,[21] and Finback Investment Partners[22] hold ownership interest in Sevita.[23] As part of the transaction, Centerbridge will acquire assets and equities from BrightSpring.[24]

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16 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 11.
The ResCare entities that are selling assets include CNC/Access, Inc., Community Alternatives Illinois, Inc., Res-Care Florida, Inc., Res-Care Kansas, Inc., Res-Care Oklahoma, Inc., Res-Care Premier, Inc., ResCare Residential Services, Inc., and Res-Care Washington, Inc.

17 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 12.

18 https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 12.

19 Centerbridge Partners was founded in 2005 and describes itself as a "global alternative investment manager founded on the complementary relationship between Private Equity, Private Credit and Real Estate investing through the full investment cycle." https://www.centerbridge.com/.

20 Vistria Group is a private investment firm that focuses on industries such as health care, knowledge and learning solutions, financial services, and housing. https://vistria.com/.

21 Madison Dearborn is a private equity firm that describes itself as having "three dedicated industry verticals: Financial & Transaction Services; Healthcare; and Technology and Government." https://www.mdcp.com/about. Madison Dearborn acquired a minority stake in Sevita in May 2022. https://www.mdcp.com/portfolio/sevita-health.

22 FinBack Investment Partners is a private equity firm founded in 2017 by former Governor Jeb Bush. https://www.finbackinvestmentpartners.com/portfolio.

23 Centerbridge and Vistria invested in Sevita 2019. Civitas Solutions 8-k, March 7, 2019, https://www.sec.gov/Archives/edgar/data/1608638/000119312519069320/d713806d8k.htm, Reuters, "Civitas to sell itself to Centerbridge Partners for $641 million", December 18, 2018, https://www.reuters.com/article/world/americas/civitas-to-sell-itself-to-centerbridge-partners-for-641-million-idUSKBN1OH2KE/.

24 https://www.ftc.gov/system/files/ftc_gov/pdf/2510060sevitacomplaintfin.pdf, 1 ("Respondent Centerbridge Seaport Acquisition Fund, L.P., through its subsidiary Respondent National Mentor Holdings, Inc., agreed to acquire certain assets and equities from Respondent BrightSpring Health Services, Inc., for $835 million.").

V. Landscape of facilities serving individuals with intellectual and developmental disabilities in California

This section provides background on the types of services this transaction involves, how and where those services are delivered, and how they are typically paid for.

V.A. IDD services

In California, adults with intellectual and developmental disabilities (IDD) can typically receive services in three potential ways:

- Institutional settings that provide both 24-hour residential and health care services. Intermediate Care Facilities (ICFs) are the primary example of an institutional setting and can vary based on the residents' needs for the level and continuity of nursing care.
- Community-based residential settings that provide housing and supervision but not skilled nursing care. Adult Residential Facilities (ARFs) are examples of such care provision.
- Non-residential, community-based programs. Adult Day Programs (ADPs) are examples of such programs.

ICFs for individuals with IDD (ICFs/IDD) "are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health (CDPH) to provide 24-hour-per-day residential services."[25] In addition to providing skilled nursing care, these facilities provide habilitation, developmental, supportive health services, and skills training to residents.[26] For example, ResCare states that its ICFs/IDD "strive[] to promote individual independence and safety while also providing 24/7 care, which may include nursing care and intensive medical care, as well as opportunities for group development and social interaction."[27]

There are four types of ICFs:[28]

- ICF/DD (Developmentally Disabled): "[A] facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to

[25] https://www.dds.ca.gov/services/icf/.

[26] https://scdd.ca.gov/wp-content/uploads/sites/33/2016/10/Living-Options.pdf; https://healthlaw.org/wp-content/uploads/2022/12/NHeLP-MediServicesGuide-Chapter-9.pdf, 4.

[27] https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 2–3.

[28] https://nbrc.net/client-services/adult-services/living-arrangements/intermediate-care-facilities/.

developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services." These facilities support 15 beds or more.

- ICF/DD-H (Habilitative): "[A] facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care."
- ICF/DD-N (Nursing): "[A] facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated."
- Developmentally Disabled-Continuous Nursing Care (ICF/DD-CNC): "The DD-CNC Waiver program provides 24-hour continuous skilled nursing care in home and community-based residential settings to persons with developmental disabilities who are medically fragile. … The DD-CNC program is initially licensed as an ICF/DD-N type facility. However, the license is suspended while the facility operates under a Waiver program. DD-CNC development is currently limited by a Regional Center's assessed need for this program."

Individuals with IDD can also receive home-and-community-based services (HCBS). As the name suggests, these services are typically provided in a home setting (e.g., the individual's own home or a group home) or in a community setting (e.g., day programs) rather than in an institution.[29] This transaction concerns two specific kinds of HCBS: ARFs and ADPs for individuals with IDD.

- ARF: "Individually tailored supports available in a provider-owned or controlled residential setting…that assist with the acquisition, retention, or improvement in skills related to living in the community. […] These supports include adaptive skill development, assistance with activities of daily living, community inclusion,

[29] https://www.medicaid.gov/medicaid/home-community-based-services ("Home and community based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own homes or communities rather than institutions or other isolated settings. These programs serve a variety of targeted groups, such as older adults, people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders."). *See also* https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx ("The Waiver services make it possible for consumers to live in the community instead of an Intermediate Care Facility for the developmentally disabled or a State Developmental Center.").

transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision."[30]

- ADP: "Any community-based facility or program that provides care to persons 18 years of age or older in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of these individuals on less than a 24-hour basis." [31]

In California, the services discussed above are coordinated through non-profit entities called "Regional Centers," which contract with providers like ResCare and Sevita.[32] Individuals are eligible for Regional Center services if they were diagnosed with a substantial developmental disability before their 18th birthday that is expected to continue indefinitely.[33] According to the California Department of Developmental Services (DDS), "Regional Centers provide diagnosis and assessment of eligibility and help plan, access, coordinate and monitor the services and supports that are needed because of a developmental disability. …Once eligibility is determined, a case manager or service coordinator is assigned to help develop a plan for services, tell you where services are available, and help you get the services. Most services and supports are free regardless of age or income."[34] The Regional Center and the individual work together to create an "individual program plan" that includes "a list of services and supports that [the individual] and [their] planning team agree will help [them] meet those goals."[35]

There are 21 Regional Centers, which are defined based on population density and, with the exception of the Los Angeles County Regional Centers, serve geographic areas that conform to county boundaries or groups of counties.[36] Regional Centers

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30 CMS, "Version 3.7, 1915(c), Instructions, Technical Guide and Review Criteria," https://wms-mmdl.cms.gov/WMS/help/version_3.7_1915c_Waiver_Application_and_Accompanying_Materials.zip, 161–162.

31 California Code, Health and Safety Code - HSC § 1502(a)(2), https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1502.&lawCode=HSC.

32 https://www.dds.ca.gov/rc/information-about-regional-centers/ ("Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities."); https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 17 (noting that ResCare serves as a vendor for several regional centers).

33 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-011.pdf, 5. *See also* https://www.dds.ca.gov/rc/information-about-regional-centers/.

34 https://www.dds.ca.gov/rc/information-about-regional-centers/.

35 https://www.dds.ca.gov/rc/ipp/.

36 https://www.dds.ca.gov/rc/lookup-rcs-by-county/ ("California has 21 regional centers with more than 40

maintain a list of service providers that act as vendors for the Regional Centers.[37] Individuals who move to a different part of the state receive services from their new Regional Center.[38] Thus, Regional Centers play an important role in determining what services individuals with IDD receive and where they receive those services.

Facilities providing IDD services in California require licensure from the relevant state licensing authority: CDPH for ICFs/IDD and California Department of Social Services (CDSS) for ARFs and ADPs.[39] Regional Centers conduct "vendorizations" of service providers, which is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services to consumers.[40] The vendorization process can be conducted through a Regional Center's Request for Proposals (RFPs) or as otherwise provided in Title 17 of the California Code of Regulations.[41] To successfully respond to an RFP, facility coordinators must complete steps such as acquiring licensure from the relevant state agency, submitting a detailed proposal, attending trainings, and hiring staff with the requisite experience and skills. Once the provider is identified through an RFP, becoming a vendor can take additional time.[42] Facilities may take additional time to open depending on the coordinators' relevant experience. Costs of opening a facility can include, among others, facility acquisition or construction costs, property leasing costs, costs of licensing fees and regulatory compliance, and costs involved with hiring and training staff.[43]

V.B. Facility landscape

In 2025, California had 994 ICFs providing services to individuals with IDD. In the same year, California had 6,298 ARFs and 965 ADPs. Not all of these ARFs and

offices located throughout the state. Both geographic accessibility and population density were considered when selecting locations for the 21 regional centers. The catchment area boundaries for the regional centers conform to county boundaries or groups of counties, except in Los Angeles County, which is by health districts and not by county.").

37 *See*, for example, https://www.altaregional.org/transparency/contracts/vendors.

38 https://rula.disabilityrightsca.org/rula-book/chapter-3-regional-centers/what-if-i-move-to-a-different-part-of-the-state-away-from-my-regional-center/.

39 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AppPacket/ICF-Initial.aspx; https://www.cdss.ca.gov/inforesources/adult-care-licensing/resources-for-residents-and-families.

40 https://www.dds.ca.gov/wp-content/uploads/2025/11/Vendorization_FAQs_General.pdf

41 *See*, for example, https://westsiderc.org/vendor-provider/current-service-needs/request-for-proposals.

42 *See* https://www.dds.ca.gov/wp-content/uploads/2025/11/D-2025-RegionalCenterOperations-004.pdf; and https://www.dds.ca.gov/wp-content/uploads/2025/08/Vendorization-steps-response_04082025-1.pdf.

43 As of 2025, the per bed licensing fee for ICFs/IDD in California is $2,066, and for ARF/ADP facilities with less than 50-person capacity, the per facility application fee is $2,270 or lower. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LC-Health-Care-Facility-Licensing-Fees.aspx; https://www.cdss.ca.gov/Portals/9/CCLD/Old/res/pdf/annualfees2015.pdf.

ADPs serve individuals with IDD. Figure 4 shows the distribution of these facilities by Regional Center.

Figure 4. Count of ICFs, ARFs, and ADPs by CA Regional Center, 2025

Regional Center	#ICFs	#ARFs	#ADPs
Alta California	36	474	92
Central Valley	72	328	66
East Bay	60	493	75
Far Northern	17	145	43
Golden Gate	34	198	40
Inland	167	865	78
Kern	28	119	33
LA County RCs	222	1,632	194
North Bay	28	190	52
Orange County	112	401	38
Redwood Coast	2	20	14
San Andreas	36	300	58
San Diego	95	627	76
Tri-Counties	48	174	57
Valley Mountain	37	332	49
Total	994	6,298	965

Source: CalHHS – Licensed and Certified Healthcare Facility Listing (pulled approximately June 2025); CDSS – Adult Residential Facilities data (pulled on January 23, 2026).

Note: LA County RCs is composed of North LA County, San Gabriel/Pomona, South Central LA, Harbor, Frank D Lanterman, Westside, and Eastern LA Regional Centers. ARF and ADP counts are not limited to facilities that serve individuals with IDD.

According to Sevita's filings, as of 2025, Sevita had 20 ICFs/IDD, 53 ARFs, and 54 ADPs providing IDD services. According to ResCare's filings, ResCare had 75 ICFs/IDD, 11 ARFs, and 6 ADPs in the same year (see Figure 5).

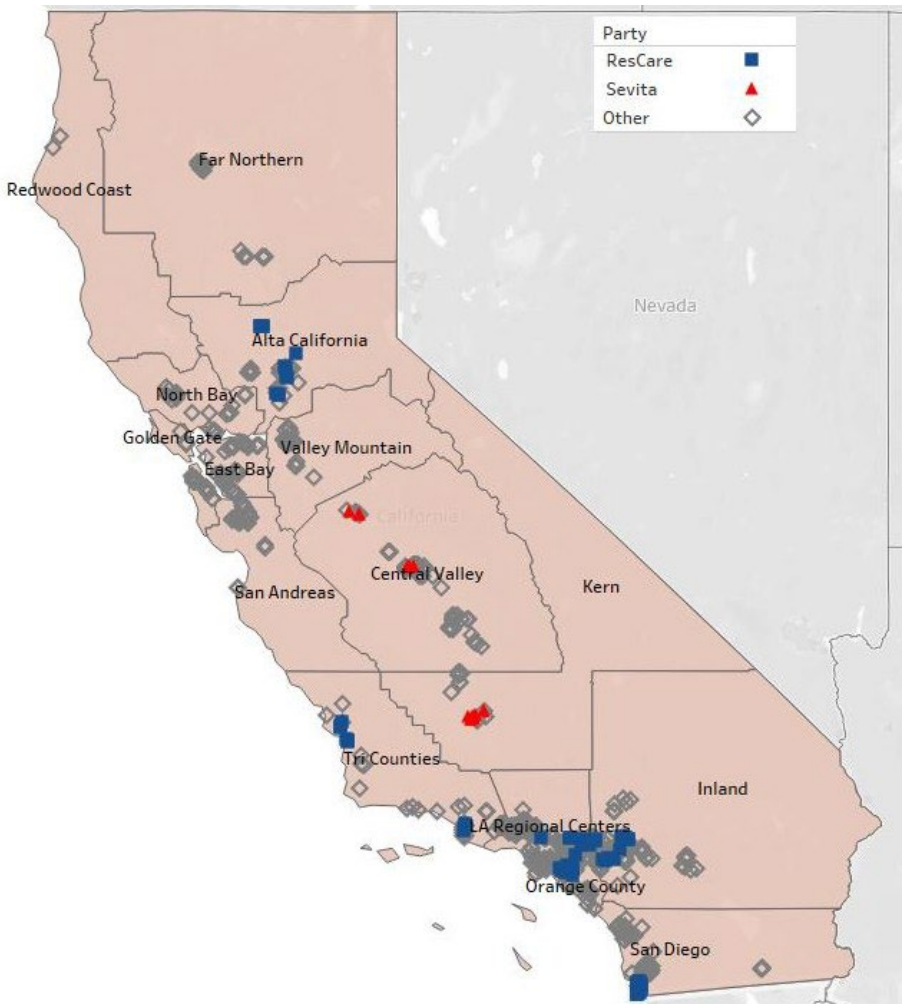
Figure 5. ResCare's and Sevita's facility counts in California, 2025

Service	ResCare	Sevita
ICF	75	20
ARF	11	53
ADP	6	54

Source: BrightSpring and Sevita facility location data.

Figure 6 shows the locations of all ICFs/IDD in California as of 2025. Sevita's ICFs are primarily concentrated in the Central Valley and Kern Regional Centers. ResCare's ICFs are primarily concentrated in the Alta California, Inland, Los Angeles, and Tri-Counties Regional Centers.

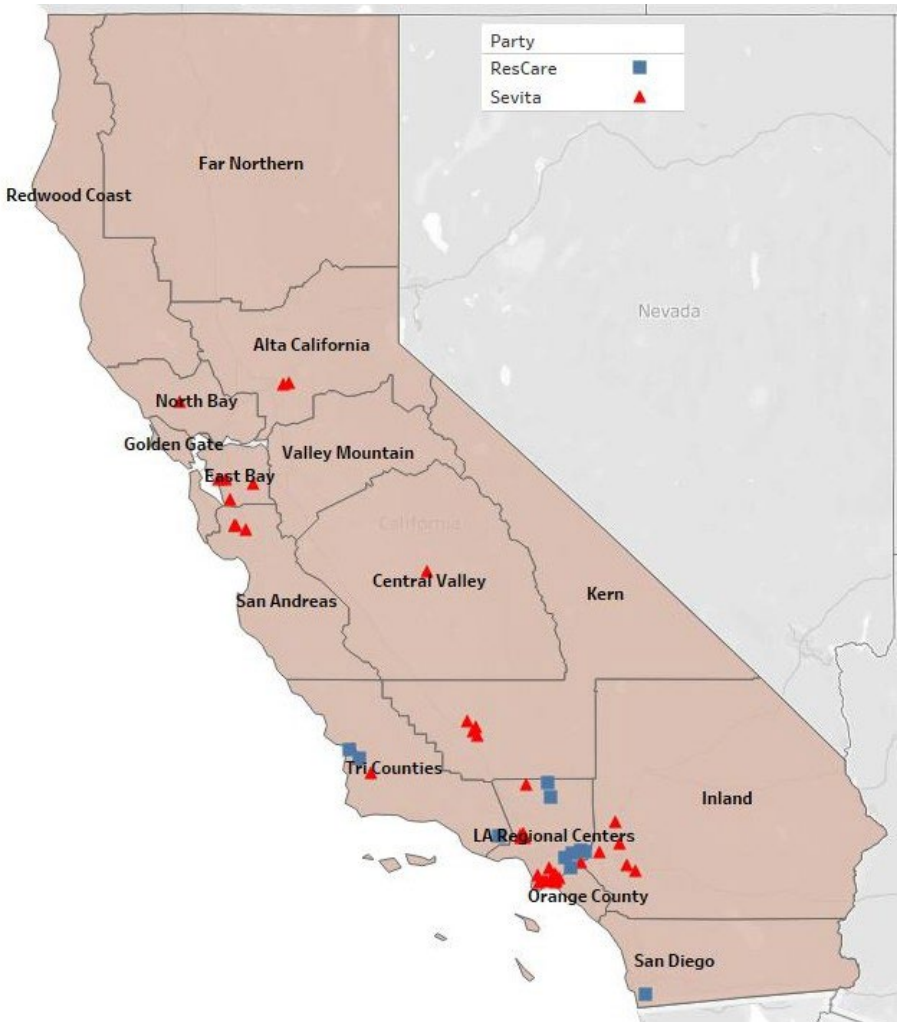
Figure 6. Landscape of California intermediate care facilities, 2025



Source: BrightSpring and Sevita facility location data; CDPH ICF data.

Over 3,900 ARFs are available to individuals with IDD in Alta California, Inland, San Diego, Tri-Counties, Orange County, and LA County Regional Centers—the areas where Sevita and ResCare primarily operate. These areas account for about 65% of California's population.[44] Figure 7 shows the locations of ResCare and Sevita's California ARFs as of 2025. ResCare and Sevita's ARFs overlap in the Los Angeles County and Tri-Counties Regional Centers.

Figure 7. Landscape of ResCare and Sevita California ARFs, 2025



Source: BrightSpring and Sevita facility location data.

[44] The share was calculated by dividing the total population within Regional Centers' covered counties by the total population in California in 2023. *See* https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html#v2023.

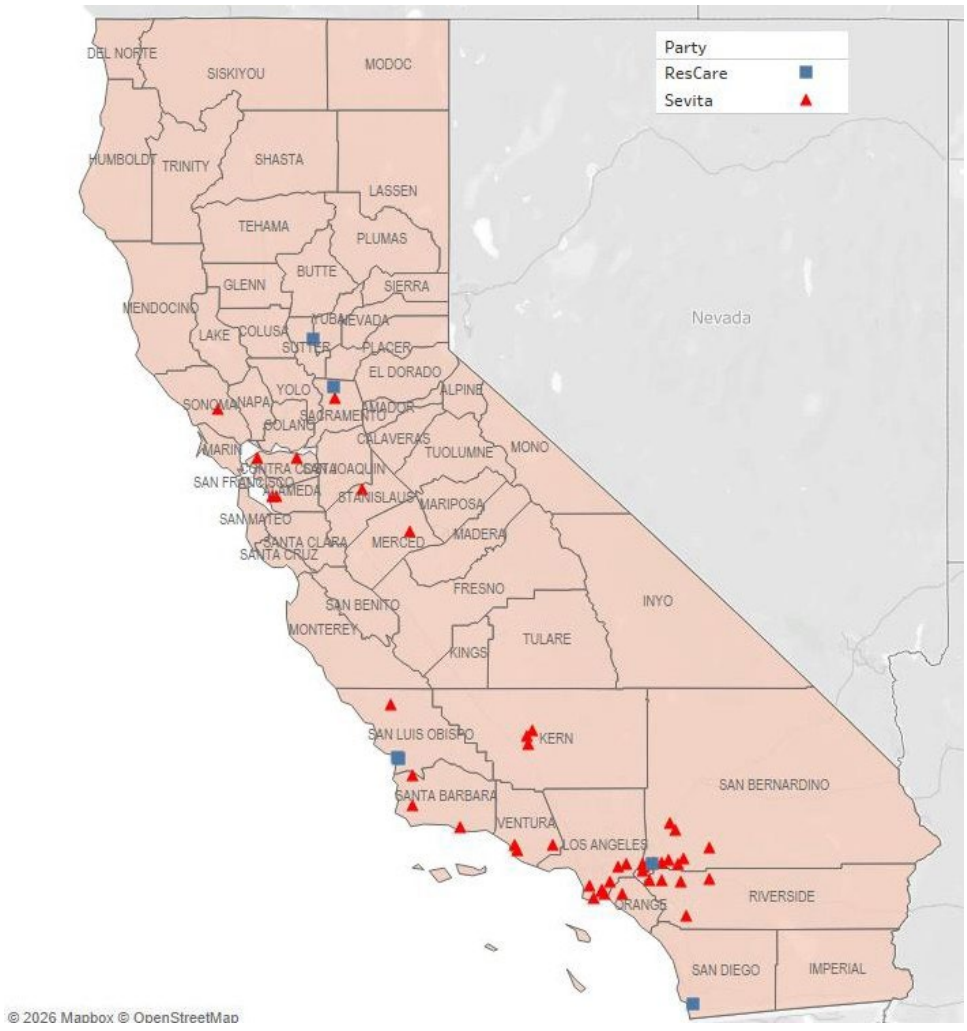
As explained in section VII.A, ARF data were collected and submitted to OHCA by ResCare and Sevita. These data were collected only for the Regional Centers where parties provide overlapping services.

Around 400 ADPs are available to individuals with IDD in Alta California, Inland, and Tri-Counties Regional Centers—the areas where Sevita and ResCare overlap. These areas account for about 23% of California's population.[45] Figure 8 shows the locations of ResCare and Sevita's California ADPs as of 2025. Sevita's ADPs are primarily concentrated in San Bernardino and Los Angeles Counties. ResCare and Sevita's ADPs overlap in Sacramento, San Luis Obispo, and San Bernardino Counties.

[45] The share is calculated by dividing the total population within Regional Centers' covered counties by the total population in California in 2023. See https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html#v2023.

As explained in section VII.A, ADP data were collected and submitted to OHCA by ResCare and Sevita. These data were collected only for the Regional Centers where parties provide overlapping services and appear to come from the Regional Centers' websites. Regional Centers can refer consumers to providers outside of their catchment area, and Regional Centers' websites include providers who are physically located outside of the Regional Center boundary (this applies to ARFs as well). https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendorization-rates-frequently-asked-questions/. For example, Inland Regional Center's website lists ADPs located in Los Angeles County. https://www.inlandrc.org/wp-content/uploads/2024/02/IRC-VENDOR-LISTING.pdf. For this reason, the count of ADPs in Alta California, Inland, and Tri-Counties Regional Centers reported above is higher than what is reported in Figure 4.

Figure 8. Landscape of ResCare and Sevita California ADPs, 2025 (county-level)



Source: BrightSpring and Sevita facility location data.

Other large operators in the ICF/HCBS space include:

- Ability Pathways Incorporated. Provides “a lifetime of support services for children, adults, and seniors with developmental disabilities and their families in the greater Bay Area.” Operates ICFs in the Inland and LA County Regional Centers and day services in the Bay Area.[46]

[46] https://abilitypath.org/; CalHHS - Licensed and Certified Healthcare Facility Listing.

- Home of Guiding Hands Corporation. “[O]ne of the largest organizations in San Diego and Imperial Counties providing disability support services . . . ” Operates ICFs, ARFs, and day services in the San Diego Regional Center.[47]
- Independent Options, Inc. Provides “residential, day service, independent & supported living, and foster & adult family supports to people with developmental disabilities.” Operates ICFs, ARFs, and ADPs in the Inland, LA County, and San Diego Regional Centers.[48]
- JonBec Care Incorporated. “[P]rovides comprehensive community-based programs for individuals with intellectual disabilities including residential and adult day care services.” Operates ICFs and ADPs in the Inland Regional Center.[49]
- Mountain Shadows Community Homes. “[A] community of homes designed to provide a normal family-like living environment for individuals with intellectual disabilities.”[50] Operates ICFs in the Inland and San Diego Regional Centers and ADPs in San Marcos.[51]

V.C. Payment sources

ICF, ARF, and ADP services for individuals with IDD are primarily funded by California’s Medicaid program Medi-Cal. Medicaid is a government program that provides health insurance primarily to low-income individuals, children, and pregnant women. It is funded jointly by the federal government and states.[52]

Traditionally, Medicaid paid health care providers using a fee-for-service (FFS) model in which providers received a set dollar amount for a given service directly from the government. Providers cannot negotiate over reimbursements under FFS Medicaid. Over time, many states have adopted a “managed care” model in which private health insurance companies administer and pay for Medicaid services and are in turn paid by the government.[53] In California, nearly all Medi-Cal members obtain their coverage through managed care plans.[54] Medi-Cal Managed Care Plans

47 https://www.guidinghands.org/; https://www.ccld.dss.ca.gov/carefacilitysearch/; CalHHS - Licensed and Certified Healthcare Facility Listing.

48 http://www.independentoptions.org/.

49 http://www.jonbeccare.com/scope-of-services/.

50 https://mtnshadows.org/about/.

51 https://mtnshadows.org/residential-services/; https://mtnshadows.org/mountain-shadows-outreach-services/.

52 https://www.medicaid.gov/medicaid.

53 https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/.

54 https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-at-a-Glance.pdf.

reimburse some services at fixed rates and others at negotiated rates.[55] Both FFS Medi-Cal and Medi-Cal Managed Care Plans are regulated by the Department of Health Care Services (DHCS).[56]

Before 2024, ICF/IDD services were covered by Medi-Cal managed care plans in some counties, but not in others (FFS Medi-Cal covered ICF/IDD services statewide). As of January 2024, ICF benefits were standardized across different types of Medi-Cal managed care plans and all individuals residing in ICFs/IDD were transitioned to a managed care plan.[57] For counties where ICF/IDD services transitioned from being delivered by FFS to managed care, managed care plans were required to reimburse ICFs/IDD at the *same* rate they would have been reimbursed under FFS through December 31, 2025. For counties where ICF/IDD services were already provided by managed care plans, the plans were required to reimburse ICFs/IDD *at least* as much as they would have been under FFS through December 31, 2025.[58] Hence, in the latter scenario, there is scope for ICFs/IDD to negotiate *higher* reimbursement rates than the FFS rates from managed care plans.[59] DHCS has elected to extended these minimum/maximum and minimum payment requirements through at least December 31, 2026, and is authorized under state law to elect to continue these payment requirements in future years. If DHCS takes no further action, these payment requirements will sunset and ICFs/IDD would

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55 https://www.chcf.org/wp-content/uploads/2019/02/MediCalExplainedPaymentManagedCarePlansCurrentProcessChallenges.pdf.

56 https://www.dhcs.ca.gov/Medi-Cal/Pages/help.aspx at "Basics".

57 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-011.pdf, 2. This did not apply to ICF/DD-CNC. 36 counties transitioned from FFS Medi-Cal to managed care. *Id.*, 16.

58 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-011.pdf, 15–16 ("In accordance with W&I section 14184.201(c)(2), for contract periods from January 1, 2024, to December 31, 2025, inclusive, each MCP must reimburse a Network Provider furnishing ICF/DD Home services to a Member, and each Network Provider of ICF/DD Home services must accept, the payment amount the Network Provider would be paid for those services in the FFS delivery system, as defined by DHCS in the Medi-Cal State Plan and as authorized by W&I sections 14105.075(b) and 14184.102(d). … MCPs in counties where ICF/DD Home services benefit coverage is newly transitioning from the Medi-Cal FFS delivery system to the Medi-Cal managed care delivery system on January 1, 2024, must reimburse Network Providers of ICF/DD Home services for those services at **exactly** the Medi-Cal FFS per-diem rates applicable to that particular type of ICF/DD Home services Provider for dates of service from January 1, 2024, through December 31, 2025…MCPs in counties where ICF/DD Home services are already Medi-Cal managed care Covered Services prior to January 1, 2024, must reimburse Network Providers of ICF/DD Home services for those services at **no less than** the Medi-Cal FFS per-diem rates applicable to that particular type of ICF/DD Home services Provider for dates of service from January 1, 2024, through December 31, 2025…" (emphasis in original)).

59 Moreover, not all ICF/IDD services are covered by Medi-Cal and therefore do not have an FFS rate. These services are also subject to negotiation. *Id.*, 16–17. Examples of uncovered services include allied health services, dental services, durable medical equipment, and insulin. *Id.*, 27–28.

negotiate reimbursement rates with managed care plans with no minimum or maximum amount.

ARFs and ADPs for individuals with IDD are also paid through Medi-Cal. While these types of services were not originally covered by Medicaid, California has a 1915(c) HCBS-DD and 1915(i) HCBS-DD SPA waiver program that allows Medi-Cal to pay for these services for individuals with IDDs.[60] Rates for these services are largely administratively set.[61] Historically, rates for HCBS were determined using a variety of methodologies, resulting in different payments to different providers for the same services in the same region. Moreover, rates were reduced or frozen multiple times due to funding constraints. In 2019, DDS submitted a rate study that proposed simplifying and standardizing reimbursements such that providers were paid standard amounts for the same service at the Regional Center level.[62] Pursuant to Section 4519.10 of the Welfare and Institutions Code, DDS has implemented the rate models proposed in the rate study.

Figure 9 below summarizes key similarities and differences among ICF, ARF, and ADP settings.

60 https://www.dds.ca.gov/wp-content/uploads/2019/02/HCBS_WaiverDDEng_20190212.pdf. *See also* https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, pp. 2–3.

61 *See, e.g.,* https://www.chcf.org/wp-content/uploads/2020/10/MediCalExplainedLongTermServicesSupports.pdf, 3–4; https://www.dds.ca.gov/wp-content/uploads/2024/12/D-2024RateReform-008_RateReformImplementationForAdultDayServices.pdf.

62 https://www.healthmanagement.com/wp-content/uploads/DDS-Vendor-Rate-Study-Report.pdf.

Figure 9. Comparison of ICF, ARF, and ADP settings

Features	ICF	ARF	ADP
Residential	Yes	Yes	No
Health care/Skilled nursing care	Yes	No	No
Institutional setting	Yes	No	No
Payment mechanism (for covered services)	Medicaid State Plan, Medicaid governed rates (Medicaid HCBS Waiver rates for ICF/DD-CNC)	Medicaid HCBS Waiver rates	Medicaid HCBS Waiver rates
Regulatory and licensing authorities	CDPH, DDS, DHCS	DDS, Regional Centers, CDSS	DDS, Regional Centers, CDSS

Source: https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability; https://www.dds.ca.gov/services/icf/; https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.ICF_DD.aspx; https://www.cdss.ca.gov/inforesources/community-care/ascp-centralized-application-units; https://www.dds.ca.gov/initiatives/hcbs/; https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/33702.

VI. Services and California geographies impacted by the proposed transaction

This section discusses how the Sevita-ResCare transaction may affect the markets in which the parties compete. Mergers and acquisitions typically alter "market structure," which refers to key characteristics of a market—such as the number and size of sellers, the degree of concentration, and conditions of entry and exit. These characteristics influence the nature and intensity of competition among sellers. A merger between two sellers of a product or a service can reduce competition, potentially leading to higher prices, lower quality, or deterioration in other aspects of the service. Economists describe these outcomes as "competitive effects" arising from changes in market structure.

Changes in market structure can be assessed by examining changes in market shares and concentration. Doing so requires defining a market or markets in which shares and concentration will be calculated. Competition economists refer to these as "relevant markets." These markets may differ from how firms describe their operations in the ordinary course of business. In defining relevant markets, economists consider the products that consumers would reasonably substitute between. Markets have both product and geographic dimensions—the *types* of products that consumers view as substitutes (product market) and the *locations* where consumers go to obtain these products (geographic market).[63]

Importantly, a relevant market need not include *all* products that consumers may consider substitutes, only those that are sufficiently close substitutes.[64] For example, some consumers may be willing to travel long distances to seek hospital care, but most prefer to choose a hospital located close to their home and family. Thus, hospitals close to a consumer's home are likely to be closer substitutes than those located at a significant distance—such as in a distant city or another state.

In section VI.A, the report explains why ICFs, ARFs, and ADPs providing IDD services likely belong in separate product markets. In section VI.B, the report explains why Regional Centers and county areas are plausible geographic markets

[63] 2023 Merger Guidelines, § 4.3.

[64] 2023 Merger Guidelines, § 4.3. ("Market participants often encounter a range of possible substitutes for the products of the merging firms. However, a relevant market cannot meaningfully encompass that infinite range of substitutes. There may be effective competition among a narrow group of products, and the loss of that competition may be harmful, making the narrow group a relevant market, even if competitive constraints from significant substitutes are outside the group." (internal citations omitted)).

in which to assess the change in shares and concentration resulting from the transaction, while also considering other plausible geographic markets.

VI.A. Sevita and ResCare serve Californians with IDD in ICF, ARF, and ADP settings

While both ResCare and Sevita provide IDD services in ICF, ARF, and ADP settings, their facility ownership is differentiated. Of the three settings, ResCare primarily operates ICFs, with over 80% of its facilities in that format. Sevita, in comparison, provides ICF services in about 15% of its facilities. Of Sevita's remaining facilities, about half provide IDD services in an ARF setting (see Figure 5), and the rest in an ADP setting.

As section V shows, there are meaningful distinctions between ICFs, ARFs, and ADPs, indicating that most consumers likely do not treat them as close substitutes. For example, an individual with IDD who requires a higher level of skilled nursing care provided in an ICF may not be able to easily seek care in an ARF or an ADP as an alternative.[65] Individuals who do not have at least intermittent skilled nursing care needs are likely better suited to other settings, such as ARFs. Similarly, an individual with IDD who requires 24/7 supervision may consider an ARF but will likely not consider an ADP as an alternative because ADPs are day programs that do not provide residential services.

Regulatory mechanisms further highlight the differentiation among these settings and why most consumers likely do not treat them as close substitutes. In California, individuals with IDD work with their Regional Center to develop an individual program plan (IPP) that specifies the services the individual needs. This plan effectively functions as a contract between the individual and the Regional Center. The Regional Center, as part of the IPP team, works with the individual and their IPP

[65] The FTC took a similar position in its Complaint challenging this transaction. *See* https://www.ftc.gov/system/files/ftc_gov/pdf/2510060SevitaComplaint.pdf, ¶¶ 14–15 ("Other types of IDD Services, including HCBS, state-owned ICFs, and non-residential services, are not reasonable substitutes for and do not competitively constrain ICF services. HCBS are excluded from an ICF services market because HCBS are not substitutable for ICF services and are offered under different competitive conditions. HCBS do not provide the same oversight, structure, or level of support as ICF services. As a result, individuals cannot substitute HCBS for ICF residential services. Non-residential services such as day habilitation and other periodic services are excluded from an ICF services market. Periodic services are intermittent and are less than 24-hour. The ICF services market excludes periodic services because such services are not substitutable for residential services and are offered under different competitive conditions. Residential services are 24-hour services provided in a residential setting, and as a result, individuals cannot substitute periodic or intermittent services for 24-hour residential services.").

team to identify the appropriate level of care which is then outlined in the IPP.[66] For example, when the IPP team identifies a need for ICF level of care with skilled nursing, the Regional Center would make referrals based on the level of care, which would likely not include an ARF or an ADP. A Medi-Cal member's medical condition must be taken into account before determining the need for an ICF/IDD setting.[67]

Thus, for the purpose of analyzing the impact of this transaction, IDD services provided in ICF, ARF, and ADP settings are treated as distinct and belonging to different product markets.

VI.B. Sevita and ResCare serve individuals with IDD across multiple regions in California

Both ResCare's and Sevita's California footprints are largely concentrated in Southern California, particularly in the Los Angeles, Orange County, and Inland Empire regions. About two-thirds of ResCare's facilities are in Los Angeles, the Inland Empire, Orange County, and San Diego, with the rest primarily in Sacramento, San Luis Obispo, and Yuba City. Sevita's Southern California presence also encompasses areas of Los Angeles and the Inland Empire, with additional facilities in San Luis Obispo. Relative to ResCare, Sevita has a larger footprint in the Central Valley, including the Bakersfield, Fresno, and Merced areas.

Given the conclusion that IDD services provided at ICFs, ARFs, and ADPs constitute separate product markets, the geographic markets analysis is conducted separately for each service type. Identifying a relevant geographic market for each service requires assessing the span of the area in which consumers would reasonably turn to alternative providers.[68] As section V shows, there are several ICFs, ARFs, and

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66 *See* https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-011.pdf, 4 ("Regional Centers develop an IPP for each individual with intellectual and/or developmental disabilities, based on the individual's person-centered goals and needs. An IPP serves as a contract between the Regional Center and an individual, and identifies (1) all services and supports the individual needs and is entitled to receive, and (2) whether the Regional Center will provide, supervise, or pay for the services, or another agency will." (internal citations omitted)). *See also* https://www.dds.ca.gov/wp-content/uploads/2025/02/Guide_to_Californias_Regional_Center_Services_System.pdf.

67 https://www.law.cornell.edu/regulations/california/22-CCR-51343.2; https://www.law.cornell.edu/regulations/california/22-CCR-51343.1; https://www.law.cornell.edu/regulations/california/22-CCR-51343.

68 2023 Merger Guidelines, § 4.3 ("A relevant antitrust market is an area of effective competition, comprising both product (or service) and geographic elements. The outer boundaries of a relevant product market are determined by the 'reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it.'" (internal citations omitted)).

In technical terms, the "area of effective competition" is often determined using the "hypothetical monopolist test." The test proceeds by asking whether a single seller of all products in a candidate market (a

ADPs located throughout various regions of California, with facilities tending to locate closer to large population centers, indicating that consumers prefer to minimize travel time. Because travel costs and proximity to families and caregivers materially affect utilization, the relevant geographic markets for these services are likely to be narrower than the entire state.[69]

Additional factors further affect geographic market definition. As section V discusses, Regional Centers play an important role in arranging and authorizing services for eligible individuals with IDD and work with "vendored" service providers.[70] As a practical matter, the set of providers considered for an individual is substantially shaped by the Regional Center's vendored provider network and referral/authorization practices.[71] Accordingly, to analyze the transaction's impact, it is appropriate to consider a geographic market definition that is anchored to Regional Center service areas, while also testing other geographies, including ones narrower than a Regional Center area. Among other things, a narrower geography may better account for travel burden.

Travel burden is likely to constrain demand more strongly for ADPs because services are typically used multiple days per week and typically involve transportation logistics—such as provider transportation, caregiver drop-off/pick-up, and ride-time tolerance.[72] In contrast, because ICFs and ARFs are residential facilities, placement decisions do not create a frequent commuting requirement on

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"hypothetical monopolist") could profitably implement a "small but significant non-transitory increase in price" (SSNIP) of at least one product over existing levels (a 5% increase in price is a common benchmark). If the hypothetical monopolist could profitably implement a SSNIP, that indicates that products outside the candidate market are not sufficiently close substitutes to prevent the price increase—if they were, consumers would substitute to those products and the price increase would not be profitable. 2023 Merger Guidelines, § 4.3.A.

It is not always necessary to use the hypothetical monopolist test if other evidence is available and conclusions are not likely to be materially impacted by the choice of geographic market. In this case, commercial realities indicate that ICF, ARF, and ADP services are in separate product markets. And, in a range of plausible geographic markets, conclusions are not materially different.

69 For example, *see* https://canhr.org/how-to-choose-a-nursing-home/ ("It is important to select a nursing home that is close and convenient to the person(s) who will be visiting the resident most often. Residents who have frequent visitors often recover faster, are happier and healthier from the love and attention received and tend to receive a higher quality of care. When family members and friends are close enough to visit frequently, they can monitor the resident's condition, participate in care planning and respond quickly to emergencies.").

70 https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendorization-rates-frequently-asked-questions/.

71 https://rula.disabilityrightsca.org/rula-book/chapter-3-regional-centers/what-if-i-move-to-a-different-part-of-the-state-away-from-my-regional-center/. Though service providers are vendored only by the Regional Center in which they operate, Regional Centers may refer consumers to providers outside their catchment area. https://www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendorization-rates-frequently-asked-questions/.

72 https://www.nadsa.org/wp-content/uploads/2018/08/Metlife_ADS_Study.pdf; https://www.nadsa.org/wp-content/uploads/2022/09/ARCH-Adult_Day_Services.pdf

the part of the resident, though distance still matters for family visitation and continuity of care. Thus, individuals and caregivers may have greater tolerance for travel time to ICFs and ARFs than to ADPs.

Given the Regional Center's role in placement and authorization, this report uses Regional Center service areas (i.e., the counties and facilities covered by a Regional Center) as a primary geographic market for analyzing the impact of combining Sevita and ResCare's ICFs and ARFs under a single owner. For Los Angeles County—served by multiple Regional Centers—this report evaluates transaction impact using Los Angeles County as a consolidated geography, while separately testing alternative definitions as robustness checks.[73]

To analyze the impact of the parties' ADP consolidation, this report—given the frequent travel requirements for ADPs—considers primary geographic markets that are narrower than Regional Center service areas. One informative approach would have been to define ADP markets using drive-time or distance bands (e.g., 15–30 minutes or miles) around each facility or around the population served. However, county-level markets provide a practical approximation to drive-time/distance bands (and are tested through sensitivity analyses). Accordingly, drive-time modeling is not necessary in this case.

Limiting the impact analysis to a particular geography does not imply that providers outside the geographic boundary are not substitutes. Rather, it means that more distant providers are typically weaker substitutes because travel and coordination costs reduce the likelihood of individuals with IDD switching to remote alternatives in response to, say, a deterioration in the quality of care at their preferred facility.

In addition to the primary geographic markets above, this report also analyzes transaction impact using alternative geographies—specifically, Core Based Statistical Areas (CBSAs) for all three services, counties for ARFs, and Regional Centers for ADPs.[74] These sensitivity analyses help assess whether conclusions are

[73] Within the Los Angeles County Regional Centers, the parties' ARFs overlap in the North LA and San Gabriel/Pomona Regional Centers. The impact of the transaction within these individual Regional Centers is tested below. The parties' facilities' location information was used to determine which are located in these Regional Centers. The total number of ARFs serving individuals with IDD was determined using the Regional Centers' websites.

[74] CBSAs are Census-defined areas that are based on population density and typical commuting patterns and generally capture an urban core and its associated outlying areas. *See* https://www.census.gov/programs-surveys/metro-micro/about/glossary.html. CBSAs can be larger or smaller than the area covered by a Regional Center. In contrast, with the exception of Los Angeles County, counties are almost always smaller than the area covered by a Regional Center. Because patient travel patterns for ICFs, ARFs, and ADPs are unavailable, CBSA- and county-level geographies serve as good alternatives to assess the robustness of conclusions.

robust to reasonable differences in travel tolerance and referral patterns across the three product types.[75] Results are reported in Appendix B and indicate that the main conclusions are not materially affected by the choice of geographic market.[76]

[75] In some cases, Regional Centers can encompass a large geography for purposes of capturing the alternatives an individual with IDD would likely consider. For example, an individual residing in Merced County may not be likely to choose a facility located in Tulare County, despite both being included in the vendor list of Central Valley Regional Center. These counties are 145 miles and over 2.5 hours by drive apart. Thus, analyzing alternative geographic markets allows to stress test the impact of the choice of market definition on the merger impact.

[76] As explained below, the parties' ICFs do not overlap in any Regional Center, so testing narrower geographies is unnecessary. For ARFs, sensitivity analyses are performed only for the counties/CBSAs in which both parties operate at least one facility, and for all such counties/CBSAs. For ADPs, sensitivity analyses are performed for all CBSAs and Regional Centers in which both parties operate at least one facility.

VII. Impact of the proposed transaction

This report examines the transaction's likely impact in California by focusing on the following factors:

- The effect of lessening competition or potentially creating a monopoly, which could result in raising costs, reducing quality or equity, or restricting access or innovation.
- The effect on competition for workers and the impact on the labor market.
- The effect on the quality of health care services provided to any of the communities affected by the transaction.
- The effect on the availability or accessibility of health care services to any community affected by the transaction.
- Consumer concerns including, but not limited to, complaints or other allegations against any health care entity that is a party to the transaction related to access, care, quality, equity, affordability, or coverage.

This section presents findings of the impact analysis, organized as follows:

- Section VII.A explains why the transaction is unlikely to significantly affect health care costs for the relevant IDD services.
- Section VII.B explains why the transaction is unlikely to affect labor competition among ICFs, ARFs, and ADPs.
- Section VII.C explains why the transaction does not appear to further a trend toward consolidation in the provision of IDD services at ICFs, ARFs, and ADPs.
- Section VII.D discusses why the transaction is likely to increase the risk of reduced quality and access to IDD services given Sevita's mixed quality record and aggressive financial practices.

VII.A. The transaction is not likely to significantly impact health care costs in California

The competitive effects from a merger, such as higher costs and/or reduction in service quality, are more likely when the merging parties compete directly. The greater the overlap between the parties, the stronger the competitive pressure they exert on each other and the larger the competitive effects from its elimination.

Conversely, when there is little overlap between the merging firms, competitive effects are less likely to arise.[77]

This section evaluates the existing overlap among ResCare and Sevita and assesses the impact of combining their facilities under a single owner across the relevant product and geographic markets. Overall, the analysis indicates that the transaction will not result in a significant change in market structure in most relevant markets. In addition, Medi-Cal reimbursement rules impose constraints to varying degrees on the merged firm's ability to raise prices. Therefore, the transaction is unlikely to significantly increase health care costs in the relevant markets.

VII.A.1. The transaction will not significantly alter shares and concentration in California markets

Although Sevita and ResCare's overall statewide footprints overlap, the proximity of their facilities varies substantially by service type. ResCare operates ICFs in areas served by the following Regional Centers: Alta California, Tri-Counties, Orange County, San Diego, Inland, and the Los Angeles County Regional Centers. Sevita, in contrast, operates ICFs in the Central Valley and Kern Regional Centers. The closest ResCare and Sevita ICFs are in Ventura (ResCare) and Bakersfield (Sevita), more than 100 miles apart.

There is greater geographic overlap in Sevita and ResCare's ARF and ADP offerings. Both parties operate ARFs in the Tri-Counties and Los Angeles County Regional Centers. Sevita also operates ARFs in the Inland Regional Center and ResCare has ARF operations in the Orange County Regional Center, both of which are adjacent to the Los Angeles County Regional Centers. Accordingly, there are ResCare and Sevita facilities within 5 miles of each other in the Tri-Counties Regional Center and Sevita operates Los Angeles facilities within 15 miles of ResCare facilities in the Orange County and Los Angeles County Regional Centers.[78]

Sevita and ResCare also overlap in ADP operations in the Alta California, Tri-Counties, and Inland Regional Centers. The closest ResCare and Sevita facilities

[77] 2023 Merger Guidelines, § 2.2 ("A merger eliminates competition between the merging firms by bringing them under joint control. If evidence demonstrates substantial competition between the merging parties prior to the merger, that ordinarily suggests that the merger may substantially lessen competition." (internal citations omitted)).

[78] These distances are computed using the straight-as-a-crow-flies methodology and are, therefore, only an approximation. The drive time between some facilities can be much higher than implied by the short straight-as-a-crow-flies distance.

are less than 2 miles of each other in the Inland Regional Center, within 15 miles of each other in the Alta California Regional Center, and within 25 miles in the Tri-Counties Regional Center.

Given the proximity of the parties' facilities and the similarity of their services in certain areas, changes in shares and concentration help assess whether the transaction could materially alter market structure or reduce competition. Specifically:

- Market shares are a common indicator of a firm's "market power." Higher market shares imply greater ability to raise prices and/or reduce quality. Market shares range from 0% to 100%. All else equal, the larger the post-transaction share, the greater the potential for cost increases.
- Market concentration reflects how many meaningful alternatives consumers have. More concentrated markets generally offer fewer options to consumers. For example, if two firms each have a 45% share, consumers effectively have two primary choices (with a possible fringe of smaller options). All else equal, the larger the increase in concentration due to the transaction, the greater the potential for cost increases.
  - A widely used measure of market concentration is the "Herfindahl-Hirschman Index" (HHI), which can take values from 0 to 10,000; the more concentrated the market, the higher the HHI will be.[79]
  - When assessing merger impact, economists commonly focus on the change in HHI[80] due to the merger.[81]

In their 2023 Merger Guidelines (referred to as "Merger Guidelines" hereafter), the Department of Justice (DOJ) and the Federal Trade Commission (FTC)—the two federal antitrust enforcers—describe structural thresholds beyond which changes in market shares and market concentrations indicate competitive harm. Specifically, the Merger Guidelines state that a merger raises a "presumption of illegality" if it results in (1) an increase in HHI of at least 100 and either (2a) a combined share of at least

[79] The HHI is calculated by (1) multiplying each market participant's market share by 100, (2) squaring the result, and (3) summing all of the squared shares. In a market where a single firm has 100% of the share, the HHI is 10,000 (=(1*100)^2). This is the maximum value the HHI can take. Highly unconcentrated markets where there are many small firms will have HHIs closer to 0.

[80] Mechanically, change in HHI is calculated as twice the product of the merging party's market shares (expressed as whole numbers).

[81] Miller, Berry, et al, "On the misuse of regressions of price on the HHI in merger review," Journal of Antitrust Enforcement, 2022, 248–259 ("Economic theory provides support for the established legal presumption that a merger in a market is likely to have adverse competitive effects when it occurs in a concentrated market and makes it more concentrated (i.e., increases the HHI) . . . ") (p. 251).

30% or (2b) a post-merger HHI of at least 1,800.[82] If the increase in HHI is less than 100, then the presumption is not triggered, regardless of the combined share or post-merger HHI.

VII.A.1.a. Changes in market shares and concentration

This section examines ResCare's and Sevita's combined market shares and the change in concentration due to the transaction.[83] As shown below, under several alternative relevant market definitions, the transaction generally does not trigger the presumption of illegality.[84]

Figure 10 identifies the Regional Centers where the parties overlap, i.e., where both parties operate at least one facility. The parties do not overlap in any Regional Center for ICF services. They do overlap in the Los Angeles County and Tri-Counties Regional Center areas for ARF services, and in the Alta California, Inland, and Tri-Counties Regional Center areas for ADP services. The analysis therefore focuses on these overlapping areas; in areas without overlap, the transaction will not change market structure.

[82] 2023 Merger Guidelines, § 2.1.

[83] Market shares are calculated using facility counts as a proxy for competitive significance. For each market (e.g., ARF services in the Tri-Counties Regional Center), a party's share equals the number of facilities the party operates in that market divided by the total number of facilities in that market. For example, if Sevita operates two facilities in a market that has 100 total facilities, its market share would be 2% (i.e., 2/100).

Data limitations regarding the ownership of non-party facilities prevent reliable systematic calculation of market-wide HHIs. The limitation does not extend to the increase in HHI calculations, as those can be calculated based on information submitted by the parties.

[84] The one exception is for ADP services in San Luis Obispo County.

Figure 10. Regional center areas where parties provide overlapping services

Regional center	ICF	ARF	ADP
Alta California	No overlap	No overlap	Overlap
Central Valley	No overlap	No overlap	No overlap
Far Northern	No overlap	No overlap	No overlap
Golden Gate	No overlap	No overlap	No overlap
Inland	No overlap	No overlap	Overlap
Kern	No overlap	No overlap	No overlap
LA County RCs	No overlap	Overlap	No overlap
North Bay	No overlap	No overlap	No overlap
Redwood Coast	No overlap	No overlap	No overlap
Orange County	No overlap	No overlap	No overlap
East Bay	No overlap	No overlap	No overlap
San Andreas	No overlap	No overlap	No overlap
San Diego	No overlap	No overlap	No overlap
Tri-Counties	No overlap	Overlap	Overlap
Valley Mountain	No overlap	No overlap	No overlap

Source: BrightSpring and Sevita facility location data.

Notes: Overlap is defined as both parties having at least one facility in a given Regional Center.

Figure 11 shows the parties' statewide shares of ICFs in California in 2025. The numerator is based on facility location data provided by the parties and the denominator is based on data from the California Health and Human Services Agency (CalHHS), which provides a list of all ICFs in the state.[85] The last column of the figure, "Above MG presumption thresholds," reports whether the share and concentration metrics exceed the presumption thresholds in the Merger Guidelines. Although geographic markets are likely no broader than Regional Centers, statewide shares are presented for context because the parties do not overlap in any Regional Center for ICF services. As of 2025, ResCare has a 7.5% share and Sevita has a 2.0% share of all ICFs in California.[86] The combined share is 9.6%.[87] Even under a

[85] Specifically, the parties provided the list of ICFs from CalHHS; this sample, along with the parties' ICF lists, appears to have been compiled as of June 2025 (note that CalHHS updates its ICF list regularly). *See* https://data.chhs.ca.gov/dataset/healthcare-facility-locations.

[86] The expected change in concentration due to the acquisition is about 30, which indicates that the transaction would not significantly increase concentration statewide.

[87] Combined shares may not exactly equal the sum of ResCare's and Sevita's shares due to rounding.

hypothetical statewide market definition, the transaction would not exceed the Merger Guidelines' presumption thresholds.

Figure 11. Combined shares for ICFs/IDD, 2025

Market	ResCare		Sevita		Combined share	Above MG presumption thresholds
	Count	Share	Count	Share		
California	75	7.5%	20	2.0%	9.6%	No
Regional centers	No overlap					

Source: CalHHS - Licensed and Certified Healthcare Facility Listing; BrightSpring and Sevita facility location data.

For ARFs and ADPs, there is no public database listing of all California facilities that serve individuals with IDD. For the overlapping Regional Center areas (Los Angeles County and Tri-Counties), the parties compiled facility lists (as of June 2025) using Regional Center directories.[88] For the analyses below, the parties' lists are corrected in some instances to remove duplicates, facilities closed before June 2025, and facilities that do not appear to be ARFs or ADPs based on public information.[89]

As explained above, Los Angeles County contains seven Regional Centers. The parties' facilities only overlap in two: North Los Angeles and San Gabriel/Pomona.[90] As a robustness check, the report also considers the impact of the transaction in these two Regional Centers.[91]

Figure 12 shows the parties' shares of ARFs in 2025. In the Los Angeles County and Tri-Counties Regional Center areas, Sevita and ResCare have a combined share of

[88] As explained above, Regional Centers may refer consumers to facilities outside of the Regional Center's catchment area. Such facilities are included in Regional Center directories, are part of the data provided by the parties, and are included in the ARF share calculations below. For example, ARFs listed in Los Angeles County Regional Centers directories which are physically located in Inland Regional Center are included in the Los Angeles County share calculation. The same approach is taken when calculating ADP shares at the Regional Center level (see Appendix B).

[89] For example, "TMI-Family Support Srvcs Toward Maximum Independence" is listed as an ARF, but it does not appear in the CCLD database and its website states that it is primarily a foster family agency. https://www.tmi-inc.org/family-support-services. "Options for All" is listed as an ADP but appears to be a production company that hires media professionals with IDD. https://production.optionsforall.org/about-us/.

[90] The parties operate other ARFs in Los Angeles County that do not overlap at the individual Regional Center level.

[91] For non-party Los Angeles County ARFs, data provided by the parties to OHCA do not specify the facility's Regional Center. The number of ARFs in the two individual Regional Centers of overlap was gathered from the Regional Centers' websites. https://www.nlacrc.org/service-providers/service-provider-list/; https://www.sgprc.org/service-providers/.

2.2% and 4.6%, respectively. Within Los Angeles County, the parties have a combined share of less than 3% in both North Los Angeles and San Gabriel/Pomona Regional Centers. In no area does the transaction exceed the Merger Guidelines' presumption thresholds.

Figure 12. Combined shares for ARF services, 2025

Regional Center	ResCare		Sevita		Combined share	Above MG presumption thresholds
	Count	Share	Count	Share		
Los Angeles County Centers	6	0.4%	29	1.9%	2.2%	No
North Los Angeles	2	0.6%	7	2.2%	2.9%	No
San Gabriel/Pomona	4	1.2%	1	0.3%	1.5%	No
Tri-Counties	3	2.0%	4	2.6%	4.6%	No

Source: BrightSpring and Sevita facility location data; https://www.nlacrc.org/service-providers/service-provider-list/; https://www.sgprc.org/service-providers/.

Notes: Shares for the combined Los Angeles County Regional Centers are based on data provided by the parties. Shares for North Los Angeles and San Gabriel/Pomona Regional Center are based on facility counts from the Regional Centers' websites. For these two Regional Centers, the facilities are limited to service codes 090, 113, 905, 910, and 915 to align with the service codes the parties used to collect non-party facilities in the Tri-Counties Regional Center.

For ADPs, as explained in section VI.B, the relevant geographic market is likely narrower than a Regional Center because individuals generally commute to ADPs daily and providers are unlikely to provide transportation across large areas. Accordingly, ADP shares and changes in concentration are evaluated at a narrower, county-level geography.[92]

The parties overlap in ADP services in Sacramento, San Bernardino, and San Luis Obispo Counties. Figure 13 presents Sevita and ResCare's shares of ADP facilities in these counties in 2025.

- Sacramento County. The parties operate one ADP each in the County; their combined share is less than 3%.[93] The transaction does not exceed the Merger Guidelines' presumption thresholds.

[92] In the case of Los Angeles County, a county-level market is not narrower than a Regional Center-based market. However, this issue does not affect the ADP analysis because the parties do not provide overlapping ADP services in Los Angeles County.

[93] The change in concentration is less than 10 points. This means that the acquisition is unlikely to significantly

- San Bernardino County. Sevita operates 15 ADPs and ResCare operates one ADP in the County. On a county-only basis, the parties' combined share is approximately 22%, driven primarily by Sevita's pre-transaction share of about 20%.[94] The acquisition of the single ResCare facility increases the combined share by less than 2%. The transaction would not trigger the Merger Guidelines' presumption.
- San Luis Obispo County. With Sevita's one ADP and ResCare's two ADPs, the parties together operate three of the 13 ADPs in San Luis Obispo County, for a combined share of about 23%.[95] The transaction yields an increase in concentration exceeding 200 and a post-transaction HHI that is a little over 2,000—metrics that satisfy the Merger Guidelines' presumption thresholds and raise competitive concern under a county-level screen.[96] These concerns, while not eliminated, are partially mitigated by the limited geographic proximity between the parties' facilities, as their closest facilities are about a 50-minute drive apart (see Figure 33).

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increase concentration.

Party facilities are counted based on the number of unique addresses in the County. Multiple programs and ancillary services, such as transportation, can be associated with the same address. For non-party facilities, data provided by the parties do not include address. Therefore, unique facilities were identified based on provider name and zip code.

94 Both party and non-party facilities are counted based on the number of unique addresses in the County.

95 The number of ADPs in San Luis Obispo County that serve individuals with IDD was determined by cross-checking programs listed in the Tri-Counties Regional Center's service provider directory with facilities listed on the California Community Care Licensing Division's (CCLD) website. The Tri-Counties Regional Center's directory does not contain address information and lists programs that may operate out of the same facility separately, but is limited to programs that serve individuals with IDD. The directory was filtered to County = "San Luis Obispo", Age = "Adults", and Service Category = "Day Services." https://spd.tri-counties.org. CCLD lists ADPs by physical location but is not limited to facilities that serve individuals with IDD. The list of facilities on the CCLD website was filtered to Facility Type = "Adult Day Care" and County = "San Luis Obispo." https://www.ccld.dss.ca.gov/carefacilitysearch/Search/AdultResidentialAndDaycare. The two lists were matched by name to arrive at a list of ADP facilities in San Luis Obispo County that serve individuals with IDD.

Sevita categorizes its facility in north San Luis Obispo County as an ADP in data submitted to OHCA. This facility appears to have been closed on July 6, 2023 per the CCLD website. https://www.ccld.dss.ca.gov/carefacilitysearch/FacDetail/405850132. Sevita's website seems to describe this facility as a "host home" program. https://locations.sevitahealth.com/united-states/ca/paso-robles/california-mentor/146. Nevertheless, to conform with Sevita's own categorization, this report treats this facility as a currently operating ADP.

ResCare lists two ADPs in San Luis Obispo County in data submitted to OHCA. CCLD, however, shows three ResCare facilities in the County. ResCare listed one of these facilities as an ICF in its data. To conform with ResCare's own categorization, this report treats ResCare as having two ADPs in San Luis Obispo County, not three. If ResCare in fact has three ADPs in the County, the parties' combined share would be about 29%, the HHI would be over 2,100, and the change in HHI would be over 300.

96 The increase in HHI exceeds 230. According to CCLD's facility search tool, there are 15 ADPs in San Luis Obispo County. Additional web-based research indicates that 14 of these facilities serve IDD individuals. Because ResCare categorizes one of these facilities as an ICF, the baseline share and concentration metrics use 13 facilities as the relevant denominator.

Figure 13. Combined shares for ADP services, 2025

County	ResCare		Sevita		Combined	Above MG presumption thresholds
	Count	Share	Count	Share		
Sacramento	1	1.2%	1	1.2%	2.4%	No
San Bernardino	1	1.4%	15	20.3%	21.6%	No
San Luis Obispo	2	15.4%	1	7.7%	23.1%	Yes

Source: BrightSpring and Sevita facility location data.

VII.A.2. Limited market structure changes, combined with reimbursement constraints, make significant health care costs increases unlikely

As the analysis above shows, the parties' competitive overlap is limited across the three product markets:

- ICF services. The parties do not overlap within any Regional Center service area. Even under a hypothetical statewide market definition, the transaction does not meet the Merger Guidelines' presumption thresholds.
- ARF services. The parties overlap only in the Los Angeles County and Tri-Counties Regional Center areas. Their combined shares are modest and do not trigger the presumption.
- ADP services. Competition is likely more local than a Regional Center service area. Accordingly, this report evaluates ADP competition primarily at the county-level. The parties overlap in Sacramento, San Bernardino, and San Luis Obispo Counties. Under a county-only screen, the transaction satisfies the presumption thresholds in San Luis Obispo. The concentration metrics raise concerns that are partially mitigated by the distance between the parties' facilities.

In absence of regulation and all else equal, the greater the scope for providers to negotiate reimbursement rates, the greater the potential for rates to increase when a transaction materially raises market shares and concentration. Here, because the Merger Guidelines presumption thresholds are generally not triggered across the relevant markets, the concerns about higher costs for IDD services are limited. The concerns are further reduced by Medi-Cal's payment structure, which appears to

constrain a provider's ability to raise rates in this context. As discussed in section V.C:

- ICF services. For covered services, rates are largely standardized and paid as set FFS-based per-diem rates. As of 2025, there may be limited scope for negotiation in certain circumstances (e.g., non-covered services, or in counties where services for individuals with IDD were already covered by Medi-Cal Managed Care Plans as of 2024–2025).
- ARF and ADP services. Rates appear to be largely administratively set, leaving limited scope for providers to negotiate higher reimbursement.

VII.B. The transaction is not likely to impact the competition for labor in California

Mergers can impact the labor market for the types of workers employed by the parties by reducing competition for hiring such workers. This could lead to reduced wages or employment. In this case, the transaction could impact the competition for specialized health care staff working in ICFs, as well as staff working in ARFs and ADPs.

Academic research has found that mergers that do not significantly increase concentration tend not to reduce wages, as employees retain multiple employer options.[97] Accordingly, where there are no or limited competitive concerns with respect to consumers, there are typically no or limited concerns with respect to labor impact.

In this case, as discussed above, the transaction generally does not meet the Merger Guidelines' presumption thresholds across a range of plausible relevant markets. Therefore, the transaction is unlikely to harm competition with respect to consumers and, in turn, is unlikely to substantially reduce competition for workers or lead to a reduction in their wages.

[97] Prager and Schmitt (2021) find that hospital mergers which substantially increase local employer concentration lead to negative wage effects for skilled clinical employees, such as nurses and technicians. Their results suggest that higher concentration among health care facilities is negatively correlated with wage growth for staff with industry-specific skills, reflecting reduced labor market competition. Conversely, mergers that produce only limited changes in concentration are less likely to drive substantial wage effects, since workers maintain access to employer alternatives. See Elena Prager and Matt Schmitt, "Employer consolidation and wages: evidence from hospitals," American Economic Review, Vol. 111, No. 2(2021): 397–427.

VII.C. The transaction does not appear to further a trend of consolidation in the provision of relevant services in California

The proposed transaction occurs against a backdrop of broader consolidation trends in health care, which have been well documented in academic studies and public reports.[98] Private-equity acquisitions in health care have grown over time, with 937 transactions in 2020 compared to 352 in 2010, representing $806 billion across inpatient services, outpatient services, elder and disabled care, and pharmaceutical markets.[99] Private-equity-backed entities now employ over 30% of physicians across one quarter of all metropolitan areas and half of all physicians in about 13% of metropolitan areas.[100] The increasing consolidation of health care markets has led to higher prices,[101] including in California.[102]

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98 *See, e.g.,* Fulton, B. (2017), Health Care Market Concentration Trends in the United States: Evidence and Policy Responses, *Health Affairs*, 36(9): 1530–38, https://doi.org/10.1377/hlthaff.2017.0556; AMA (2024), Competition in health insurance: A comprehensive study of U.S. markets, 2025 update, *AMA*, https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf; Levinson Z., Godwin, J., Hulver, S. and Neuman, T. (2024), Ten Things to Know About Consolidation in Health Care Provider Markets, *KFF*, https://www.kff.org/health-costs/issuebrief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/; Andreyeva, E., and Gupta, A., and Ishitani, C., Sylwestrzak, M., and Ukert, B., (2022), The Corporatization of Hospital Care, SSRN, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4134007.

99 Scheffler, R. et al. (2021), Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk, *American Antitrust Institute* and *Petris Center School of Public Health, University of California, Berkeley,* https://bph-storage.s3.us-west-1.amazonaws.com/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf, 8–9.

100 Scheffler, R. et al. (2023), Monetizing Medicine: Private Equity and Competition in Physician Practice Markets, *American Antitrust Institute, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley,* and *Washington Center for Equitable Growth*, https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf, 6.

The parties have made several acquisitions over the past ten years. (Nonpublic documents submitted to OHCA by the parties); https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf, 16 (ResCare's acquisitions).

101 *See, e.g.,* Cooper Z., Craig S., Gaynor M., and Van Reenen J. (2019), "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured", *Quarterly Journal of Economics*: 134(1):51– 107, https://doi.org/10.1093/qje/qjy020; Capps C. and Dranove D. (2004), "Hospital Consolidation and Negotiated PPO Prices", *Health Affairs*, Vol. 23, No. 2, https://doi.org/10.1377/hlthaff.23.2.175; Dafny L. (2009), "Estimation and Identification of Merger Effects: An Application to Hospital Mergers", *Journal of Law and Economics*, Vol 52, No. 3, https://doi.org/10.1086/600079; Lewis M., and Pflum K. (2017), "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions", *The RAND Journal of Economics*, Vol 48, Issue 3, https://doi.org/10.1111/1756-2171.12186; Arnold D., et al. (2024), "New Evidence on The Impacts of Cross-Market Hospital Mergers on Commercial Prices and Measures of Quality", *Health Services Research*, https://doi.org/10.1111/1475-6773.14291; Capps C., Dranove D., and Ody C. (2018), "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending", *Journal of Health Economics*, May 2018, https://doi.org/10.1016/j.jhealeco.2018.04.001.

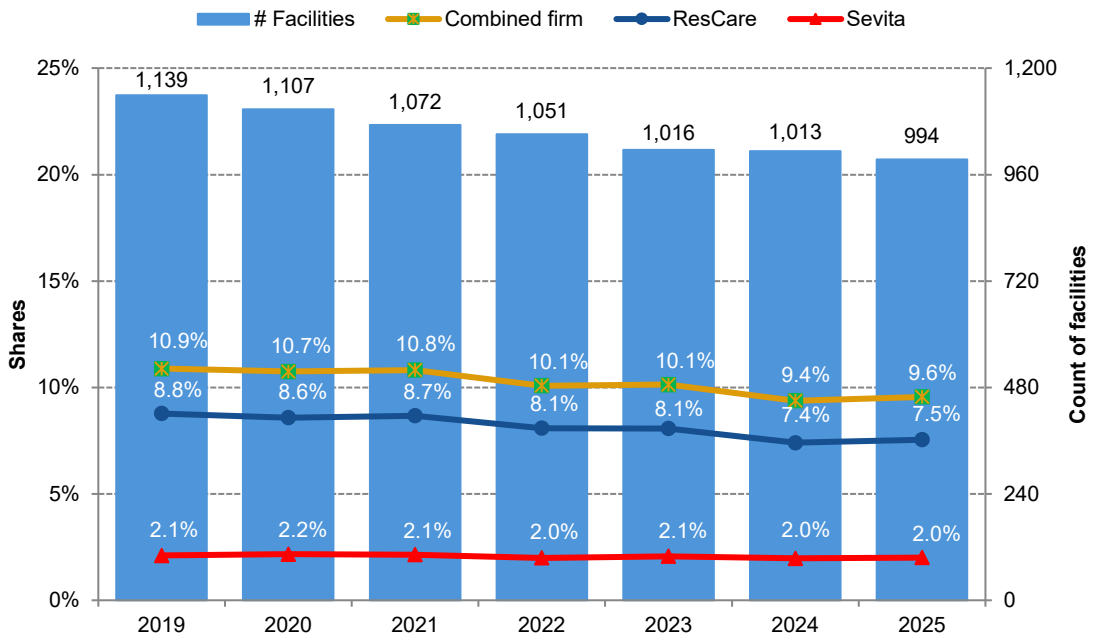
102 Scheffler R., Arnold D., and Whaley C. (2018), "Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices", *Health Affairs*, 2018, 1409–1416, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472.

Given the potential negative impacts of increasing consolidation, it is important to consider not only the impact of the current transaction, but also whether the current transaction is part of a broader trend toward consolidation in the relevant markets. This section addresses this question by measuring the parties' market shares over time in relevant markets.[103] As discussed in more detail below, the transaction does not appear to further a trend toward consolidation in the markets for ICFs, ARFs, and ADPs serving Californians with IDD.

Figure 14 shows both the number of ICFs and the parties' statewide ICF shares in California from 2019 to 2025. (Recall that the parties' ICFs do not overlap in any Regional Center; as in section VII.A, statewide shares are provided for context on the parties' size in California.) Over this period, the total number of ICFs in California declined from nearly 1,150 to about 1,000. At the same time, ResCare's share decreased from roughly 9% to 7.5% between 2019 and 2025, while Sevita's share remained relatively stable at around 2%.

[103] *See* 2023 Merger Guidelines, § 2.7 ("When an Industry Undergoes a Trend Toward Consolidation, the Agencies Consider Whether It Increases the Risk a Merger May Substantially Lessen Competition or Tend to Create a Monopoly"); § 2.8 ("When a Merger is Part of a Series of Multiple Acquisitions, the Agencies May Examine the Whole Series").

Figure 14. Total ICFs, ResCare and Sevita's shares, California, 2019–2025



Source: CalHHS – Across Time Summary Data-Licensed and Certified HealthCare Facilities; CAL HHS – Licensed and Certified Healthcare Facility Listing.

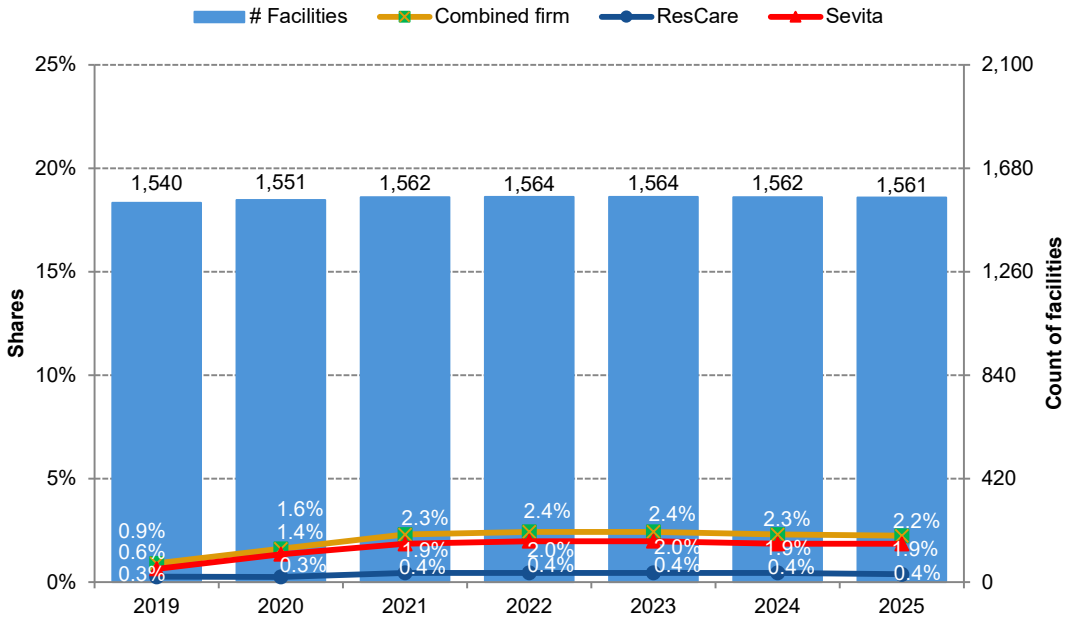
Notes: The "Across Time Summary Data-Licensed and Certified HealthCare Facilities" data contain information from 2019–2024. The "Licensed and Certified Healthcare Facility Listing" data contain 2025 data.

Figure 15 and Figure 16 show the parties' share of ARFs in the Los Angeles County Regional Centers and Tri-Counties Regional Center areas, respectively, from 2019 to 2025.[104] These are the areas where the parties' facilities overlap (see Figure 10).

- Los Angeles County Regional Centers area. From 2019 to 2025, ResCare's share remained relatively constant at less than 0.5%. Sevita's share increased from 0.6% to 1.4% between 2019 and 2020 and then remained roughly stable at around 2% from 2021 to 2025.
- Tri-Counties Regional Center area. From 2019 to 2025, ResCare's share declined from 2.6% to 2%. Sevita's share increased slightly from 2.6% to 3.2% between 2019 and 2020 but then decreased to 2.6% by 2025.

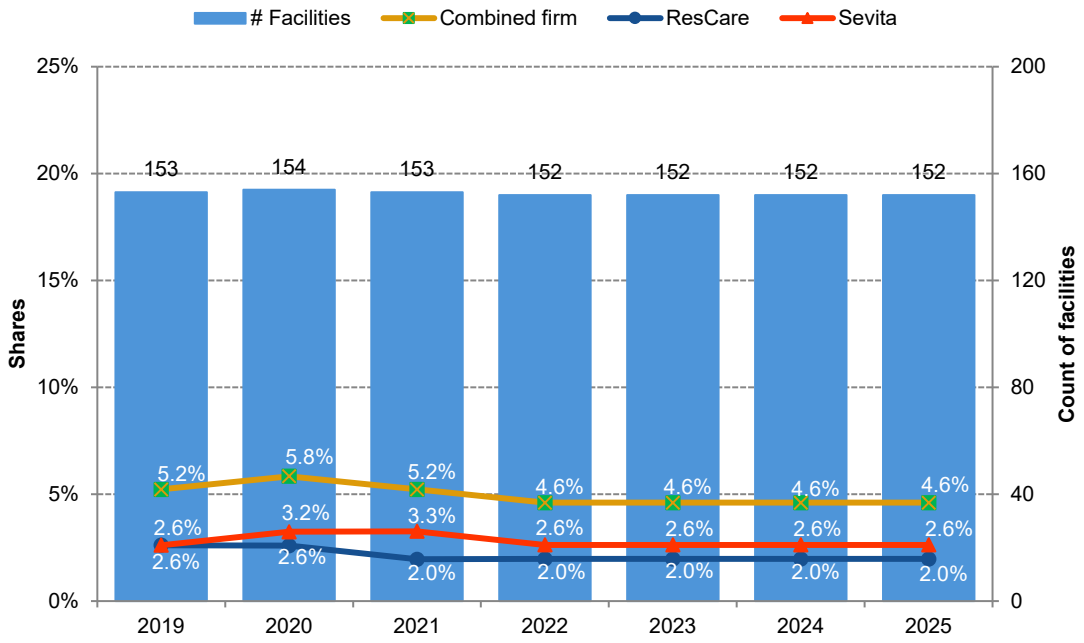
[104] Data on the number of non-party ARFs over time are unavailable. Therefore, to calculate the parties' shares over time, the number of non-party facilities is kept constant as the number of facilities as of 2025; only the number of party facilities is adjusted. For example, if there were 50 party facilities and 950 non-party facilities in 2025, the share denominator would be 1,000 (=50+950). Suppose further that there were only 25 party facilities in 2020. The share denominator in 2020 would be 975 (=25+950). Given that the parties' combined ARF shares are less than 5% in the two Regional Centers where they overlap, additional data would not change the conclusion that the transaction is unlikely to further a trend toward consolidation.

Figure 15. Total ARFs, ResCare and Sevita's shares, Los Angeles County Regional Centers, 2019–2025



Source: BrightSpring and Sevita facility location data.

Figure 16. Total ARFs, ResCare and Sevita's shares, Tri-Counties Regional Center, 2019–2025

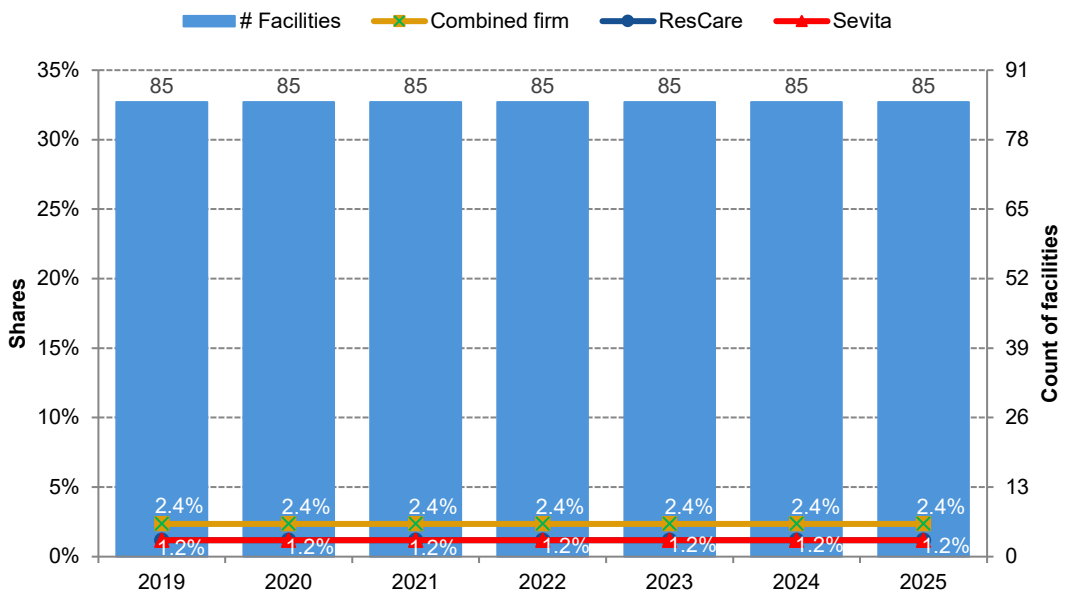


Source: BrightSpring and Sevita facility location data.

Figure 17, Figure 18, and Figure 19 show the parties' ADP shares by year from 2019 through 2025, for counties in which the parties overlap.

- Sacramento County. Throughout this period, both ResCare's and Sevita's share of county facilities remained stable at around 1%.
- San Bernardino County. From 2019 to 2025, ResCare's share of county facilities remained steady at under 2%, while Sevita's share remained stable at approximately 20% from 2021 to 2025.
- San Luis Obispo County. Over this period, the total number of facilities in the county and the number operated by the parties did not change in a meaningful way. ResCare's shares remained stable at about 15%. Sevita began operating ADPs in 2020, at which point its share was about 14%, which dropped to about 8% in 2023 after closure of one facility.[105]

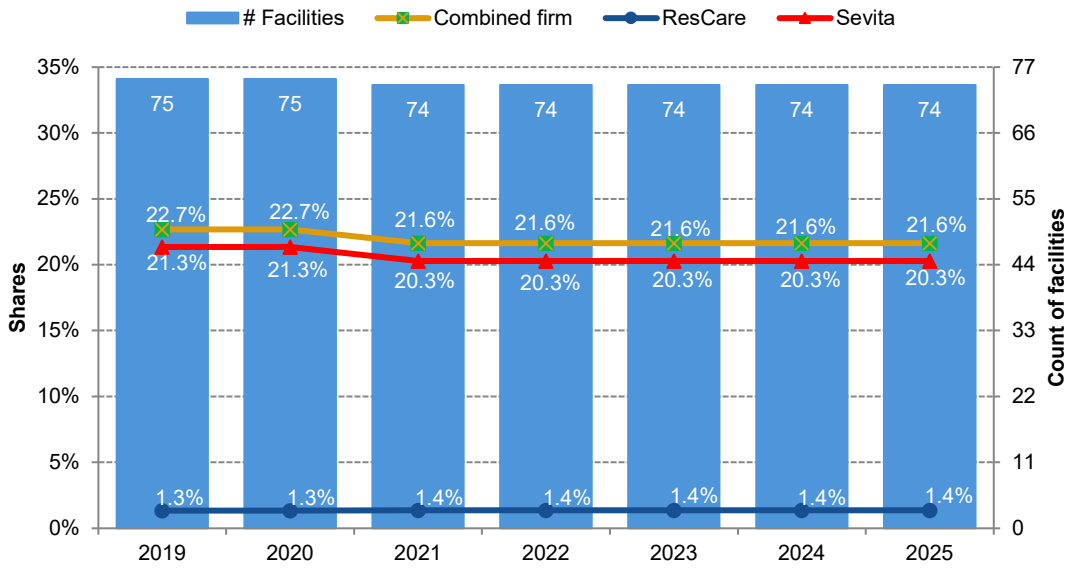
Figure 17. Total ADP facilities, ResCare and Sevita's shares, Sacramento County, 2019–2025



Source: BrightSpring and Sevita facility location data

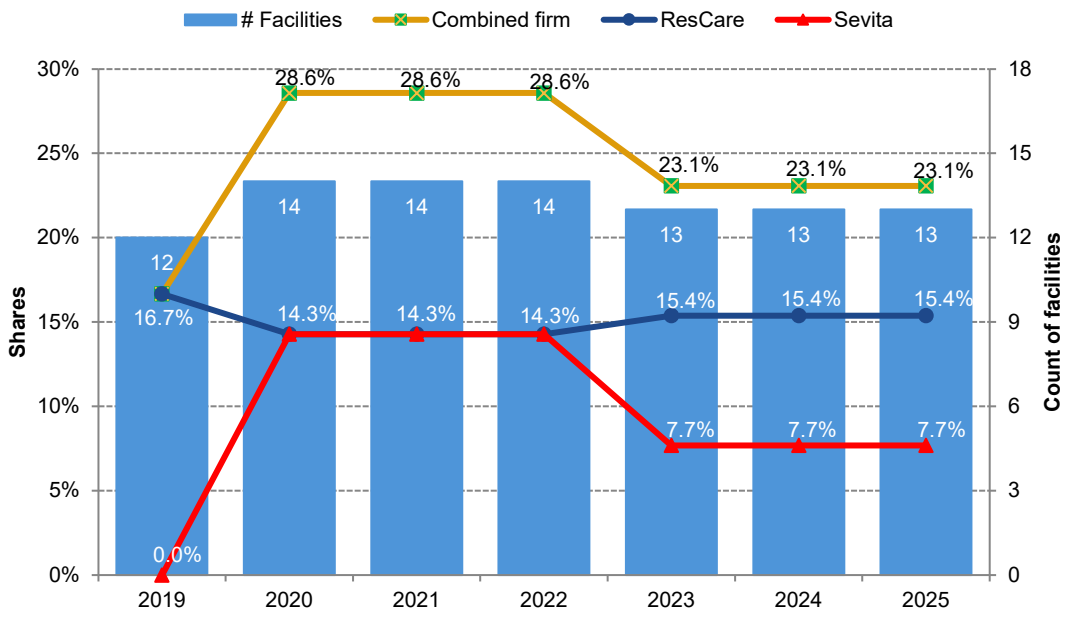
[105] As in the case of ARFs, data on the number of non-party ADPs over time are unavailable. Accordingly, the same approach is used to define the ADP share denominator (i.e., the number of non-party ADPs is assumed to be the same in prior years as the number of ADPs in 2025). Because neither Sevita nor ResCare has acquired any ADPs in California since at least 2020, additional information on non-party facilities would not change the conclusion that the transaction is unlikely to further a trend toward consolidation (additionally, the combined share in Sacramento County in 2025 remains small at less than 3%).

Figure 18. Total ADP facilities, ResCare and Sevita's shares, San Bernardino County, 2019–2025



Source: BrightSpring and Sevita facility location data.

Figure 19. Total ADP facilities, ResCare and Sevita's shares, San Luis Obispo County, 2019–2025



Source: BrightSpring and Sevita facility location data; https://spd.tri-counties.org/.

VII.D. The transaction is likely to increase the risk of reduced quality and access to IDD services

VII.D.1. Sevita's quality track record is inconsistent across internal and public sources

Given the conclusion that the transaction is not likely to significantly affect competition, the quality of health care provided to Californians with IDD should not be significantly affected by changes in competitive conditions for provision of IDD services. However, the change in ownership of ResCare facilities from BrightSpring to Sevita (and its private-equity owners) may pose quality-related risks. Specifically, despite Sevita's claims and internal quality metrics, publicly available information reflects a concerning nationwide history of quality issues. This public record is also consistent with evidence of lower quality at certain California facilities, as reflected in data collected by CDPH.

The next subsection summarizes evidence from Sevita's internal data, including client satisfaction surveys and quality metrics. It is followed by a subsection that summarizes publicly available indicators of Sevita's service quality.

VII.D.1.a. Sevita's statements and internal metrics indicate positive quality performance

Sevita describes itself as having a strong track record of improving services and outcomes for individuals with IDD. The parties' filings claim that the transaction will create an opportunity to improve service delivery by leveraging best practices of both Sevita and ResCare.[106] Sevita further points to its recent acquisitions of distressed facilities as evidence supporting these claims.[107]

As part of its submissions to OHCA, Sevita provided results from internal client satisfaction surveys. These surveys include questions that can be benchmarked to similar questions on National Core Indicators (NCI) surveys.[108] NCI is a national non-profit organization that partners with state health organizations to survey individuals with IDD.[109] According to NCI, "[s]urvey responses help California evaluate how it is doing compared to other states" and "help Regional Centers see

[106] *See* https://hcai.ca.gov/wp-content/uploads/2025/06/MCN-Notice-for-Res-Care_Website-Posting.pdf,12.

[107] Nonpublic documents submitted to OHCA by the parties.

[108] https://www.dds.ca.gov/wp-content/uploads/2025/06/2022-23_IPS-CA-StatewideReport_v4.pdf.

[109] https://nationalcoreindicators.org/.

what they are doing well and what they can improve."[110] NCI results are also used in federal Medicaid quality measurement.[111] These results provide a useful benchmark against which Sevita's internal performance can be evaluated.

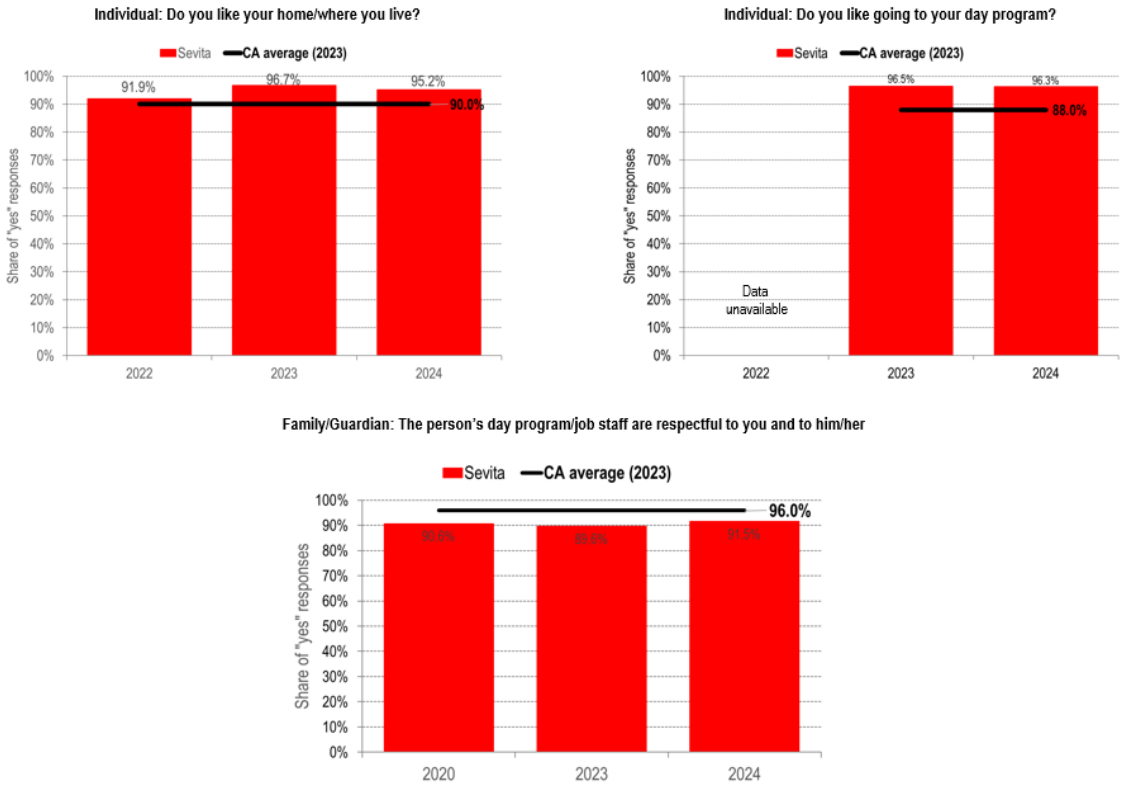
Three useful measures for assessing overall quality relate to (i) individual satisfaction with residential services, (ii) individual satisfaction with day programs, and (iii) family/guardian experience with day programs. Figure 20 presents Sevita's internally reported performance on these measures and compares it with California averages from NCI data. The first two measures are based on the percentage of "yes" responses to the questions "Do you like your home/where you live?" and "Do you like going to your day program?" Sevita performs higher on both measures relative to NCI's 2023 California average. However, on the family/guardian measure—captured by the percentage of "yes" responses to the statement, "The person's day program/job staff are respectful to you and to him/her", Sevita's performance over 2022–2024 is consistently below NCI's 2023 California average.[112]

[110] https://www.dds.ca.gov/rc/nci/.

[111] https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measure-set-summaries.pdf?t=1768415314; https://www.dds.ca.gov/rc/nci/.

[112] There are around 15 other questions on Sevita's customer satisfaction surveys that can be matched to a corresponding NCI benchmark. These matched questions capture information regarding the individual's quality of care and autonomy (***e.g.***, "Do you get to do what you want in your free time?" and "Do you have an opportunity to learn new things at your day program?"). For most of the years with available survey results, Sevita performs above the benchmark across these metrics.

Figure 20. Sevita's performance on internal customer satisfaction surveys against the CA average benchmark



Source: Sevita's internal survey responses; https://www.dds.ca.gov/wp-content/uploads/2025/06/2022-23_IPS-CA-StatewideReport_v4.pdf.

Notes: The 2023 CA average was obtained from 2023 NCI survey for California. The top left chart is from Sevita's adult residential survey and includes individuals in ICFs/IDD and ARFs. The top right chart is from Sevita's adult day survey and includes individuals in ADPs. The bottom chart is from Sevita's family/guardian day survey, and surveys family or guardians of individuals in ADPs.

In addition to client satisfaction surveys, Sevita tracks internal performance metrics across its IDD services, many of which indicate positive quality performance.[113] For several metrics, Sevita compares results to benchmarks, which appear to be self-established. Recent performance on "program participation" (assessing whether individuals participated in their service planning), "chronic condition management" (assessing whether individuals discussed chronic condition management with their doctor), "physical requirement" (tracking whether individuals in a residential service for at least 14 months have a current physical), "medication errors" (tracking medication errors per thousand patient days, such as wrong doses or wrong patient treated), and "flu vaccination" (tracking whether individuals received a flu shot) exceeds these internal benchmarks (see Appendix Figure 42 through Figure 46). In

[113] Nonpublic documents submitted to OHCA by the parties.

particular, reported rates of physicals and flu vaccinations have improved substantially in recent years.

Not all internal metrics show improvement. On inspection compliance (tracking whether the facilities are complying with the questions in the unannounced visit evaluation) and timely incident reporting (tracking whether the deadline to enter and finalize an incident was met)—neither of which have a corresponding internal benchmark—Sevita's performance has declined somewhat in the recent years (see Appendix Figure 47 and Figure 48).[114]

Sevita also highlights investments in quality following acquisitions of struggling facilities between 2019 and 2022. Sevita filings state that it invested in facility infrastructure and increased staffing and compensation, leading to improved regulatory compliance and higher customer satisfaction.[115]

Among the five facilities Sevita highlighted to demonstrate improved quality, Homestead Residential was acquired in 2022 at the request of the State of Ohio.[116] Sevita reports that, prior to the acquisition, Homestead Residential's homes faced compliance and health and safety issues. Sevita states that, after the acquisition, the homes now have "a well-developed nutrition plan, stable medication administration, an improved nursing staff and complete active treatment program," along with additional amenities to support independent living.[117] Sevita reports similar improvements at the other four facilities (New Horizons in Iowa, Pensacola Care in Florida, ResCare in West Virginia, and DDMS of Louisiana).[118]

VII.D.1.b. Public data are inconsistent with Sevita's quality claims

In contrast to Sevita's internal metrics and statements, public data indicate that several Sevita residential facilities and day programs have faced quality issues over the past decade. These quality issues have often been covered in the public press.

[114] Sevita notes in its submissions that it formalized the protocols and policy for unannounced visits in March 2024. Therefore, results in 2024 may not be comparable to results from 2022 and 2023.

[115] Nonpublic documents submitted to OHCA by the parties.

[116] Submissions provided by the parties noted that "Sevita acquired Homestead Residential at the State's request, providing adequate necessities and implementing its quality initiatives into the homes and overall services." Nonpublic documents submitted to OHCA by the parties.

[117] Nonpublic documents submitted to OHCA by the parties.

[118] The years of the acquisitions are as follows: Living Center East – New Horizons (2019), Pensacola Care, Inc. (2020), ResCare, Inc. (2021; i.e., the ResCare that is the subject of the present transaction), DDMS of Louisiana No. 2, LLC (2022), and Homestead Residential (2022). Sevita also states that, at the request of the California Department of Development Services, it stepped in to acquire Anka Behavioral Health (an addiction treatment center) in 2019, after Anka filed for bankruptcy. Sevita did not expand further on its improvements to Anka Behavioral Health. Nonpublic documents submitted to OHCA by the parties.

Separately, public CDPH data on California ICFs/IDD also show quality concerns at Sevita-run facilities.

Figure 21 summarizes reported quality issues at Sevita's residential facilities and day programs by state and facility, along with regulatory actions and outcomes. Negative press coverage in the early 2010s contributed to U.S. Senate investigations into Sevita's operations in Iowa and Oregon in 2020.[119] Both reports describe a history of serious quality issues, including abuse and neglect of clients, inadequate staff training, inaccurate or untimely incident reports, medication administration errors, and poor facility conditions. These investigations resulted in increased scrutiny and regulatory penalties, including at least one facility closure in Oregon.[120] More recently, following public reporting on severe quality concerns, another Sevita facility in California, Illinois Home, ceased operations in June 2023.[121] Reported issues also span Sevita facilities located in Florida, Indiana, Massachusetts, Texas, and Utah.

[119] https://www.finance.senate.gov/imo/media/doc/120220%20Life%20at%20Cypress%20House%20-%20An%20Examination%20of%20Care%20Provided%20by%20MENTOR%20Oregon.pdf; https://www.finance.senate.gov/imo/media/doc/2020-12-03%20Investigative%20Report%20(REM%20Iowa).pdf.

[120] https://www.oregonlive.com/watchdog/2020/12/oregon-developmental-disabilities-company-repeatedly-failed-vulnerable-oregonians-us-senate-investigation-finds.html.

[121] Illinois Home was an Enhanced Behavioral Supports Home (EBSH). EBSHs provide 24-hour care to people with IDD, and the first one in CA started operating in 2017. Before 2023, Sevita operated at least 20 EBSHs throughout California. According to the Private Equity Stakeholder report, "following pressure from state regulators, Sevita voluntarily gave up operating the Illinois Home in June 2023 and, according to state regulators, Sevita no longer operated any EBSHs as of July 2023." https://pestakeholder.org/wp-content/uploads/2025/03/PESP_Report_IDD_2025.pdf; https://www.kqed.org/news/11969597/whistleblowers-call-out-california-group-home-for-abuse-against-disabled-residents.

Figure 21. Public reporting on Sevita's quality issues span more than a decade

State	Facility/program	Year	Quality issues	Outcome
CA	Illinois Home	2023	Abuse and neglect of residents, mismanagement of medical needs, understaffing	Sevita ceased operation of facility
FL	Pensacola Cluster	2019	Abuse and neglect of residents, failure to provide training	FL investigation, civil lawsuits
	NeuroRestorative	2024	Abuse and neglect of residents, failure to provide training, inadequately maintained facilities, understaffing	FL threatened closure, Sevita settled
	Florida Mentor	2024	Abuse and neglect of residents, failure to screen staff	FL fined Sevita
	Greenridge	2024	Abuse and neglect of residents	FL fined Sevita
IA	REM Iowa - Urbandale	2014	Abuse and neglect of residents, mismanagement of medical needs	Sevita closed facility
	REM Iowa - Coralville	2015	Abuse and neglect of residents	Worker arrested
	REM Iowa - Glenwood	2016	Failure to screen staff	-
	REM Iowa	2018	Abuse and neglect of residents	Worker arrested
	REM Iowa - Davenport	2019	Abuse and neglect of residents	Worker arrested
	REM Iowa, REM Iowa Community Services	2020	Abuse and neglect of residents, failure to provide training, failure to report incidents, mismanagement of medical needs	Senate investigation, recommendations issued
	NeuroRestorative	2022	Abuse and neglect of residents, failure to provide training	IA fined Sevita
	REM Iowa	2025	Abuse and neglect of residents	IA fined Sevita
IN	REM	2023	Abuse and neglect of residents, failure to provide training, failure to report incidents	CMS and IN investigation
MA	NeuroRestorative	2022	Abuse and neglect of residents, failure to provide training, mismanagement of medical needs	MA deferred licensure
OR	Mentor Oregon	2019	Abuse and neglect of residents, mismanagement of medical needs	Senate investigation, OR closed facility
	Alameda Home, Cypress Home	2020	Abuse and neglect of residents, failure to provide training, failure to report incidents, mismanagement of medical needs, inadequately maintained facilities	Senate investigation, Sevita settled with state
TX	D&S Community Services	2024	Abuse and neglect of residents	Private lawsuit
UT	NeuroRestorative	2025	Abuse and neglect of residents	CMS fined Sevita

Source: See Appendix A.

Sevita's assertions regarding its high quality are also inconsistent with public data on the average quality of its ICFs.[122] These data include substantiated complaints, deficiencies, and citations issued by the California Department of Public Health (CDPH) to California ICFs/IDD. Compared with its acquisition target in this transaction, ResCare, and with other relevant California facilities, Sevita performs worse on all three measures.

In California, facility representatives and citizens can submit incident reports and complaints concerning ICFs/IDD to CDPH.[123] Examples of incident reports and complaints include alleged abuse of clients, inadequate facility maintenance, and improper medical care. Depending on the allegation, the agency investigates whether there is sufficient evidence to support the claim.[124] If CDPH finds sufficient evidence, it "substantiates" the complaint. If the substantiated complaint reflects violations of federal and/or state regulations, CDPH issues deficiency notices for each violated regulation. Depending on the facility type, scope, and severity of the deficiency, CDPH may issue citations, which are enforcement actions or administrative penalties.[125] Citations may include moratoria on new admissions, facility closures, and monetary fines.

CDPH summarizes California ICF/IDD complaint and incidents information in its Cal Health Find Database.[126] These data allow comparisons between Sevita facilities and other comparable facilities in California, including ResCare.[127] In 2024, Sevita had more substantiated complaints, deficiencies, and citations than ResCare and other ICFs/IDD in California (see Figure 22). Per 100 beds, Sevita averaged 66 complaints, 257 reported deficiencies, and 6 citations, with an average citation amount of $27,500. Relative to ResCare, Sevita averaged 22 more complaints, 61 more reported deficiencies, and 5 more citations per 100 beds. Relative to other comparably sized ICFs/IDD, Sevita averaged 41 more complaints, 103 more reported deficiencies, and 5 more citations per 100 beds. Sevita's average citation amount due per 100 beds ($27,500) was more than eight times the average citation

[122] Sevita described itself as "clearly a quality leader among providers." Nonpublic documents submitted to OHCA by the parties.

[123] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/ConsumerGuide.aspx#ERI_Complaint.

[124] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/pages/complaintinvestigationprocess.aspx.

[125] https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/pages/complaintinvestigationprocess.aspx.

[126] https://www.cdph.ca.gov/programs/chcq/lcp/calhealthfind/Pages/Home.aspx.

[127] The comparable facilities are identified as those with 12 beds or fewer. This limits the set of facilities to those closer in size to an average Sevita ICF/IDD.

amount for other comparably sized ICFs/IDD in California. Higher citation amounts are consistent with more serious or more severe compliance failures.[128]

Figure 22. CDPH 2024 data show that Sevita has more incidents per 100 ICF/IDD beds than comparables

Entity	Average #beds per facility	Substantiated complaints	Deficiencies	Citations	Citations: amount due
		Per 100 ICF/IDD beds			
Sevita	6	66	257	6	$27,500
ResCare	6	44	196	1	$1,678
Other facilities	6	25	154	1	$3,104

Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The row "Other facilities" presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

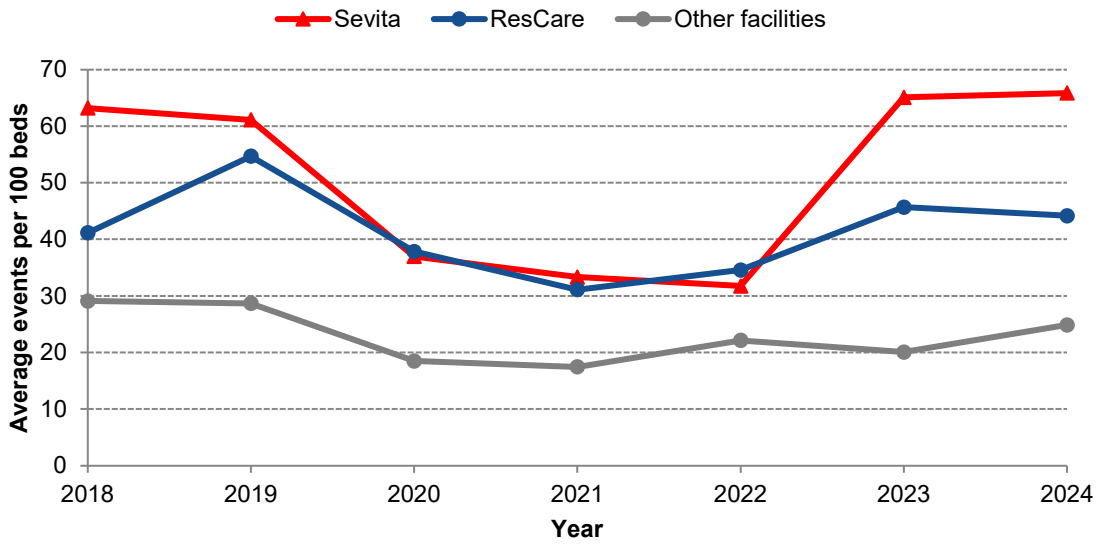
Figure 23 through Figure 26 examine trends over a longer period, 2018–2024, covering both pre-pandemic and post-pandemic years.

- Substantiated complaints. In the pre-pandemic period, Sevita generally had higher rates of substantiated complaints than other ICFs/IDD (see Figure 23). From 2022 to 2023, Sevita's complaint rate increased sharply—from around 30 to nearly 65 reports/complaints per 100 beds—while ResCare and other ICFs/IDD experienced smaller increases or remained relatively stable.
- Deficiencies. Excluding the pandemic years of 2020 and 2021, Sevita reported a higher average number of deficiencies than ResCare and other ICFs/IDD (see Figure 24).
- Citations. Although Sevita typically reported more substantiated complaints and deficiencies than other ICFs/IDD, it had no citations from 2019 through 2022. Except for 2019 (when ResCare experienced an increase in citations), citation rates at Sevita and ResCare were otherwise largely similar. In 2024, however, citations against Sevita increased substantially both in count and in amounts due (see Figure 25 and Figure 26). Because financial penalties depend on the scope

[128] California Code, Health and Safety Code - HSC § 1424, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1424.

and severity of the deficiencies, the disproportionately high average fines may indicate more serious compliance failures.[129]

Figure 23. Sevita has higher numbers of substantiated complaints per 100 ICF/IDD beds in California for majority of years from 2018–2024

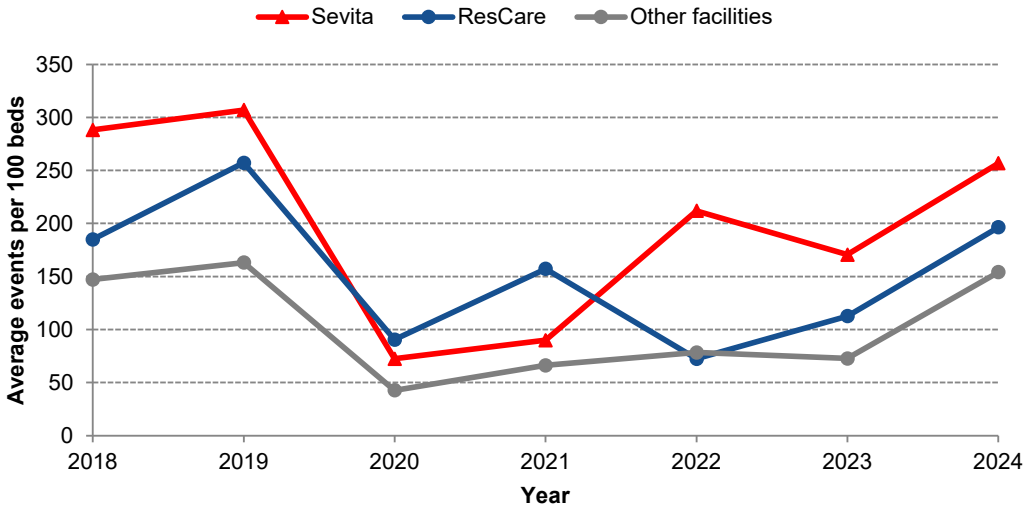


Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line "Other facilities" presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

[129] California Code, Health and Safety Code - HSC § 1424, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1424.

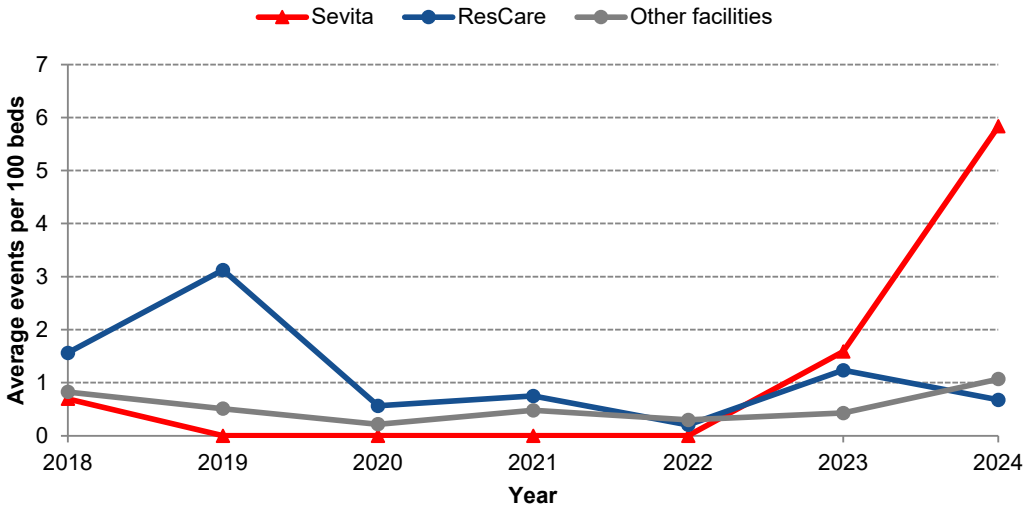
Figure 24. Sevita has higher numbers of deficiencies per 100 ICF/IDD beds in California for most years from 2018–2024



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line “Other facilities” presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

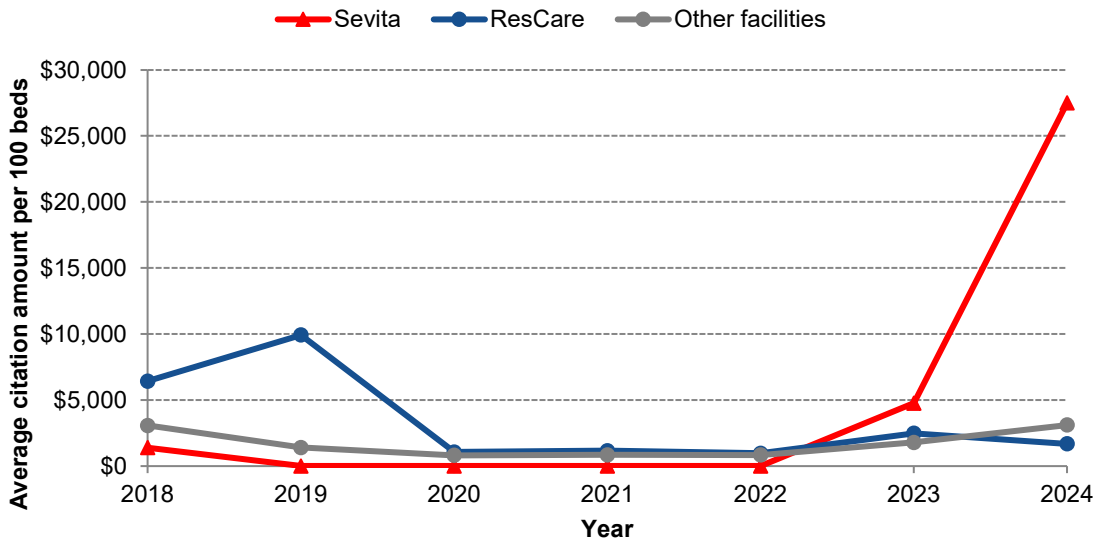
Figure 25. Sevita’s citations per 100 ICF/IDD beds in California increased dramatically in 2023 and 2024 while comparators remain stable



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line “Other facilities” presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

Figure 26. Sevita's citation amount due per 100 ICF/IDD beds in California increased dramatically in 2023 and 2024 while comparators remain stable



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line "Other facilities" presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

VII.D.2. Sevita's financial practices may pose a risk of reduced investment in quality and facility closures

Sevita's private-equity owners have historically relied on aggressive financial strategies, including taking on new debt to pay themselves dividends.[130] This practice, called dividend recapitalization, is riskier than a typical dividend payment because it is not funded out of a company's earnings—it is paid by borrowing money.[131] Taking on extra debt to pay dividends weakens the balance sheet because it increases what a firm owes (i.e., increases leverage) and reduces its financial cushion. The dividend recapitalization benefits the private-equity owners of the firm but can limit the company's flexibility if economic conditions worsen. Moody's, a major U.S. credit rating agency that grades the creditworthiness of companies, governments, and bonds, notes that it "views debt-financed dividends as 'particularly aggressive' when they are paid within about a year after a leveraged

[130] This section analyzes Sevita's financial performance at the national level and does not assign specific revenues, costs, or debt to California operations. In the absence of contrary evidence, national-level financial decisions are reasonably expected to affect investment in service quality and operational practices at the local facility level.

[131] https://corporatefinanceinstitute.com/resources/management/dividend-recapitalization/.

buyout, or they exceed 75 percent of a private equity firm's initial equity investment in the deal."[132]

In March 2019, private equity firms Centerbridge and Vistria acquired Sevita through a leveraged buyout (LBO).[133] In an LBO, the acquisition is financed largely with bank loans and other debt.[134] Within six months of the acquisition, Sevita paid its owners a $100 million dividend, financed through a new term loan, a decision Moody's described as "rather aggressive."[135]

Over the next two years, Sevita paid an additional $387 million in dividends primarily funded by debt, bringing total dividends to $487 million and exceeding the owners' initial equity investment of $430 million.[136] Approximately $87 million of the payout was funded through an August 2020 sale-lease back transaction, and the remaining $300 million payout in March 2021 was funded by additional debt.[137] Moody's characterized the "aggressive nature" of the company's financial policies as "a key governance issue" and further noted that "the aggressive private equity policies pose social risks, given the high value society and state governments place on providing quality care for these individuals and the company's dependence on Medicaid reimbursement."[138]

In total, Sevita's dividend payments to its private-equity owners equaled approximately 113% of owners' initial $430 million equity investment. This payout,

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[132] https://www.institutionalinvestor.com/article/2bsxi2no82x949jl4sxds/portfolio/the-most-aggressive-buyout-firms-taking-debt-financed-dividends.

[133] https://www.sec.gov/Archives/edgar/data/1608638/000119312519069320/d713806d8k.htm; https://www.reuters.com/article/world/americas/civitas-to-sell-itself-to-centerbridge-partners-for-641-million-idUSKBN1OH2KE/. *See also* https://www.sec.gov/Archives/edgar/data/1608638/000119312519039441/d689911ddefm14a.htm, 36; https://ratings.moodys.com/ratings-news/281101.

[134] Charles-Henri Larreur, Structured Finance (Hoboken, NJ: Wiley, 2021), 15. *See also* https://corporatefinanceinstitute.com/resources/valuation/leveraged-buyout-lbo/.

[135] https://ratings.moodys.com/ratings-news/306916 ("National Mentor issued an incremental $100 million first lien term loan to fund a $100 million dividend to the private equity sponsor, Centerbridge Partners LP only about 6 months after the completion of the LBO.").

[136] https://www.sec.gov/Archives/edgar/data/1608638/000119312519039441/d689911ddefm14a.htm, 66; https://ratings.moodys.com/ratings-news/333597. Moody's noted that "Proceeds from the new debt will be used to repay its existing term loans in full and fund a $375 million distribution to shareholders."; Nonpublic financial disclosures provided to OHCA by Sevita.

[137] Nonpublic financial disclosures provided to OHCA by Sevita. See also https://ratings.moodys.com/ratings-news/333597. Moody's noted that "Proceeds from the new debt will be used to repay its existing term loans in full and fund a $375 million distribution to shareholders."; https://www.sec.gov/Archives/edgar/data/1608638/000119312519039441/d689911ddefm14a.htm, 66.

[138] https://ratings.moodys.com/ratings-news/333597. Moody's also noted that "The current reimbursement outlook is positive, with increases expected in several states. Since the LBO, notwithstanding shareholder dividends, the company has generally executed its strategy well and has demonstrated an ability to deleverage through earnings growth."

relative to invested equity, appears higher than in a comparable transaction involving the same owners in the home care services industry. In October 2020, Centerbridge and Vistria acquired Help at Home (HAH) in a $1.4 billion transaction financed with $685 million in equity and the remainder in debt.[139] In 2024, HAH issued $1.5 billion in debt to refinance existing debt and pay a $262.6 million dividend—approximately 38% of the owners' initial equity investment.[140]

Consistent with these dividend recapitalizations, Sevita's debt nearly tripled by 2022 from its pre-acquisition level. As of 2018, Sevita's total debt was about $706 million.[141] Following the 2019 LBO and 2021 dividend payouts, Sevita's debt increased to over $2 billion in 2022 and has remained above that level based on the most recent public disclosures from 2024.[142]

A common way to assess financial risk is to compare debt to earnings (the net debt to EBITDA ratio).[143] Providers that rely heavily on Medicaid payments, like Sevita, often face heightened credit risk because Medicaid reimbursement rates tend to be relatively low compared to other payers and are subject to state budget constraints, which can impact revenues and cash flows.[144] Prior to the full set of dividend payouts, Sevita's leverage ratio (or debt-to-earnings ratio) was around 4.7x–4.9x, meaning debt was about five times the earnings. After the payouts, net leverage

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139 https://www.prnewswire.com/news-releases/help-at-home-acquired-by-centerbridge-partners-and-the-vistria-group-from-wellspring-301163971.html; https://www.pehub.com/centerbridge-vistria-team-up-in-1-4bn-deal-for-wellsprings-help-at-home/; https://www.moodys.com/research/Moodys-assigns-a-B2-CFR-to-Help-at-Home-stable-Rating-Action--PR_433679.

140 https://www.moodys.com/research/Moodys-Ratings-affirms-HAH-Group-Holdings-B2-CFR-assigns-B2-Rating-Action--PR_492715 ("Proceeds from the new $900 million term loan and $600 million secured notes will be used to fully repay HAH's existing $1.04 billion first lien term loans and $165 million second lien term loan, fund a $262.6 million dividend to existing shareholders, and pay related fees and expenses."). *See also* https://www.spglobal.com/ratings/en/regulatory/article/-/view/type/HTML/id/3247866.

141 This includes current and long-term portions of debt of $694.2 million and capital leases of $11.4 million. https://www.sec.gov/Archives/edgar/data/1608638/000160863819000006/civi12311810q.htm, 3 and 12.

142 https://www.sec.gov/Archives/edgar/data/1914496/000114036124045424/ny20037894x1_ex99-1.htm; https://www.sec.gov/Archives/edgar/data/1914496/000191449625000017/nationalmentorfy24audite.htm.

143 https://www.jpmorgan.com/insights/banking/commercial-loans-and-lines-of-credit/debt-to-ebitda-calculating-business-borrowing-capacity.

144 https://ratings.moodys.com/ratings-news/392841 ("Sevita's Caa1 CFR reflects the company's high business risk given its reliance on government payors, specifically Medicaid, and its exposure to state budgets, which may come under pressure during weak economic periods. Rapidly rising labor costs due to a tight labor market, moderately high geographic concentration, and a very aggressive expansion strategy that includes both new facility openings and acquisitions also constrain the company's rating. Moody's expects financial leverage to remain above 8 times over the next 12 to 18 months due to expenses, particularly related to labor, remaining elevated. Further, a weak liquidity position, highlighted by no cash on the balance sheet, negative free cash flow, and a utilization of the revolver, which leaves limited cushion to absorb additional operating setbacks."); https://www.spglobal.com/ratings/en/regulatory/article/-/view/type/HTML/id/3320219 ("The company will continue to be highly susceptible to government reimbursement risk, with Sevita generating approximately 85%-90% of its revenues from Medicaid. Medicaid typically reimburses at a lower rate than other payors, and rate increases can be delayed due to state budgetary restraints.").

increased to 8.7x, meaning net debt rose to nearly nine times earnings. Although leverage declined by 2025, it remained above pre-LBO levels (see Figure 27). As one point of contrast within the broader health care sector, median leverage observed for nonprofit hospital and health care systems ranged from 2.8x–4.2x during 2019–2022.[145]

Figure 27. Summary of net debt to EBITDA ratio (adjusted) ($ in million)

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Net debt / EBITDA (adjusted)	4.7x	4.9x	8.7x	7.1x	7.1x	6.6x	5.7x

Source: Nonpublic financial disclosures provided to OHCA by Sevita.

Notes: Sevita's fiscal year ends on September 30.

For the proposed ResCare transaction, after the transaction closes, the combined firm's expected leverage ratio is reported to be 5.9x, a modest improvement over Sevita's reported standalone leverage of 6.3x as of March 2025.[146] Moody's expects the transaction to leave the leverage largely unchanged, while potentially reducing interest costs. Moody's also states that Sevita's current speculative B3 corporate family rating (CFR) rating is constrained by "high regulatory exposure and reimbursement risk given its heavy reliance on Medicaid and state budgets … [e]levated labor costs and a historically aggressive expansion strategy."[147]

S&P, another major U.S. credit agency, noted that the transaction will modestly increase Sevita's leverage and the "company will continue to be highly susceptible to government reimbursement risk, with Sevita generating approximately 85%-90% of its revenues from Medicaid."[148] S&P has a current speculative grade credit rating of B- for Sevita and states that "we expect Sevita will remain highly leveraged over the next several years given its ownership by a financial sponsor."[149] While the expected

[145] https://www.fitchratings.com/research/us-public-finance/2023-median-ratios-not-for-profit-hospitals-healthcare-systems-25-07-2023.

[146] Nonpublic financial disclosures provided to OHCA by the parties.

[147] https://ratings.moodys.com/ratings-news/457429. ("Obligations rated B are considered speculative and are subject to high credit risk."). *See also* https://www.moodys.com/research/doc--PBC_79004. ("Moody's Corporate Family Ratings (CFRs) are long-term ratings that reflect the relative likelihood of a default on a corporate family's debt and debt-like obligations and the expected financial loss suffered in the event of default.").

[148] https://www.spglobal.com/ratings/en/regulatory/article/-/view/type/HTML/id/3320219.

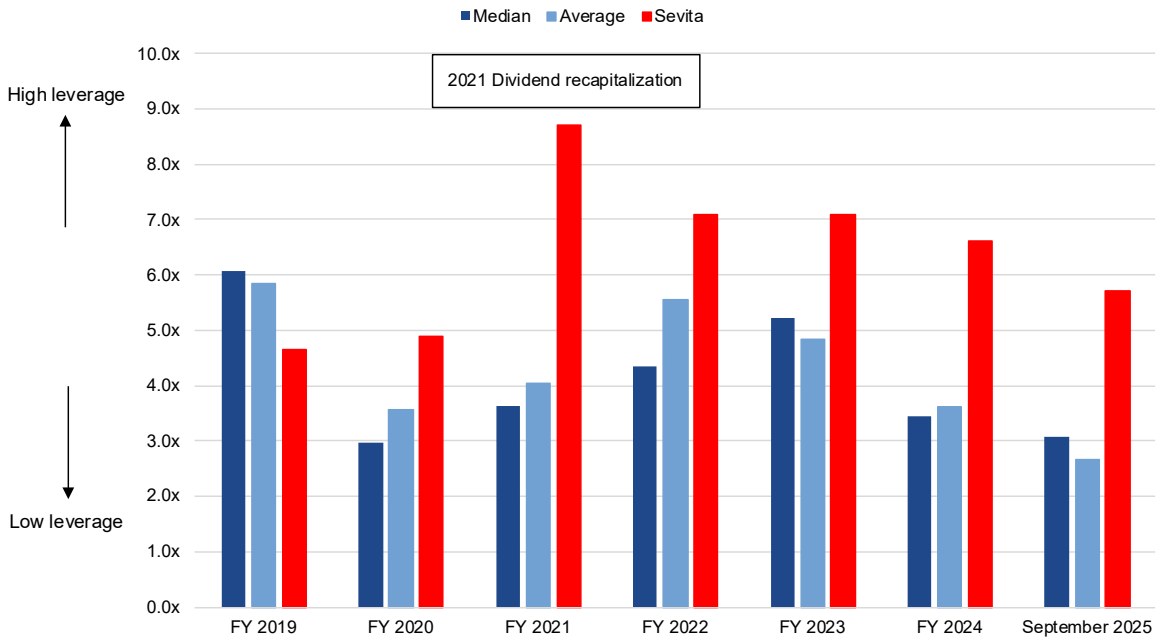
[149] https://www.spglobal.com/ratings/en/regulatory/article/-/view/type/HTML/id/3320219. *See also* https://www.spglobal.com/ratings/en/credit-ratings/about/understanding-credit-ratings. (B rating represents

leverage is below Sevita's peak leverage in recent years, it remains above Sevita's leverage as a public company (approximately 3.8x–4.4x between September 2014 and September 2018).[150] The post-transaction leverage ratio is also higher than the median leverage ratio of peer firms during 2020–2024, indicating higher relative credit risk (see Figure 28).

"[m]ore vulnerable to adverse business, financial and economic conditions but currently has the capacity to meet financial commitments.").

150 https://web.archive.org/web/20181220223934/https://civitas-solutions.com/assets/sites/5/2018/12/Q418-Investor-Presentation.pdf. Leverage ratio is calculated as net debt / LTM adjusted EBITDA.

Figure 28. Leverage ratio comparison between Sevita and peer firms, 2019–2025



Source: Nonpublic financial disclosures provided to OHCA by Sevita; S&P Capital IQ.[151]

Notes: Leverage ratio is net debt divided by adjusted EBITDA. A lower leverage ratio is better as it reflects lower debt levels compared to profits (i.e., EBITDA). The fiscal year reporting period for Sevita is September 30th. For Enhabit, Inc., Amedisys, Inc., Addus HomeCare Corporation, BrightSpring Health Services, Inc., and The Pennant Group, the fiscal year reporting period is December 31st. Aveanna Healthcare Holdings Inc. reports with a 52-week fiscal year, typically ending the last few days of December.

Peer firms Addus HomeCare Corporation, Aveanna Healthcare Holdings Inc., and BrightSpring Health Services, Inc. were identified as comparable companies by Sevita in nonpublic documents it provided to OHCA. The other three comparable companies—Enhabit Inc, Amedisys Inc, and The Pennant Group—operate in the United States, have service lines like Sevita, and operate in the Home- and Community-Based Services (HCBS) space as identified by Wall Street analysts.[152] BrightSpring and Aveanna are more than 50% owned by private equity firms or financial sponsors and the remainder are majority owned by institutional investors and health care focused funds. See Figure 57 for leverage ratios.

Another indicator of financial risk is the interest coverage ratio, which measures the extent to which operating earnings can cover interest expenses on a company's

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debt.[153] Sevita's interest coverage has been consistently lower than peers since at least 2022. Sevita's interest coverage ratio ranged from 2.3x in 2022 to 1.8x in 2025, below the peer median over the same period (see Figure 29). Lower coverage implies higher default risk and indicates that a greater share of revenue is devoted to interest payments.[154] Consequently, as debt service consumes more revenue, Sevita may have less cash available to invest in staffing, training, facility maintenance, and other inputs associated with quality of care.[155]

opinions and are not statements of fact.

[152] William Blair identified Addus, BrightSpring, Enhabit, and Pennant as public companies in the home health care space competing with Aveanna. Additionally, Amedisys was identified by William Blair as a public company in the home health care space competing with BrightSpring. *See* William Blair Analyst Report, Aveannna Healthcare Holdings, Inc., December 8, 2025, 22, 28. *See also*, William Blair Analyst Report, BrightSpring Health Services, December 8, 2025, 26. The peer firms' revenue in home health and related segments as a portion of total revenue in 2024 were: Aveanna: 11%, BrightSpring: 22%, Enhabit: 80%, Amedisys: 63%, Addus: 20%, and Pennant: 74% 2024.

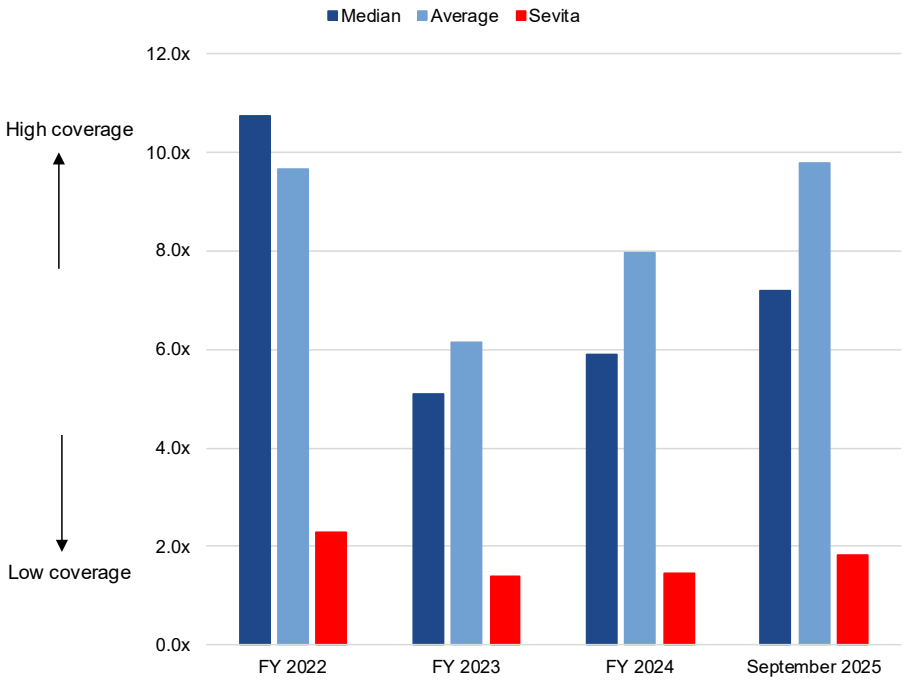
[153] https://corporatefinanceinstitute.com/resources/commercial-lending/interest-coverage-ratio/.

[154] In FY 2020, Sevita paid 4.7% of net revenue as interest expense; this increased to 6.9% of net revenue (or $208.6M) in FY 2024. Nonpublic financial disclosures provided to OHCA by Sevita; As to 2024 dollar values see https://www.sec.gov/Archives/edgar/data/1914496/000191449625000017/nationalmentorfy24audite.htm.

[155] Such outcomes have been reported in other cases where PE firms acquired health care entities. *See* https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf, 7 ("Additionally, PE investors generally finance their acquisitions with debt for which the acquired company's assets and cash flows serve as collateral. While PE firms typically target more financially sustainable companies, the practice of loading them up with debt is risky and has had negative consequences, especially as interest rates rose after March 2022. In 2023, at least 21% of health care companies that filed for bankruptcy were PE-owned, and most of the distressed health care companies, at risk of bankruptcy, in 2024 are PE-owned." (internal citations omitted)). This report also cites a case study of a PE-owned hospital system in which "[t]he PE owners have also pursued typical PE strategies of acquiring large amounts of debt and engineering leaseback deals. These tactics have put the entire health system under financial strain. . . . The consequences of these debt obligations are felt by workers and patients. According to commentors, the hospitals have increased prices, cut services, engineered layoffs, underpaid workers, and managed unsafe working conditions. They also produce worse outcomes and receive poor quality ratings and frequent regulatory investigations. Several commentors complained of staffing cuts and related quality concerns, which they attributed to the PE ownership." *Id.*, 15–16.

See also https://cepr.net/wp-content/uploads/2022/03/LBA-Advances-Chapter-Final-03-24-21.pdf.

Figure 29. Interest coverage ratio comparison between Sevita and peer firms, 2022–2025



Source: S&P Capital IQ; Nonpublic financial disclosures provided to OHCA by Sevita.

Notes: Interest coverage ratio represents EBITDA divided by interest expense. A higher interest coverage ratio is better as it means more profits available to service interest obligations. See Figure 56 for interest coverage details.

While Sevita's risk profile appears to be improving in recent years, aggressive financial practices may reduce Sevita's ability to invest in quality and increase the risk of facility closures. Taken together with the quality issues discussed above, Sevita's financial strategy raises concerns about whether the proposed transaction could be followed by reduced investment in ResCare facilities.

Appendix A. Sources for Sevita's publicly reported quality issues

- https://pestakeholder.org/wp-content/uploads/2025/03/PESP_Report_IDD_2025.pdf
- https://www.kqed.org/news/11969597/whistleblowers-call-out-california-group-home-for-abuse-against-disabled-residents
- https://www.finance.senate.gov/imo/media/doc/120220%20Life%20at%20Cypress%20House%20-%20An%20Examination%20of%20Care%20Provided%20by%20MENTOR%20Oregon.pdf
- https://www.finance.senate.gov/imo/media/doc/2020-12-03%20Investigative%20Report%20(REM%20Iowa).pdf
- https://www.oregonlive.com/watchdog/2020/12/oregon-developmental-disabilities-company-repeatedly-failed-vulnerable-oregonians-us-senate-investigation-finds.html.
- https://iowacapitaldispatch.com/2025/11/28/resident-deaths-lead-to-fines-at-three-iowa-care-facilities/
- https://www.columbian.com/news/2020/dec/03/oregon-developmental-disabilities-company-repeatedly-failed-vulnerable-oregonians-u-s-senate-investigation-finds/
- https://wcfcourier.com/news/local/crime-and-courts/waterloo-man-arrested-in-alleged-conservatorship-theft/article_2b6ae831-5688-52db-a216-bb26c1655824.html
- https://www.desmoinesregister.com/story/news/crime-and-courts/2019/11/04/care-program-supervisor-takes-deal-sex-exploitation-case/4159190002/
- https://iowacapitaldispatch.com/2025/06/06/brain-injured-woman-wandered-from-iowa-facility-before-being-found-at-nebraska-truck-stop/
- https://www.press-citizen.com/story/news/crime-and-courts/2015/08/17/police-say-woman-abandoned-clients-coralville-care-facility/31854499/
- https://nonpareilonline.com/news/local/article_a1683904-d0ca-5247-89a4-daa39e573144.html

- https://who13.com/news/group-home-closed-residents-sexually-abused-medications-missed/
- https://www.kcrg.com/content/news/Program-supervisor-accused-of-sexually-abusing-client-506974491.html
- https://www.oregonlive.com/pacific-northwest-news/2019/01/neglect-victim-smelled-of-rotting-flesh-caregivers-say-as-state-shutters-home-for-people-with-disabilities.html
- https://www.pnj.com/story/news/2019/01/19/pensacola-cluster-investigation-reports-deficiencies-facility-where-disabled-woman-raped-pregnant/2613293002/
- https://www.statesman.com/story/news/investigates/2022/09/22/texas-medicaid-waiver-system-for-disabled-issues-of-abuse-neglect-death/68304630007/
- https://www.bostonglobe.com/2023/11/24/metro/adult-day-care-centers-close-nh-families-search-other-options/
- https://iowacapitaldispatch.com/2022/03/29/care-facility-is-fined-after-woman-left-unattended-in-liquor-store-consumes-vodka/
- https://www.kalw.org/health/2023-08-29/former-disability-group-home-admin-accuses-parent-company-of-abuse-mismanagement

Appendix B. Additional analyses

Figure 30. County to Regional Center translation

County	Regional Center	County	Regional Center
Alpine	Alta California	Inyo	Kern
Colusa	Alta California	Kern	Kern
El Dorado	Alta California	Mono	Kern
Nevada	Alta California	Los Angeles	Los Angeles Counties[*]
Placer	Alta California	Napa	North Bay
Sacramento	Alta California	Solano	North Bay
Sierra	Alta California	Sonoma	North Bay
Sutter	Alta California	Del Norte	Redwood Coast
Yolo	Alta California	Humboldt	Redwood Coast
Yuba	Alta California	Lake	Redwood Coast
Fresno	Central Valley	Mendocino	Redwood Coast
Kings	Central Valley	Orange	Regional Center of Orange County
Madera	Central Valley	Alameda	Regional Center of the East Bay
Mariposa	Central Valley	Contra Costa	Regional Center of the East Bay
Merced	Central Valley	Monterey	San Andreas
Tulare	Central Valley	San Benito	San Andreas
Butte	Far Northern	Santa Clara	San Andreas
Glenn	Far Northern	Santa Cruz	San Andreas
Lassen	Far Northern	Imperial	San Diego
Modoc	Far Northern	San Diego	San Diego
Plumas	Far Northern	San Luis Obispo	Tri-Counties
Shasta	Far Northern	Santa Barbara	Tri-Counties
Siskiyou	Far Northern	Ventura	Tri-Counties
Tehama	Far Northern	Amador	Valley Mountain
Trinity	Far Northern	Calaveras	Valley Mountain
Marin	Golden Gate	San Joaquin	Valley Mountain
San Francisco	Golden Gate	Stanislaus	Valley Mountain
San Mateo	Golden Gate	Tuolumne	Valley Mountain
Riverside	Inland		
San Bernardino	Inland		

Source: California DDS – Regional Center Listings (https://www.dds.ca.gov/rc/listings/).

[*] Los Angeles County contains the following Regional Centers: North LA County, San Gabriel/Pomona, South Central LA, Harbor, Frank D Lanterman, Westside, and Eastern LA.

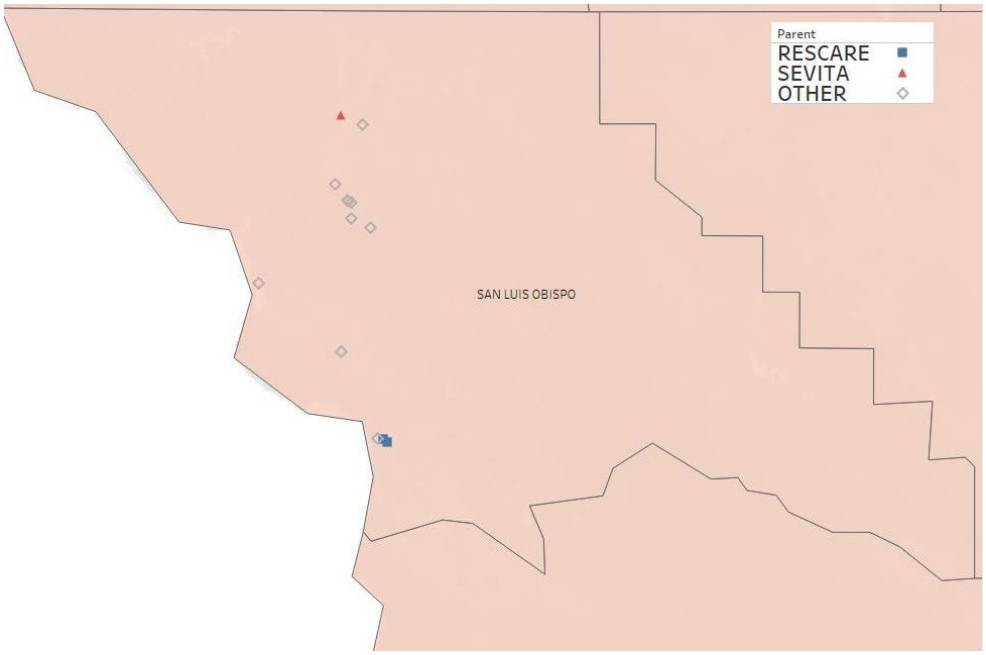
Figure 31. California Regional Centers

Source: California DDS – Regional Center Listings (https://www.dds.ca.gov/rc/listings/).

Figure 32. Landscape of ResCare and Sevita California ADPs, 2025

Source: BrightSpring and Sevita facility location data.

Figure 33. ADPs in San Luis Obispo County



Source: BrightSpring and Sevita facility location data; https://spd.tri-counties.org/.

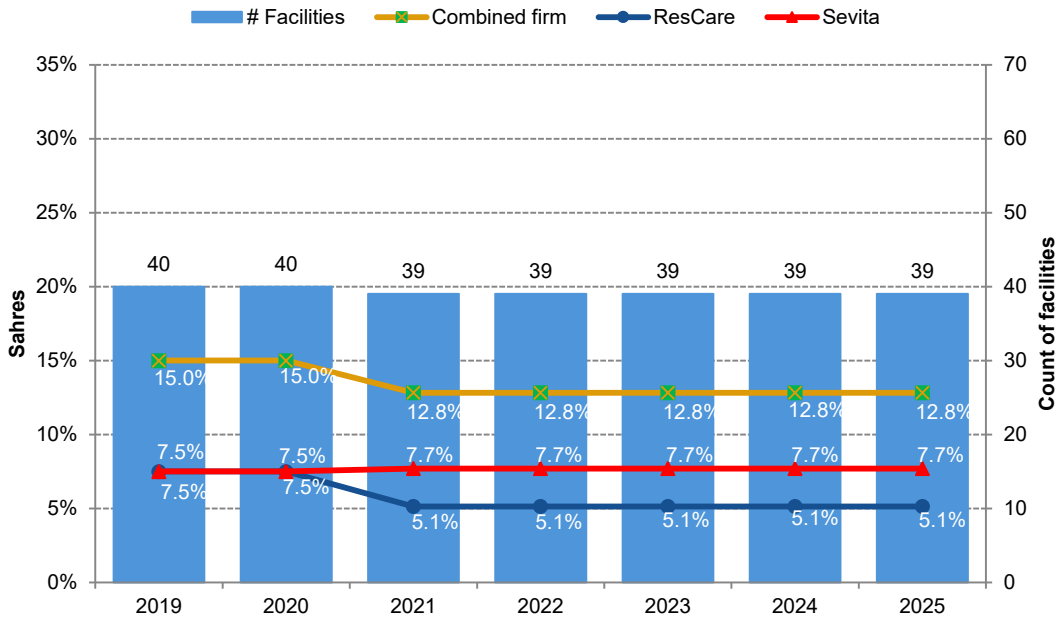
Figure 34. Shares for ARFs and ADPs in alternative geographies, 2025

Service type	Geography	Res-Care	Sevita	Non-party	Total	Combined share	Overlap	Above MG presumption thresholds
ARF	San Luis Obispo County/CBSA	2	3	34	39	12.8%	Yes	No
	Los Angeles CBSA	7	29	1,932	1,968	1.8%	Yes	No
ADP	Sacramento CBSA	1	1	125	127	1.6%	Yes	No
	San Bernardino CBSA	1	24	111	136	18.4%	Yes	No
	Alta California Regional Center	2	1	141	144	2.1%	Yes	No
	Inland Regional Center	1	24	169	194	12.9%	Yes	No
	Tri-Counties Regional Center	2	8	51	61	16.4%	Yes	No

Source: BrightSpring and Sevita facility location data.

Notes: San Luis Obispo County and CBSA are identical.

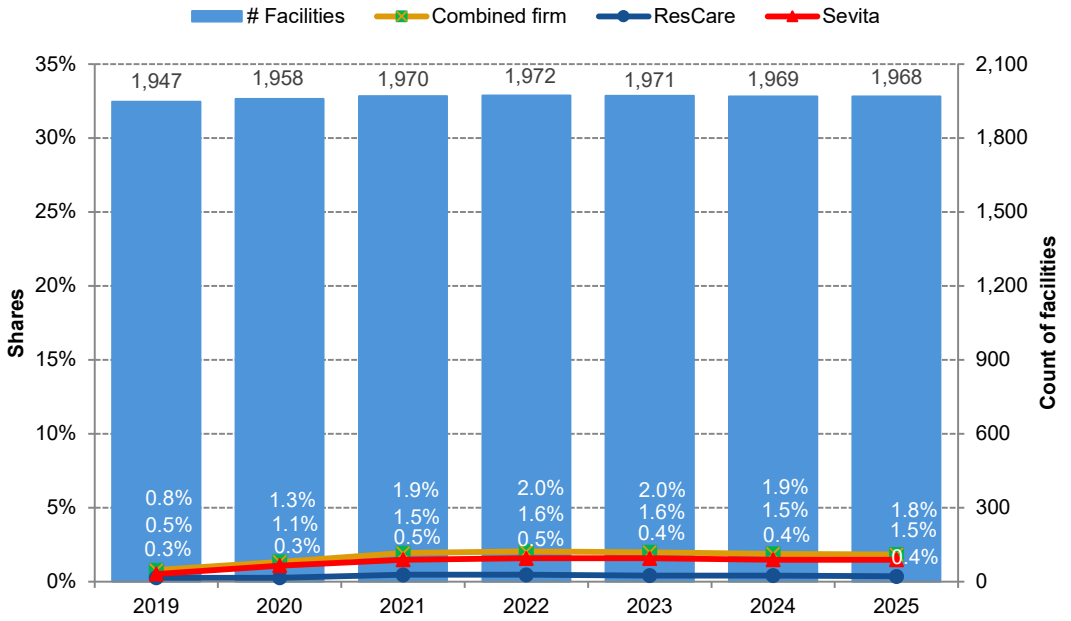
Figure 35. Total ARF facilities and ResCare and Sevita's shares, San Luis Obispo County/CBSA, 2019–2025



Source: BrightSpring and Sevita facility location data.

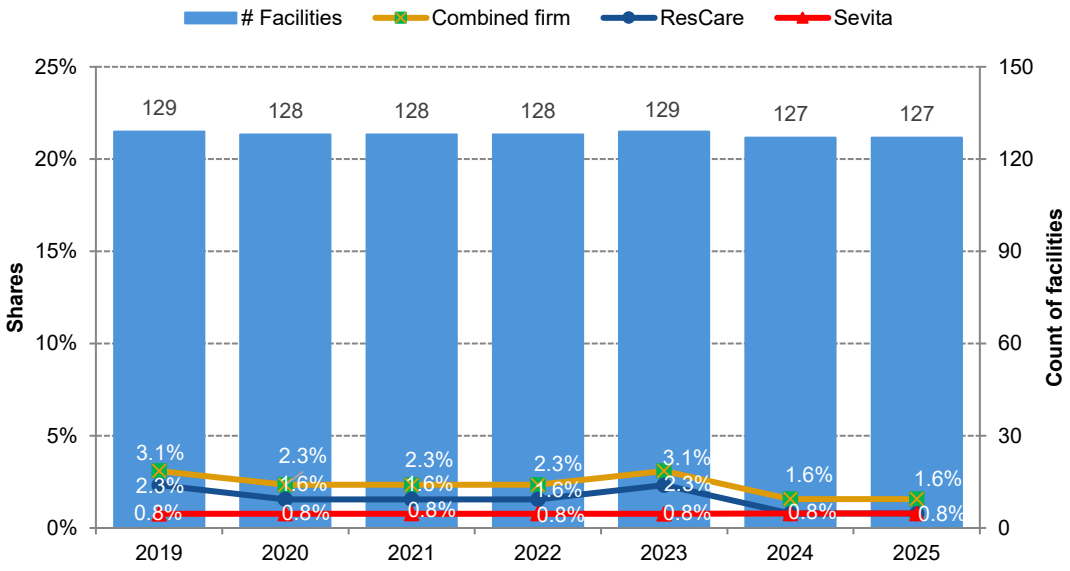
Notes: San Luis Obispo County and CBSA are identical.

Figure 36. Total ARF facilities and ResCare and Sevita's shares, Los Angeles CBSA, 2019–2025



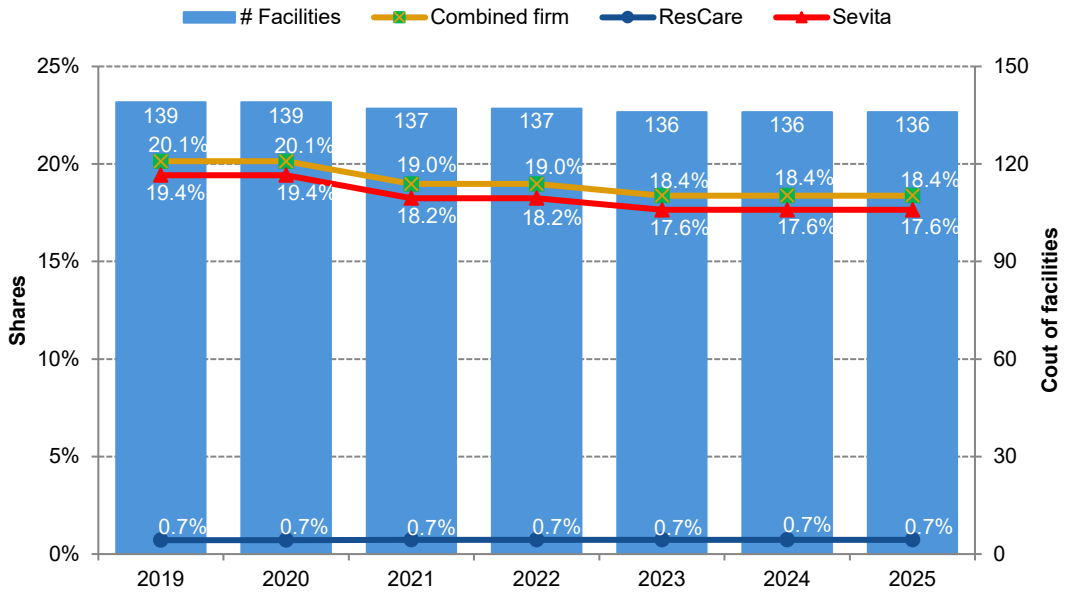
Source: BrightSpring and Sevita facility location data.

Figure 37. Total ADP facilities and ResCare and Sevita's shares, Sacramento CBSA, 2019–2025



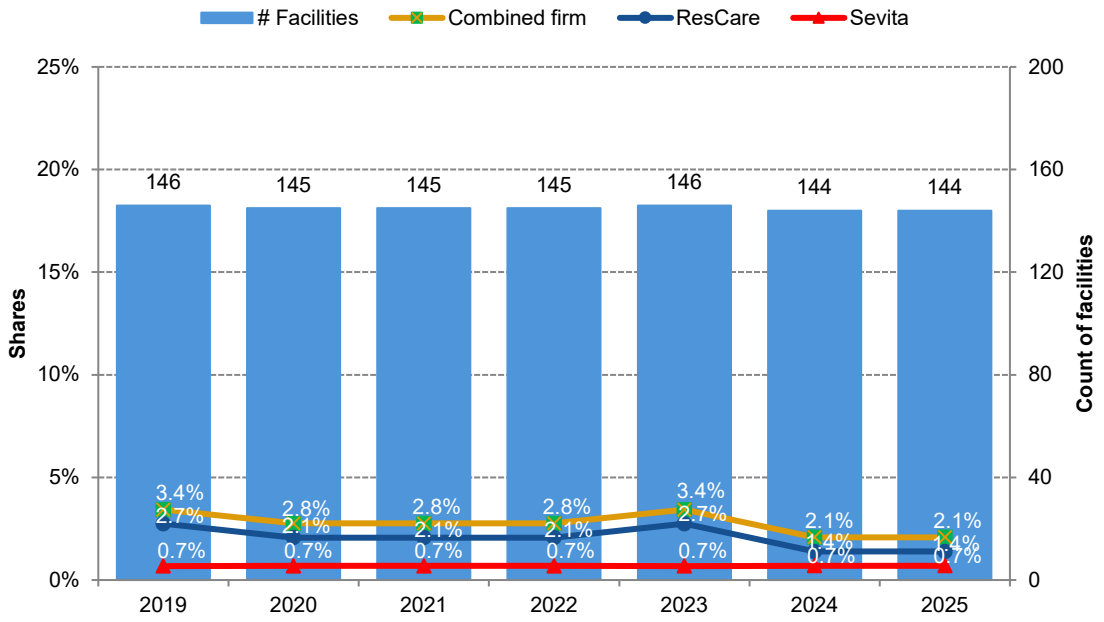
Source: BrightSpring and Sevita facility location data.

Figure 38. Total ADP facilities and ResCare and Sevita's shares, San Bernardino CBSA, 2019–2025



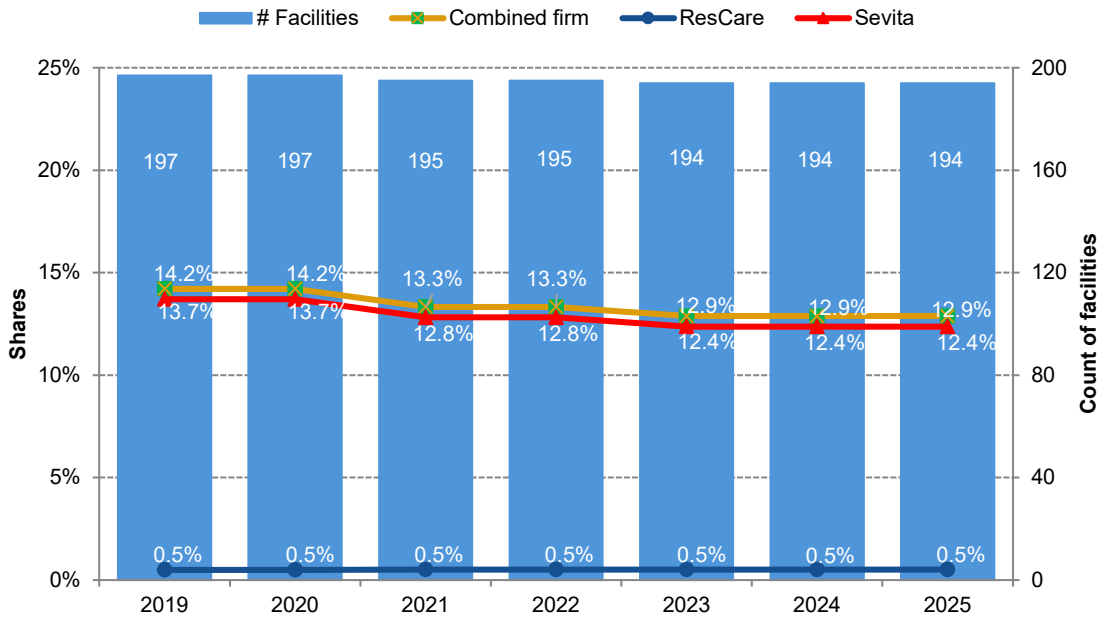
Source: BrightSpring and Sevita facility location data.

Figure 39. Total ADP facilities and ResCare and Sevita's shares, Alta California Regional Center, 2019–2025



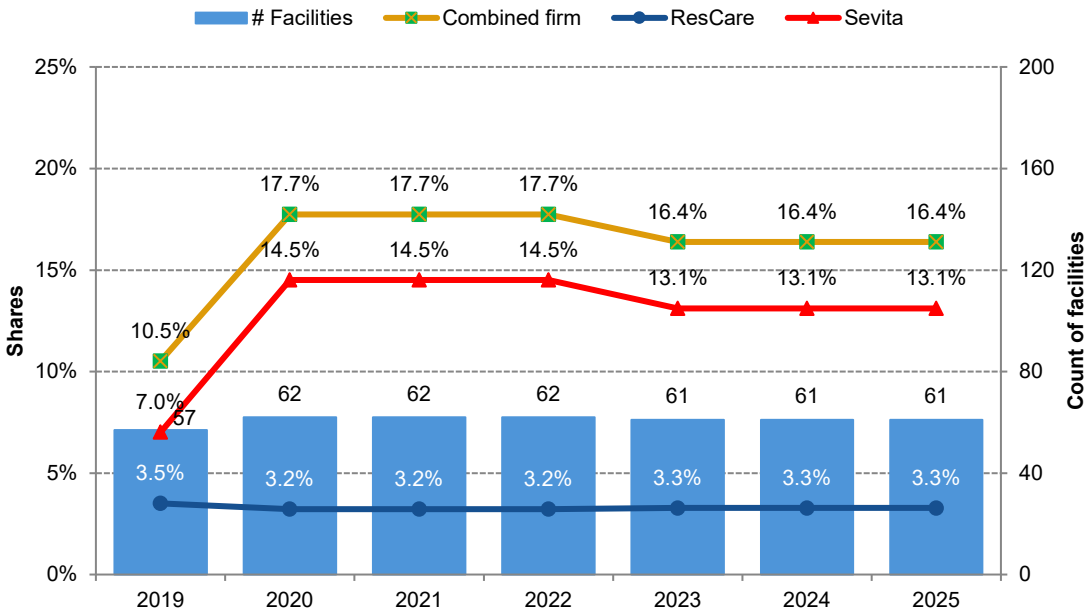
Source: BrightSpring and Sevita facility location data.

Figure 40. Total ADP facilities and ResCare and Sevita's shares, Inland Regional Center, 2019–2025



Source: BrightSpring and Sevita facility location data.

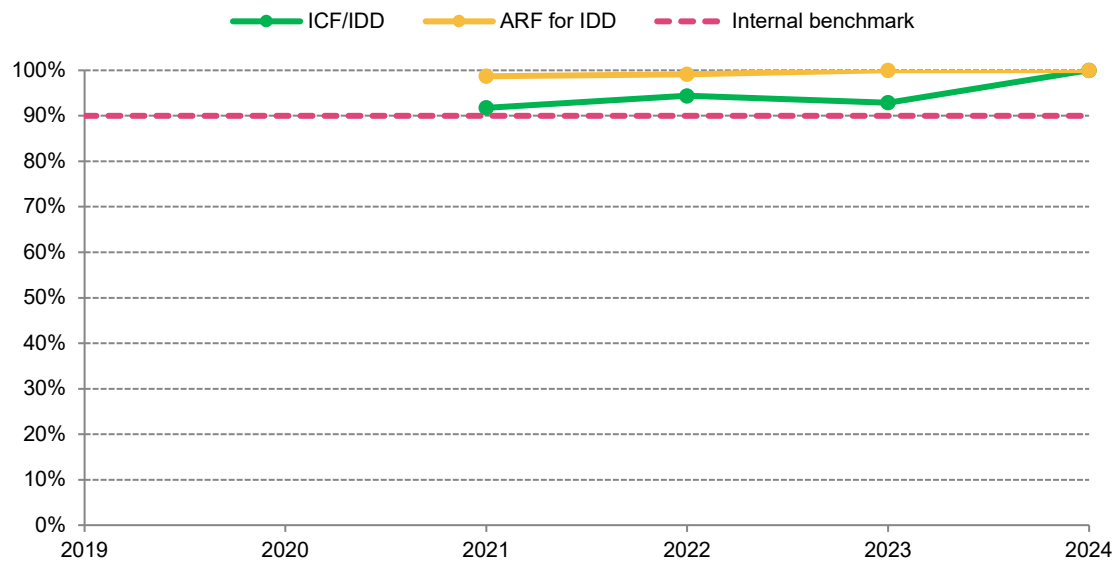
Figure 41. Total ADP facilities and ResCare and Sevita's shares, Tri-Counties Regional Center, 2019–2025



Source: BrightSpring and Sevita facility location data.

Notes: The Tri-Counties Regional Center directory does not provide address information for ADPs; therefore, to account for multiple programs/services being offered at the same facility, providers with the same root name who appear multiple times are grouped together and treated as a single facility.

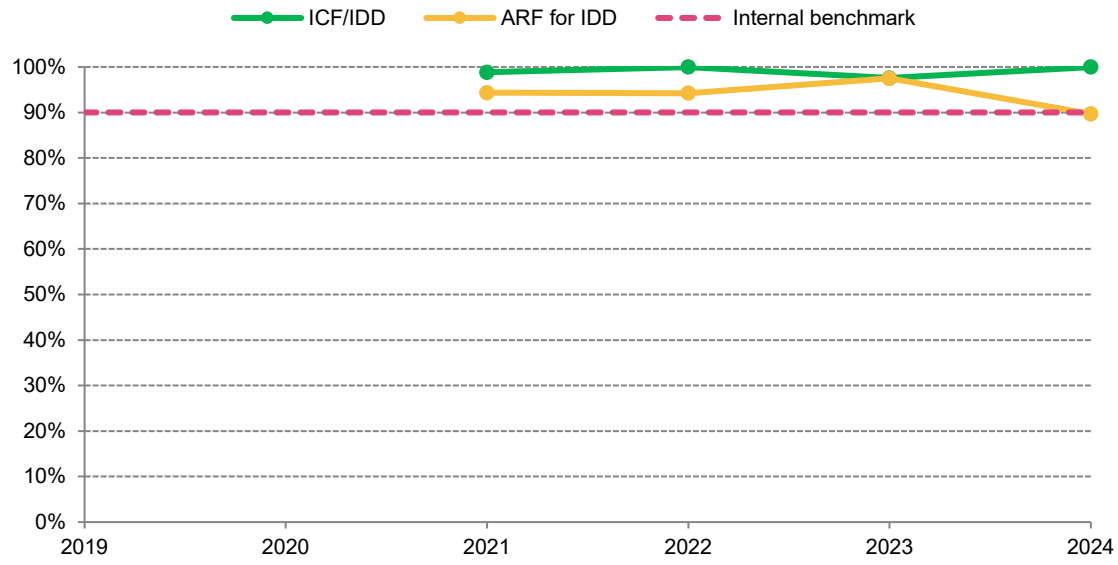
Figure 42. Sevita's program participation rate



Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: The program participation rate tracks whether individuals in residential services have participated in their service planning. Sevita's internal benchmark, 90%, is as of 2024. Data not available for 2019 and 2020.

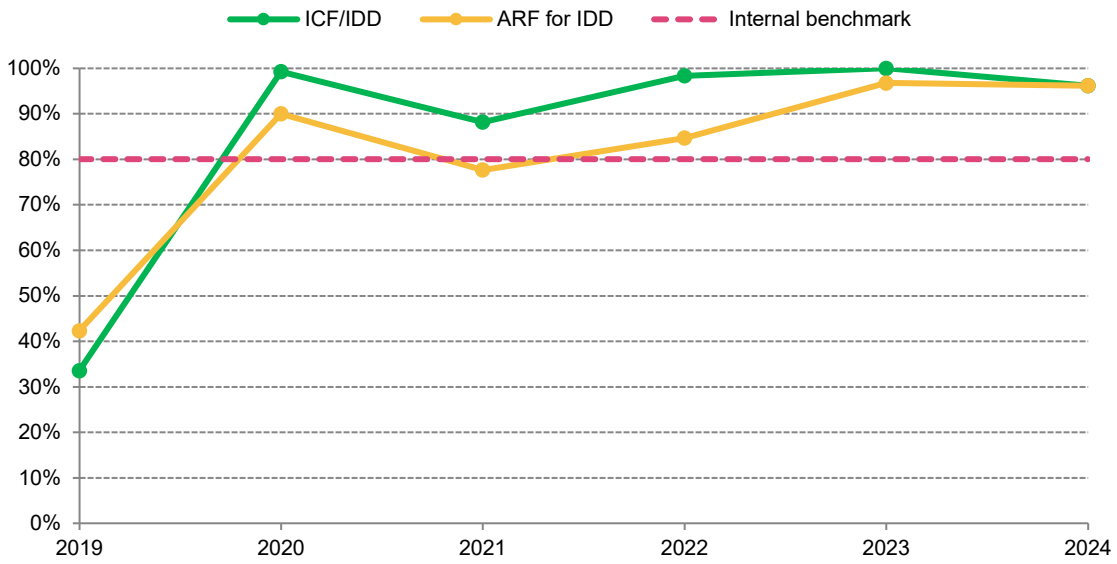
Figure 43. Sevita's chronic condition management rate



Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: Of those individuals who had a physical, the chronic condition management rate tracks whether individuals discussed chronic condition management with their doctor. Sevita's internal benchmark, 90%, is as of 2024. Data not available for 2019 and 2020.

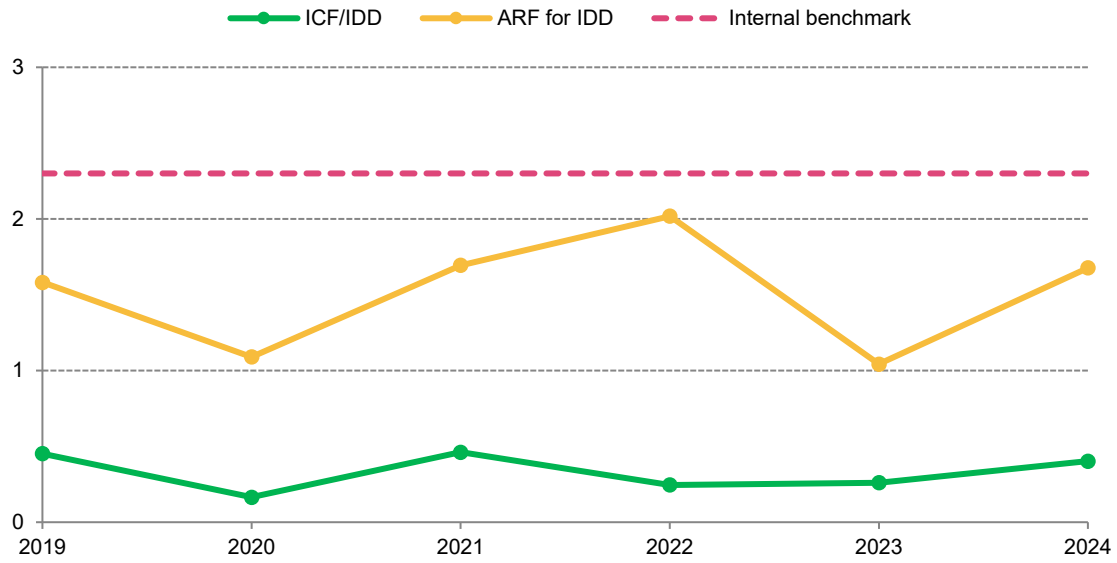
Figure 44. Sevita's physical requirement rate



Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: The physical requirement rate tracks whether individuals in a residential service for at least 14 months have a current physical. Sevita's internal benchmark, 80%, is as of 2024.

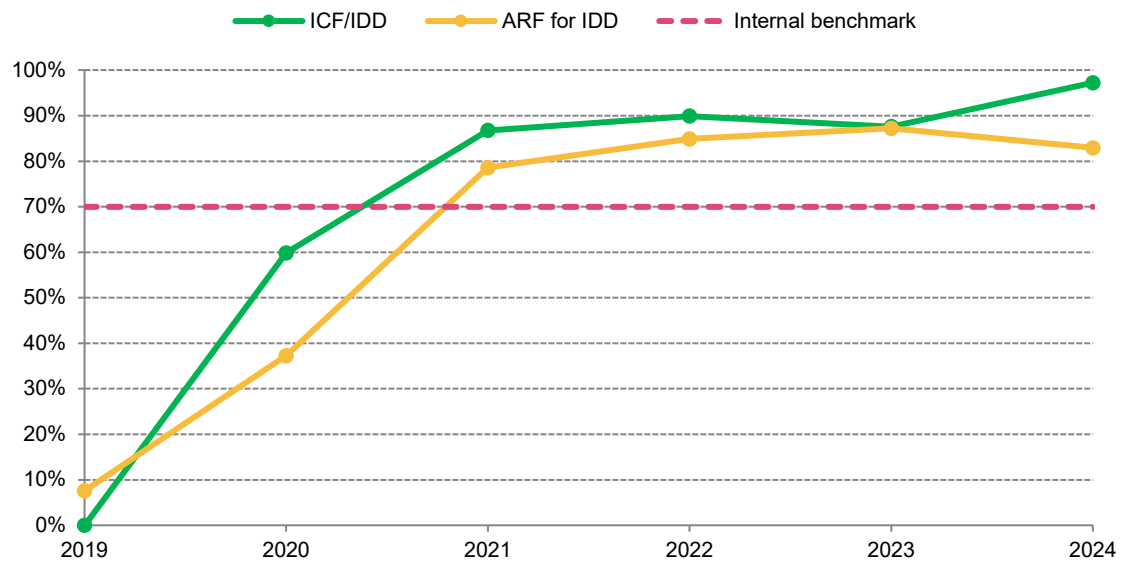
Figure 45. Sevita's medication errors per thousand patient days



Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: The medication errors per thousand patient days tracks omissions, wrong dose, wrong medication, wrong patient served, wrong member, and whether the staff member is no longer certified to administer the medication. Sevita's internal benchmark, 2.3, is as of 2024.

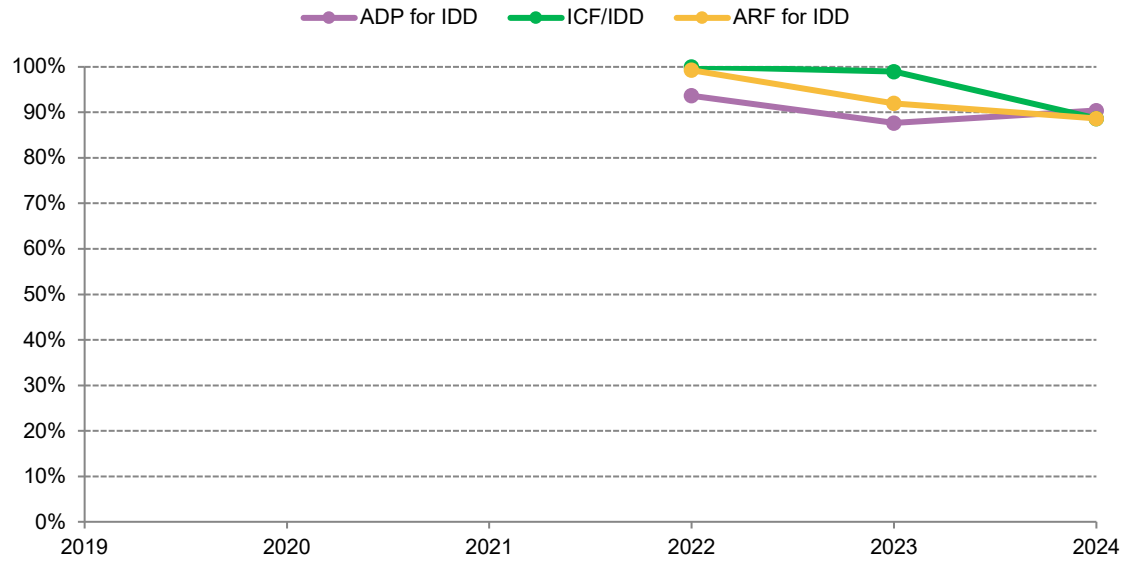
Figure 46. Sevita's flu vaccination rate



Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: The flu vaccination rate tracks whether individuals who have an active residential assignment before July 1 of the reporting period have flu vaccination documentation between August 1 and March 31. Sevita's internal benchmark, 70%, is as of 2024.

Figure 47. Sevita's rate of compliance in inspections

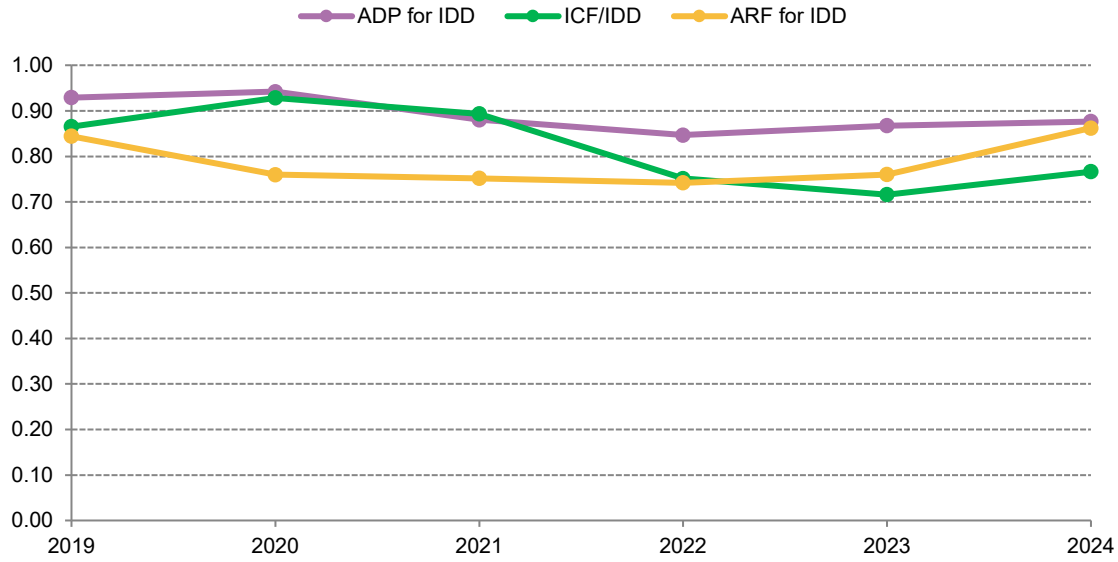


Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: The rate of compliance in inspections tracks whether the facilities are complying with the questions in the unannounced visit evaluations. Sevita states that it formalized the protocols and policy for unannounced visits on

March 2024, and therefore visits before and after this date are not comparable. Data not available for 2019, 2020 and 2021.

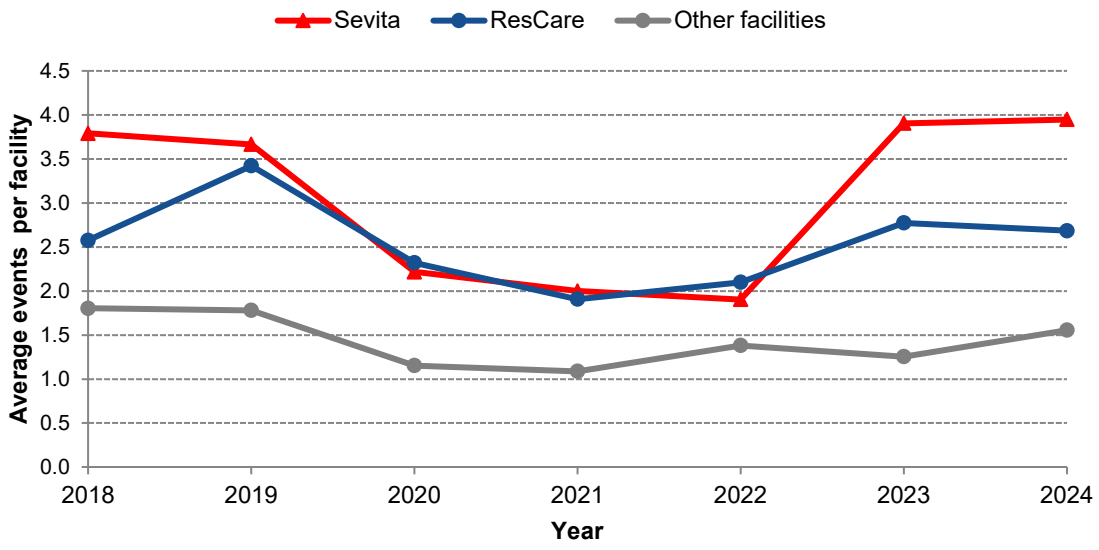
Figure 48. Sevita's rate of reports made on time



Source: Sevita's internal quality metrics (nonpublic); Sevita's internal 2024 benchmarks (nonpublic).

Notes: The rate of reports made on time tracks whether the deadline to enter and finalize an incident was met. Sevita does not have an internal benchmark for this rate.

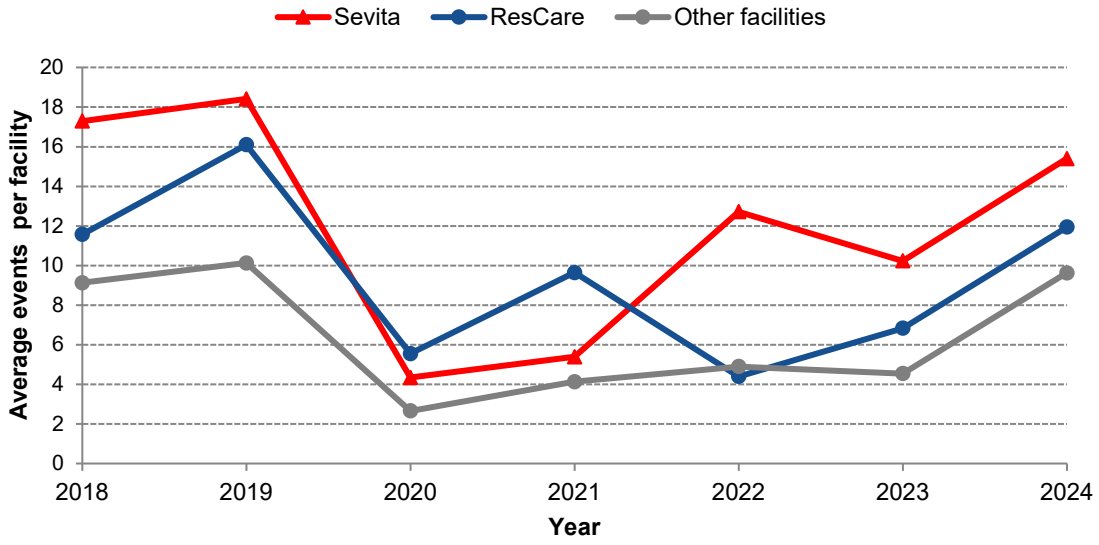
Figure 49. Complaints substantiated per California ICF/IDD facility, 2018–2024



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line “Other facilities” presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

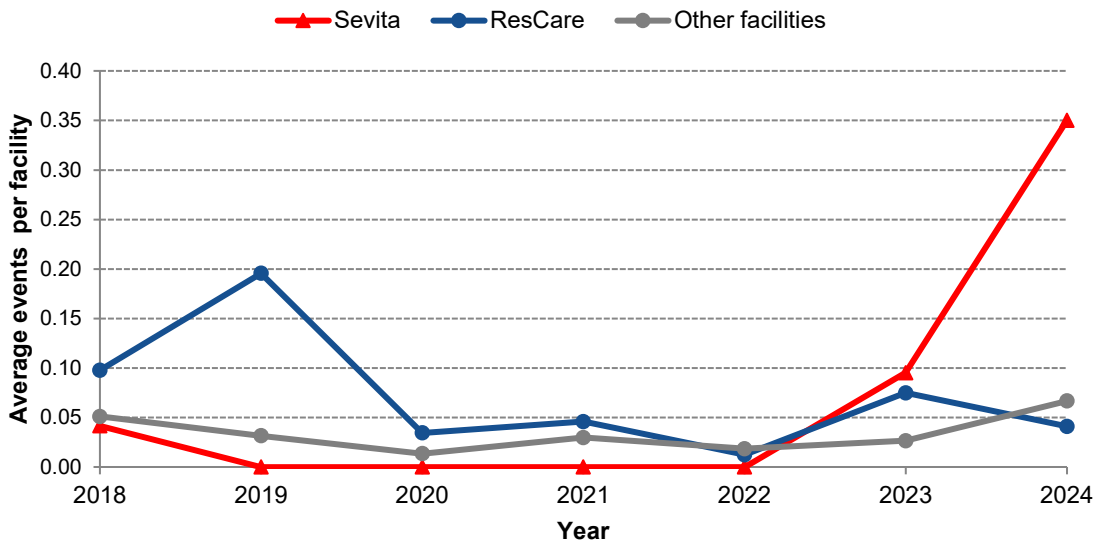
Figure 50. Deficiencies per California ICF/IDD facility, 2018–2024



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line “Other facilities” presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

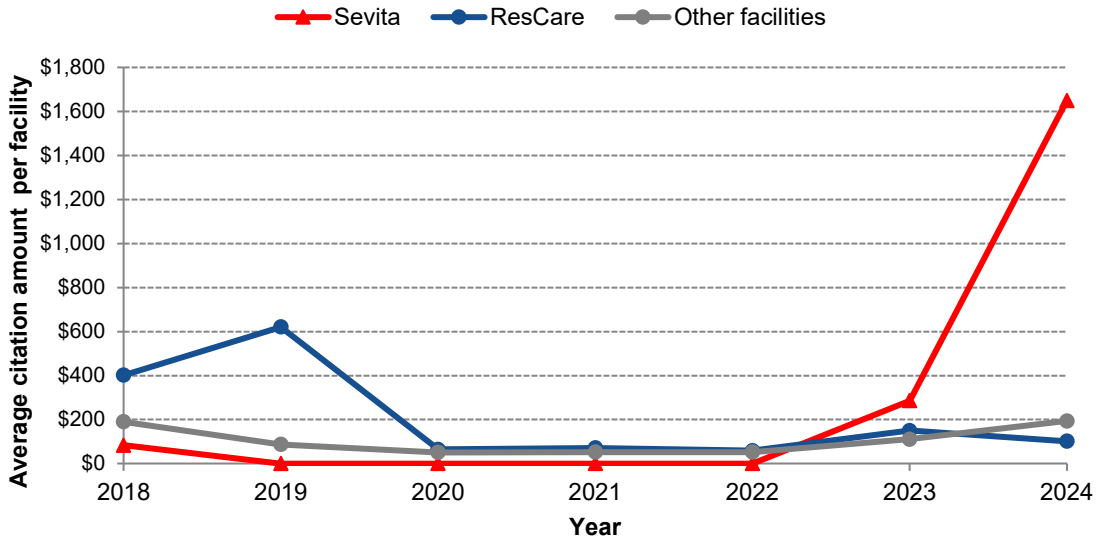
Figure 51. Citations per California ICF/IDD facility, 2018–2024



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line “Other facilities” presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

Figure 52. Citation amount due per California ICF/IDD facility, 2018–2024



Source: California Department of Public Health, Cal Health Find Database; BrightSpring and Sevita facility location data.

Notes: Limited to ICFs/IDD with 12 beds or fewer. The line “Other facilities” presents the average for all other ICF/IDD facilities not owned by either ResCare or Sevita.

Figure 53. ICF, ARF, and ADP counts by Regional Center, 2025

Regional Center	ResCare	Sevita	Non-party	Total	Combined share	Overlap	Above MG presumption thresholds
Alta California	14	3	112	129	13%	Yes	No
Central Valley	-	9	65	74	12%	No	No
Inland	16	29	263	308	15%	Yes	No
Kern	-	20	15	35	57%	No	No
LA County	17	39	1,775	1,831	3%	Yes	No
North Bay	-	2	28	30	7%	No	No
Orange County	13	1	107	121	12%	Yes	No
The East Bay	-	8	60	68	12%	No	No
San Andreas	-	3	36	39	8%	No	No
San Diego	17	-	89	106	16%	No	No
Tri-Counties	15	12	183	210	13%	Yes	No
Valley Mountain	-	1	37	38	3%	No	No
Other 3 Regional Centers	-	-	53	53	0%	No	No
California	**92**	**127**	**2,823**	**3,042**	**7%**	**Yes**	**No**

Source: BrightSpring and Sevita facility location data; CalHHS - Licensed and Certified Healthcare Facility Listing (pulled approximately June 2025); Regional Center websites.

Notes: The Tri-Counties Regional Center directory does not provide address information for ADPs; therefore, to account for multiple programs/services being offered at the same facility, providers with the same root name who appear multiple times are grouped together and treated as a single facility.

Figure 54. ICF, ARF, and ADP counts by CBSA, 2025

CBSAs	ResCare	Sevita	Non-party	Total	Combined share	Overlap	Above MG presumption thresholds
Bakersfield-Delano, CA	-	20	15	35	57%	No	No
Fresno, CA	-	5	36	41	12%	No	No
Los Angeles-Long Beach-Anaheim, CA	30	40	1,882	1,952	4%	Yes	No
Merced, CA	-	4	7	11	36%	No	No
Modesto, CA	-	1	1	2	50%	No	No
Oxnard-Thousand Oaks-Ventura, CA	4	4	103	111	7%	Yes	No
Riverside-San Bernardino-Ontario, CA	16	29	263	308	15%	Yes	No
Sacramento-Roseville-Folsom, CA	9	3	107	119	10%	Yes	No
San Diego-Chula Vista-Carlsbad, CA	17	-	86	103	17%	No	No
San Francisco-Oakland-Fremont, CA	-	8	94	102	8%	No	No
San Jose-Sunnyvale-Santa Clara, CA	-	3	34	37	8%	No	No
San Luis Obispo-Paso Robles, CA	11	4	47	49	31%	Yes	Yes
Santa Maria-Santa Barbara, CA	-	4	43	47	9%	No	No
Santa Rosa-Petaluma, CA	-	2	11	13	15%	No	No
Yuba City, CA	5	-	5	10	50%	No	No
Other 21 CA CBSAs	-	-	99	99	0%	No	No
California	**92**	**127**	**2,833**	**3,039**	**7%**	**Yes**	**No**

Source: BrightSpring and Sevita facility location data; Cal HHS - Licensed and Certified Healthcare Facility Listing (pulled approximately June 2025); Regional Center websites.

Notes: ARF and ADP counts are limited to geographies of overlap.

Figure 55. ICF, ARF, and ADP counts by County, 2025

County	ResCare	Sevita	Non-party	Total	Combined share	Overlap	Above MG presumption thresholds
Alameda	-	6	31	37	16%	No	No
Contra Costa	-	2	29	31	6%	No	No
Fresno	-	5	31	36	14%	No	No
Kern	-	20	15	35	57%	No	No
Los Angeles	17	39	1,775	1,831	3%	Yes	No
Merced	-	4	7	11	36%	No	No
Orange	13	1	107	121	12%	Yes	No
Placer	1	-	-	1	100%	No	No
Riverside	4	11	123	138	11%	Yes	No
Sacramento	8	3	100	111	10%	Yes	No
San Bernardino	12	18	140	170	18%	Yes	No
San Diego	17	-	86	103	17%	No	No
San Luis Obispo	11	4	47	49	31%	Yes	Yes
Santa Barbara	-	4	43	47	9%	No	No
Santa Clara	-	3	34	37	8%	No	No
Sonoma	-	2	11	13	15%	No	No
Stanislaus	-	1	1	2	50%	No	No
Sutter	5	-	5	10	50%	No	No
Ventura	4	4	103	111	7%	Yes	No
Other 39 CA Counties	-	-	145	145	0%	No	No
California	**92**	**127**	**2,833**	**3,039**	**7%**	**Yes**	**No**

Source: BrightSpring and Sevita facility location data; CalHHS - Licensed and Certified Healthcare Facility Listing (pulled approximately June 2025); Regional Center websites.

Notes: ARF and ADP counts are limited to geographies of overlap.

Figure 56. Interest coverage ratio comparison between Sevita and peer firms, 2020–2024

	FY 2022	FY 2023	FY 2024	September 2025
25th Percentile	5.8x	1.9x	2.5x	3.2x
Median	10.8x	5.1x	5.9x	7.2x
75th Percentile	11.5x	10.1x	12.5x	12.4x
Sevita	**2.3x**	**1.4x**	**1.5x**	**1.8x**

Source: S&P Capital IQ; Nonpublic financial disclosures provided to OHCA by Sevita.

Notes: Interest coverage ratio represents EBITDA divided by interest expense. A higher interest coverage ratio is better as it means more profits available to service debt obligations.

Figure 57. Leverage ratio comparison between Sevita and peer firms, 2020–2024

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	September 2025
25th Percentile	4.3x	1.0x	1.2x	2.5x	2.1x	1.6x	1.2x
Median	6.1x	3.0x	3.6x	4.3x	5.2x	3.4x	3.1x
75th Percentile	7.6x	5.5x	6.4x	6.3x	6.5x	5.2x	4.0x
Sevita	**4.7x**	**4.9x**	**8.7x**	**7.1x**	**7.1x**	**6.6x**	**5.7x**

Source: S&P Capital IQ; Nonpublic financial disclosures provided to OHCA by Sevita.

Notes: Peer firms Addus HomeCare Corporation, Aveanna Healthcare Holdings Inc., and BrightSpring Health Services, Inc. were identified as comparable companies by Sevita in nonpublic documents it provided to OHCA. The other three comparable companies—Enhabit Inc, Amedisys Inc, and The Pennant Group—operate in the United States, have service lines like Sevita, and operate in the Home- and Community-Based Services (HCBS) space as identified by Wall Street analysts. BrightSpring and Aveanna are more than 50% owned by private equity firms or financial sponsors and the remainder are majority owned by institutional investors and health care focused funds. Leverage ratio is net debt divided by adjusted EBITDA. A lower leverage ratio is better as it reflects lower debt levels compared to profits (i.e., EBITDA). The fiscal year reporting period for Sevita is September 30th. For Enhabit, Inc., Amedisys, Inc., Addus HomeCare Corporation, BrightSpring Health Services, Inc., and The Pennant Group, the fiscal year reporting period is December 31st. For InnovAge Holding Corp., the fiscal year reporting period is June 30th. Aveanna Healthcare Holdings Inc. reports with a 52-week fiscal year, typically ending the last few days of December.