HEALTHCARE MORTGAGEE ADVISORY COUNCIL

Financing Seniors Housing for America

Reimbursement Policy 2025-2026

Reimbursement - Whoa. This is Heavy

Ritchie Dickey, CFA
Managing Director

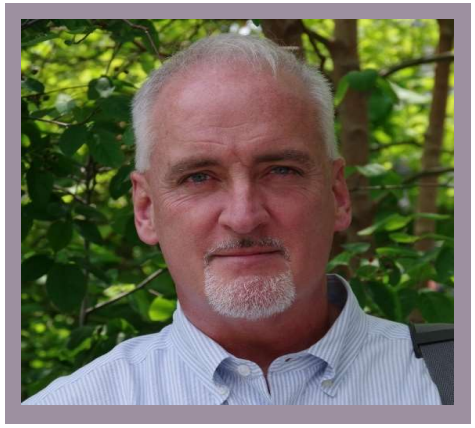
WHITE OAK

Dan Schneider, MAI
Managing Director

JLL

Jay Gormley
Chief Investment Officer and COO
Advisory

ZIMMET HEALTHCARE SERVICES GROUP, LLC



Martin Allen
Former Senior Vice President of Reimbursement Policy at AHCA/NCAL

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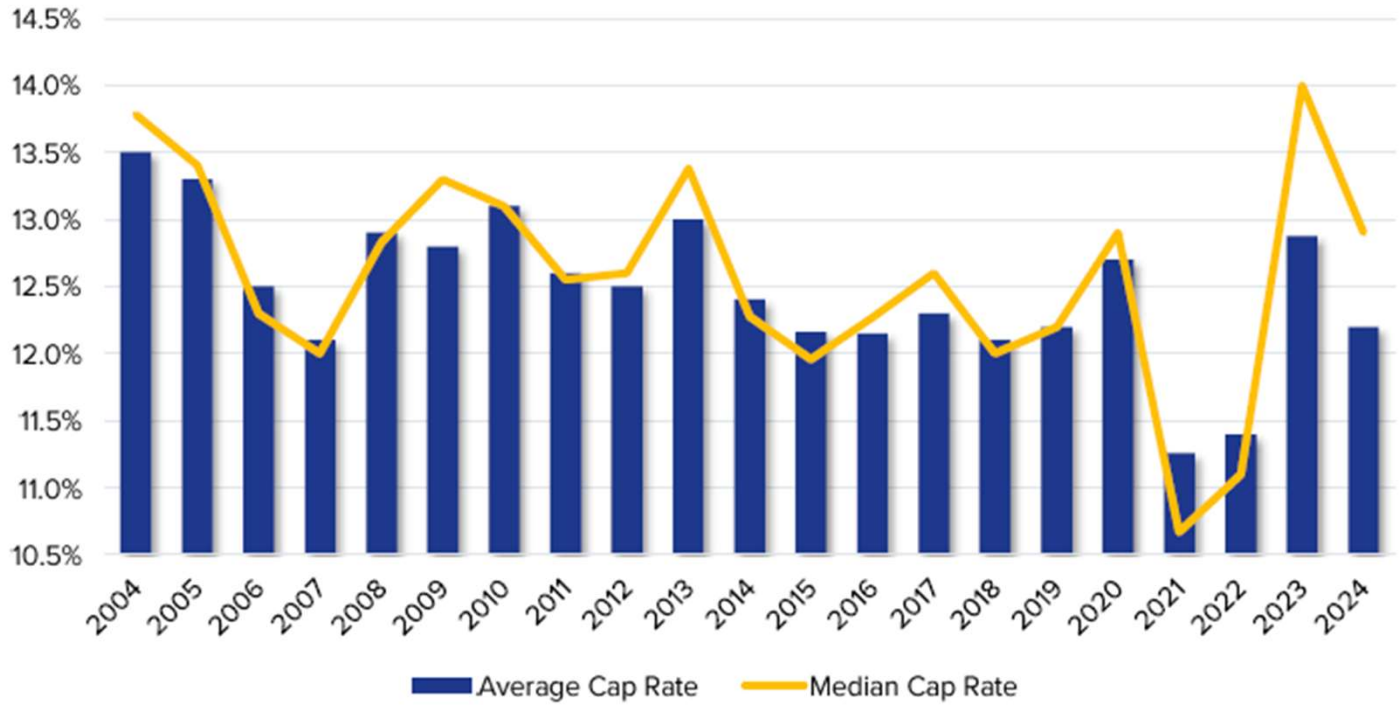
Trend in Skilled Nursing Facility Cap Rates (2004-2024)



Source: The Senior Care Acquisition Report, 2025

Impact of Medicaid Rate Changes On Price/Value

KY Rate Estimated Budget Impact is $382 Million

1/1/2024	$248.90
7/1/2024	$311.21
Difference	$62.31

	Annualized 7 Months Ending 7/31/2024	Adjusted Medicaid Rate Impact	Difference	Percentage Change
Total Beds	60	60		
Medicaid Days	15,087	15,087		
Medicaid Revenue	$3,877,659	$4,695,359	$817,699	
Average Rate	$257.01	$311.21	$54.20	21.1%
Effective Gross Income	**$4,969,009**	**$5,786,708**	**$817,699**	**16.5%**
Expenses	$4,363,115	$4,363,115		
Management Fee	$248,450	$289,335		
Total Expenses	$4,611,565	$4,652,450	$40,885	
Net Operating Income	$357,444	$1,134,258	$776,814	217.3%
Hypothetical Cap Rate	12.50%	12.50%		
Indicated Value	**$2,860,000**	**$9,070,000**	**$6,210,000**	**217.1%**
Value Per Bed	$47,667	$151,167	$103,500	217.1%

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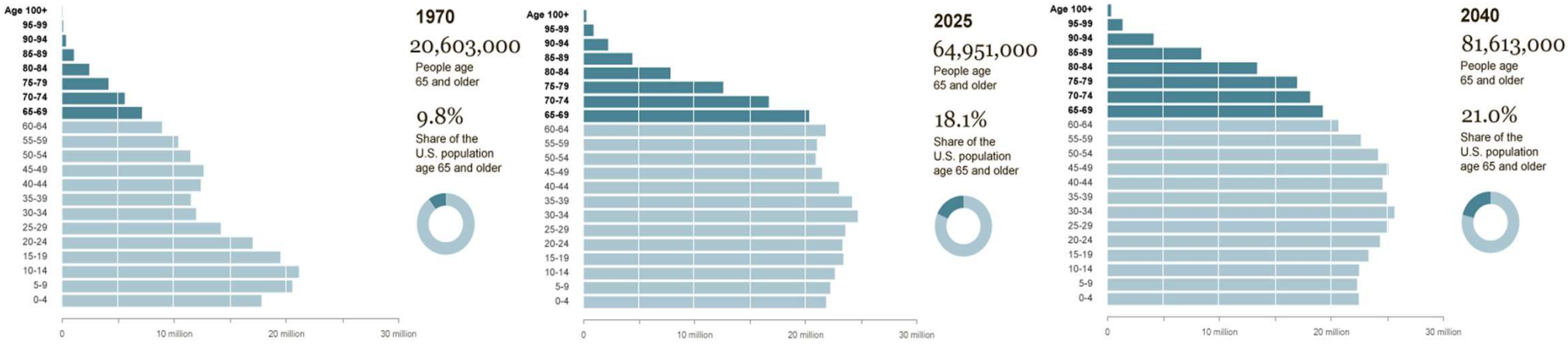
Facility	Date	Sale Price	Beds	Price/Bed
7 SNF Facility Portfolio	9/30/2025	$165,000,000	818	$201,711
Confidential - SNF	9/30/2025	$23,400,000	104	$225,000
Confidential - SNF/MC	9/25/2025	$16,600,000	80	$207,500
Confidential-SNF	1/6/2025	$33,000,000	150	$220,000
Pending - Confidential	Pending	$26,230,000	122	$215,000

Upcoming Industry Challenges

- Significant Increase in Senior Population
- Decrease in worker/retiree ratio
- Increase in Federal Debt
- Hospital and Medicare Trust Fund

Growing Market- Population Growth



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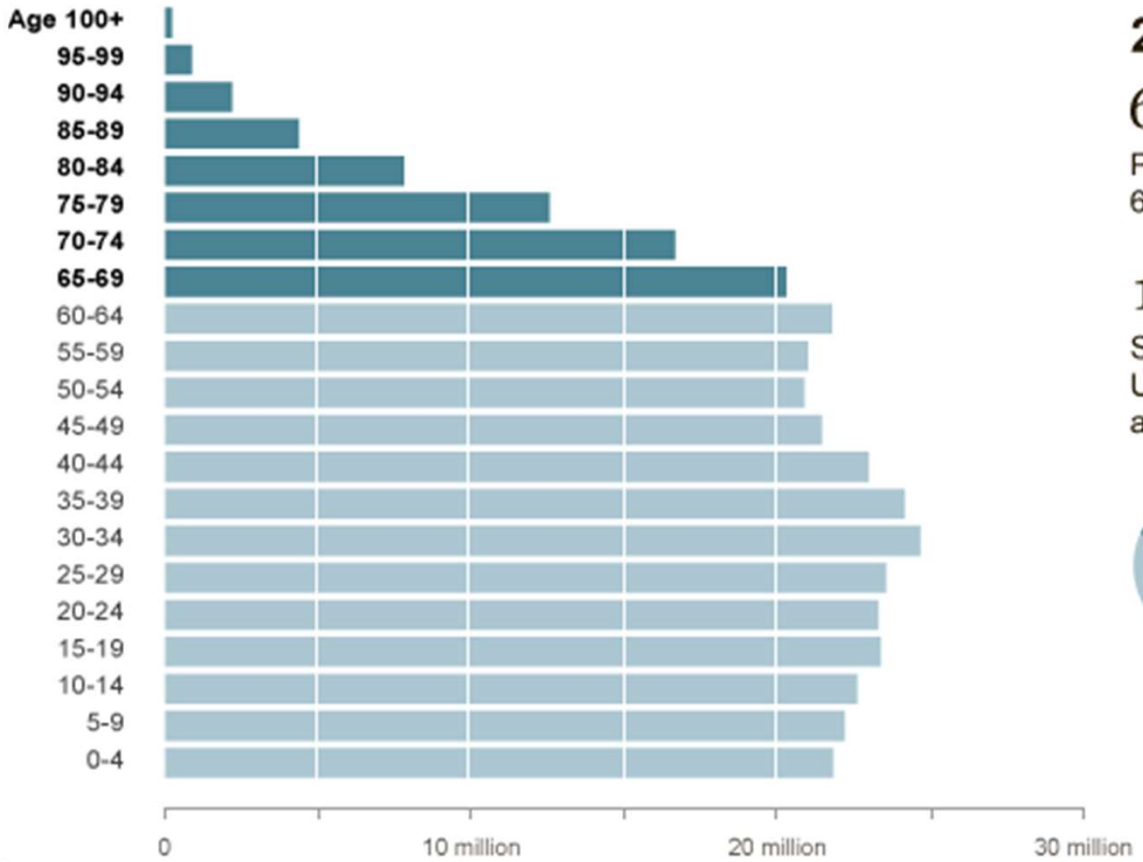
Growing Market- Population Growth



2025

64,951,000

People age
65 and older

18.1%

Share of the
U.S. population
age 65 and older

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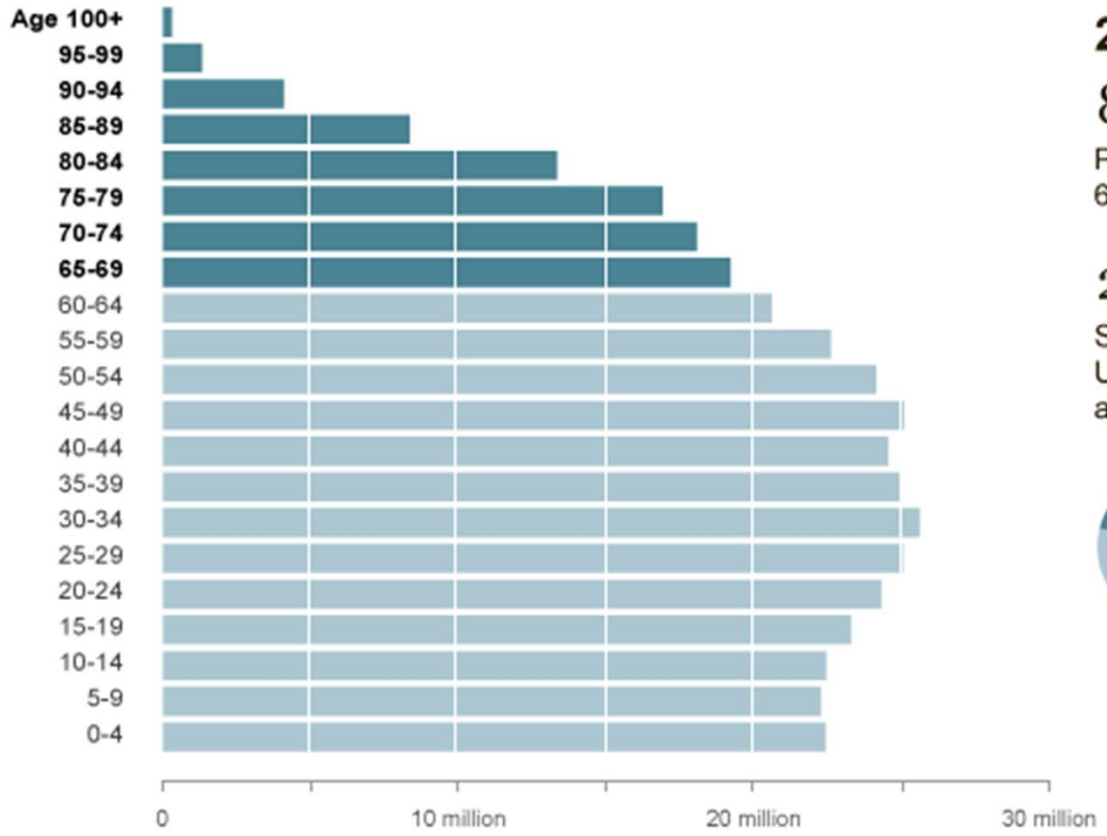
Growing Market- Population Growth



2040

81,613,000

People age
65 and older

21.0%

Share of the
U.S. population
age 65 and older

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Silver Tsunami Arrives

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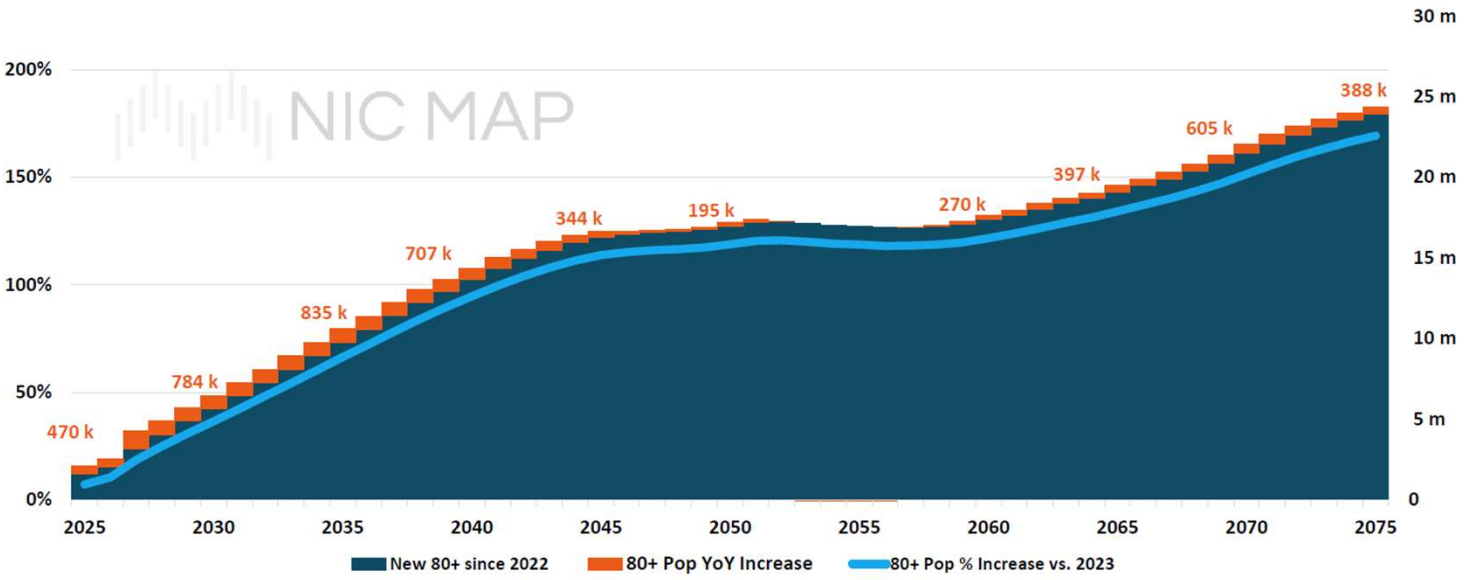
- The Oldest Baby Boomer will turn 80 in 2026
- By 2030 - All Baby Boomers will be age 65 and older



Source: NIC MAP® Data, powered by NIC MAP ®, Primary and Secondary Markets, OECD.

SNF Demand Estimates

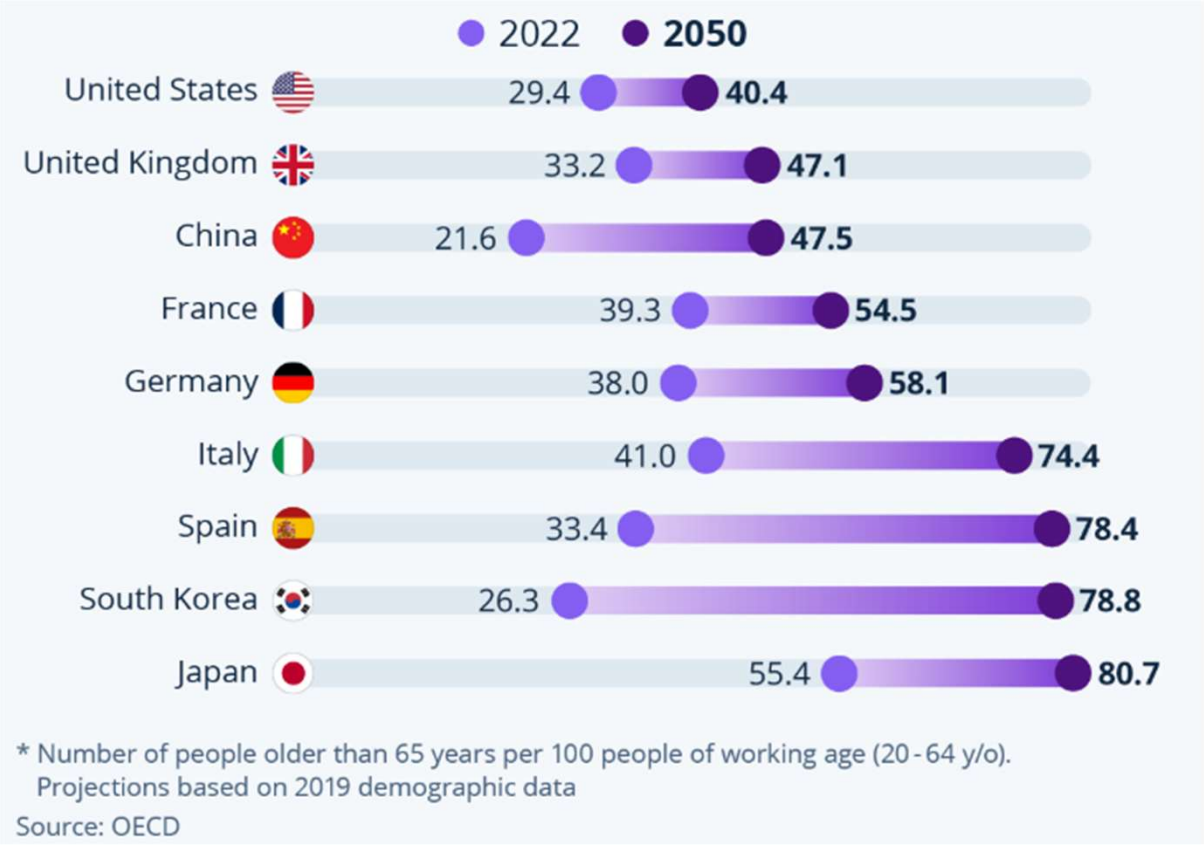
Demand Estimates (2023 Utilization)		
Age 75+	**Population**	**Growth**
2023 Population (Estimated)	24,439,098	
2025 Population (Estimated)	27,363,699	12.0%
2030 Population (Projected)	33,119,548	21.0%

	Patient Days	Beds	Occupancy
2023 total patients*	1,214,192	1,603,952	75.7%
2023 Utilization Per 1,000 age 75+	49.68		
2025 Need	1,359,493	1,576,551	86.2%
2030 Need	1,645,457	1,576,551	104.4%

Demographic Source: ESRI

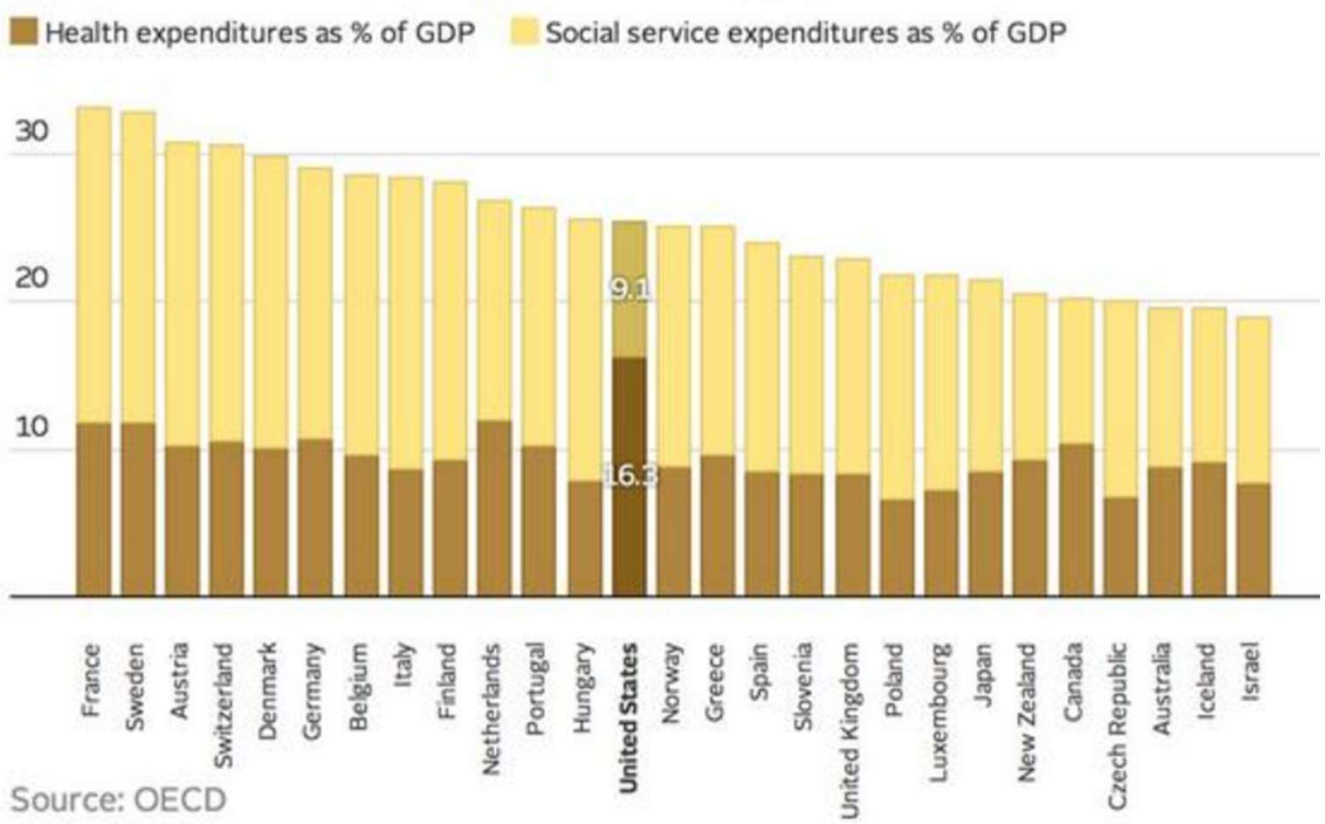
*Source: Zimmet Healthcare

Evolution of number of retirees per 100 working people



https://www.statista.com/chart/30831/evolution-of-the-number-of-retirees-per-100-working-people/

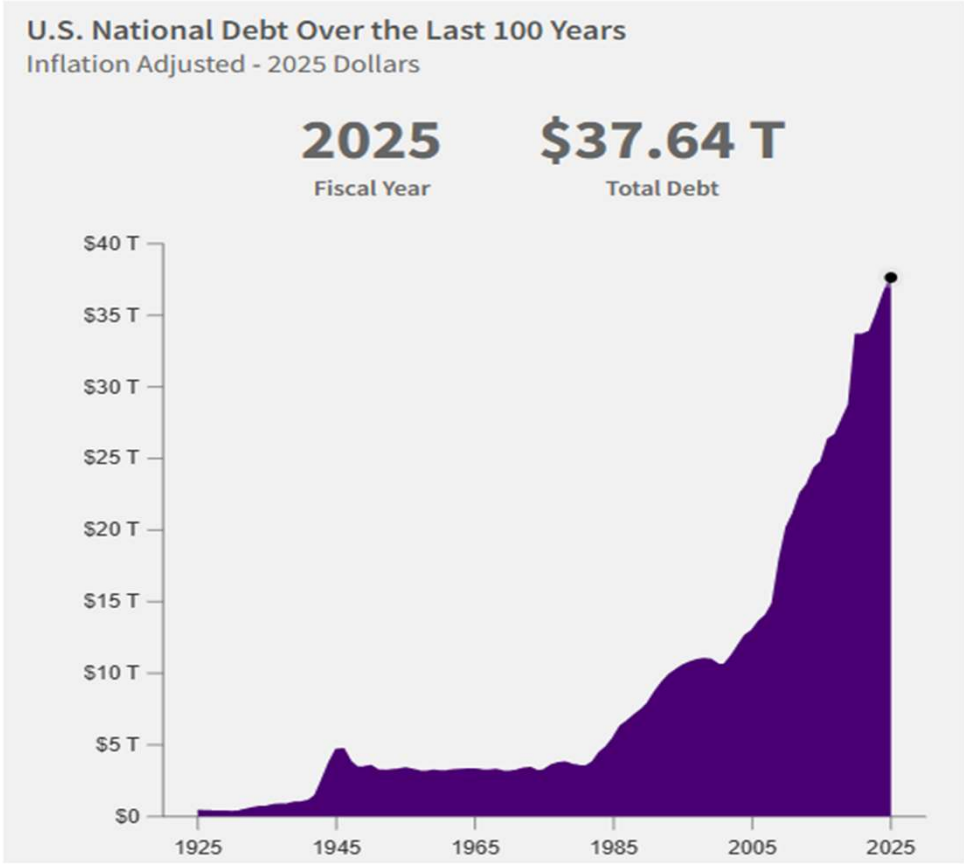
Health and Social Services Expendiutures



https://www.statista.com/chart/30831/evolution-of-the-number-of-retirees-per-100-working-people/

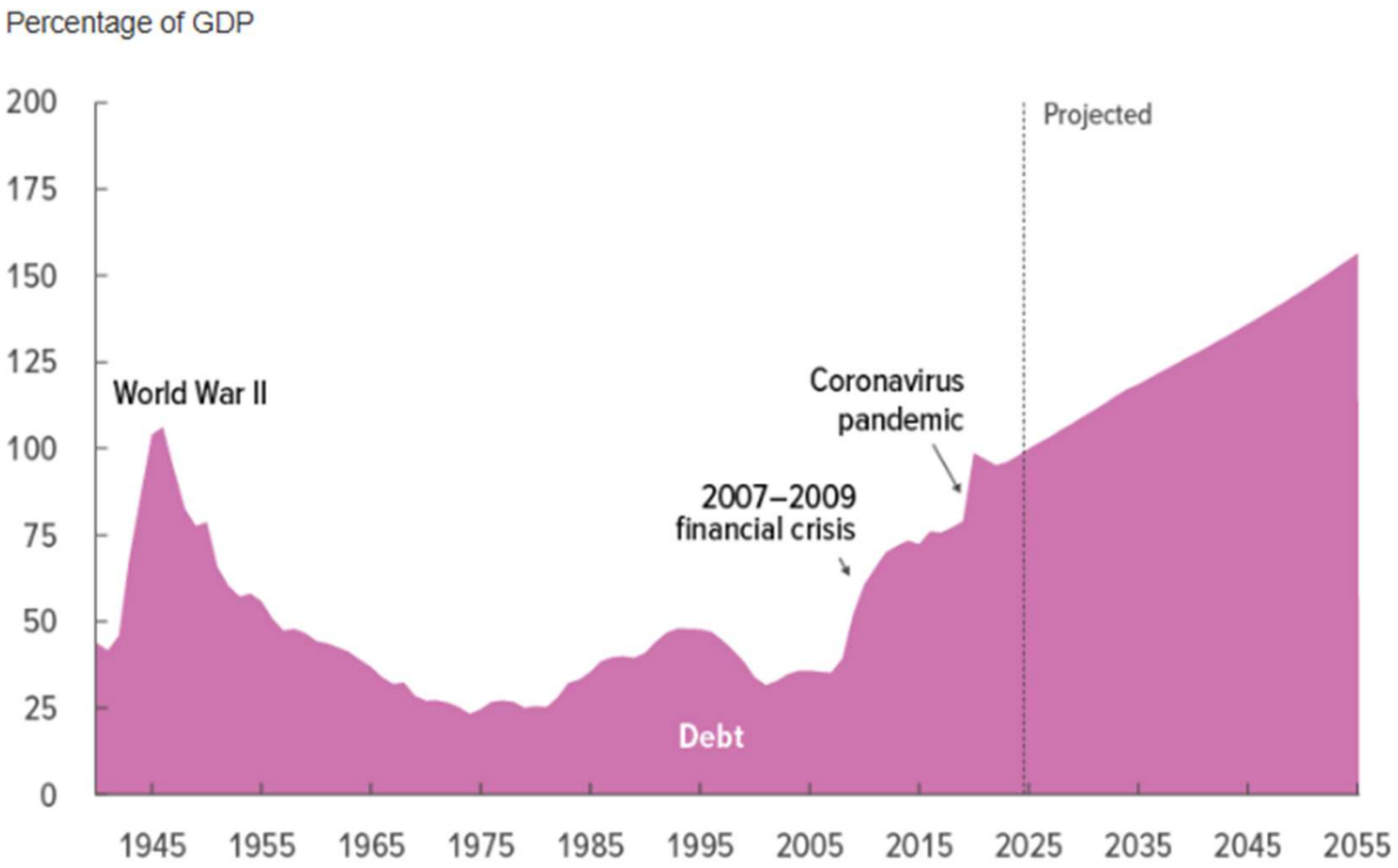
Increasing Federal Debt

- "If you had a stack of $1,000 bills in your hand only four inches high, you'd be a millionaire. A trillion dollars would be a stack of $1,000 bills sixty-seven miles high."
  - *President Ronald Regan*
- The current stack is 2,521.88 miles high
- That's about 10 times the Hight of the international space station

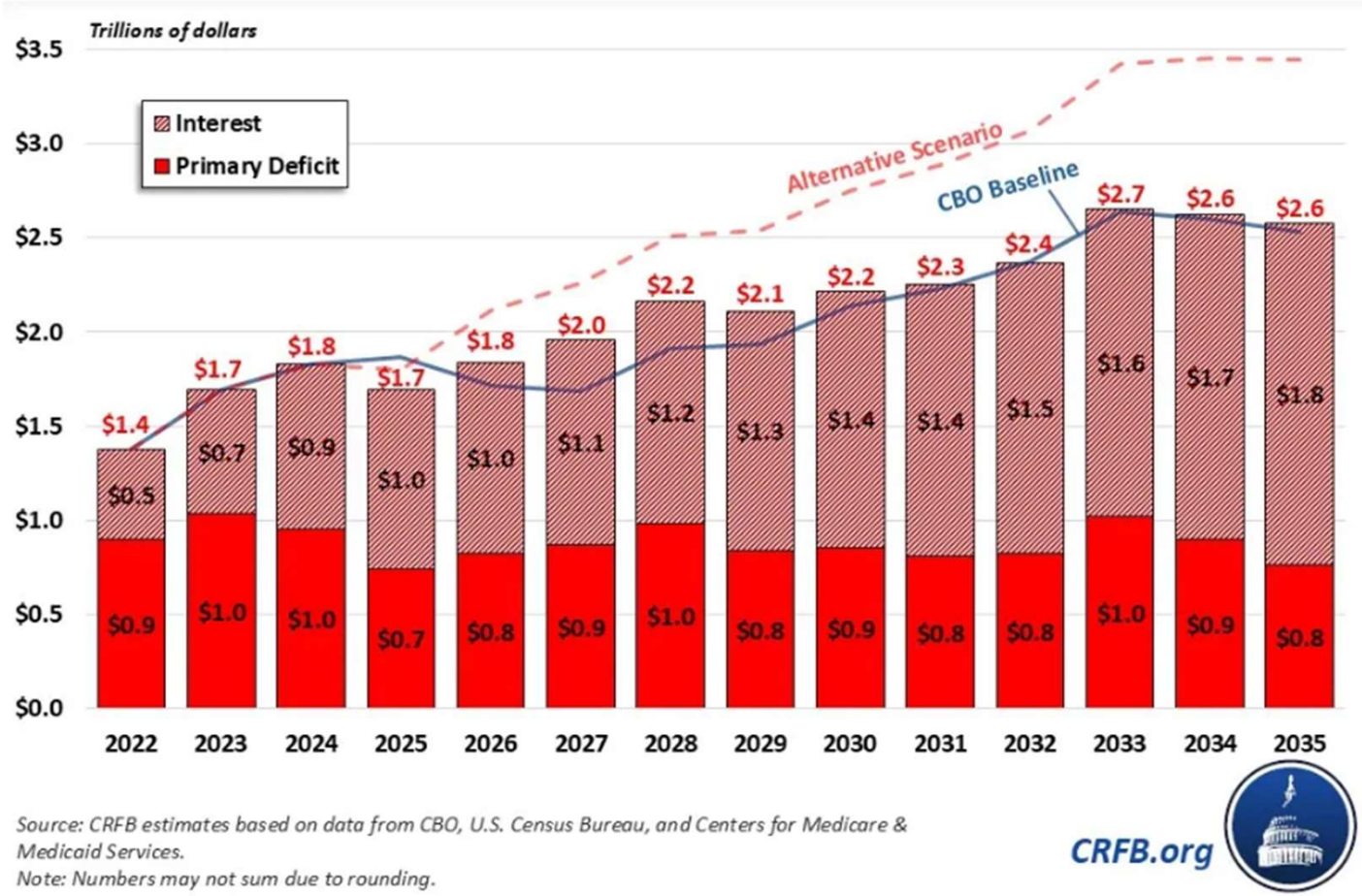


https://fiscaldata.treasury.gov/datasets/historical-debt-outstanding/historical-debt-outstanding

Federal Debt as a % of GDP



Growing Deficits



Source: CRFB estimates based on data from CBO, U.S. Census Bureau, and Centers for Medicare & Medicaid Services.
Note: Numbers may not sum due to rounding.

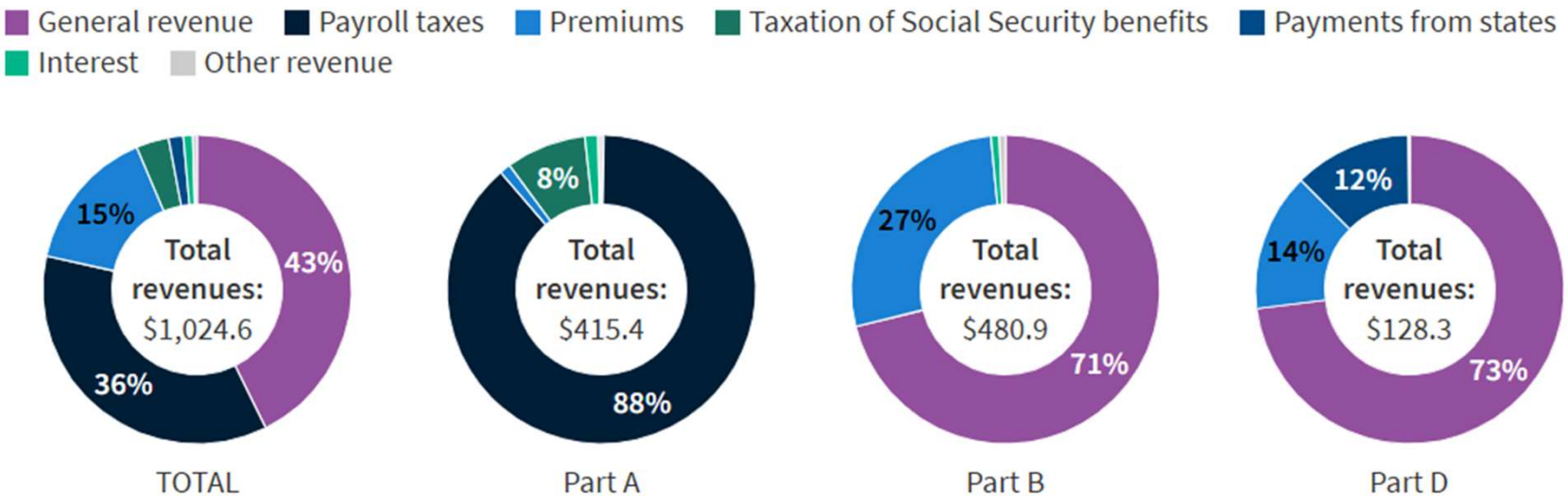
CRFB.org

Who Pays for Medicare?

Figure 1

Medicare Revenues Come from Different Sources, Primarily General Revenues, Payroll Taxes, and Premiums Paid by Beneficiaries

Revenues in billions for calendar year 2023, by source:



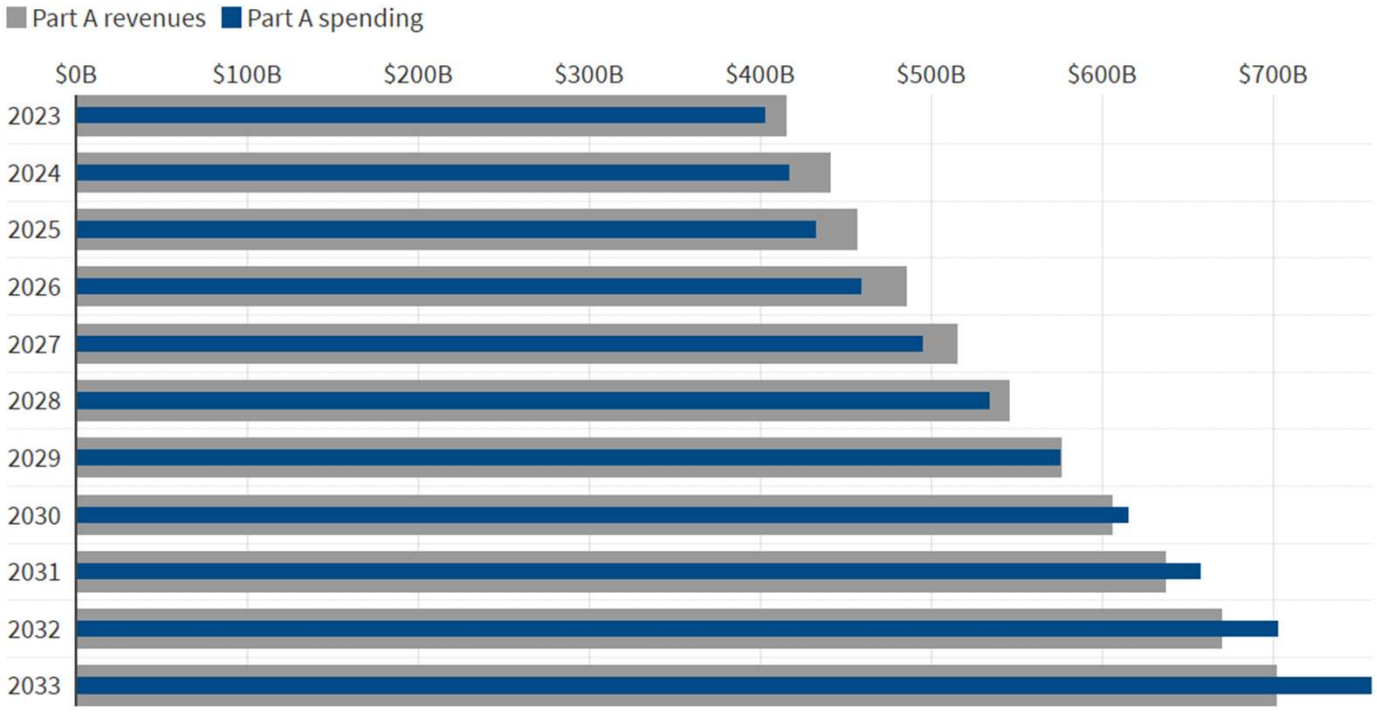
Source: KFF analysis of data from the 2024 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, Table II.B1, May 2024. • Get the data • Download PNG

KFF

Medicare Trust Fund

Figure 3

The Medicare Trustees Project that Part A Spending Will Exceed Revenues Beginning in 2030, Leading to a Gradual Depletion of Assets in the Part A Trust Fund by 2036

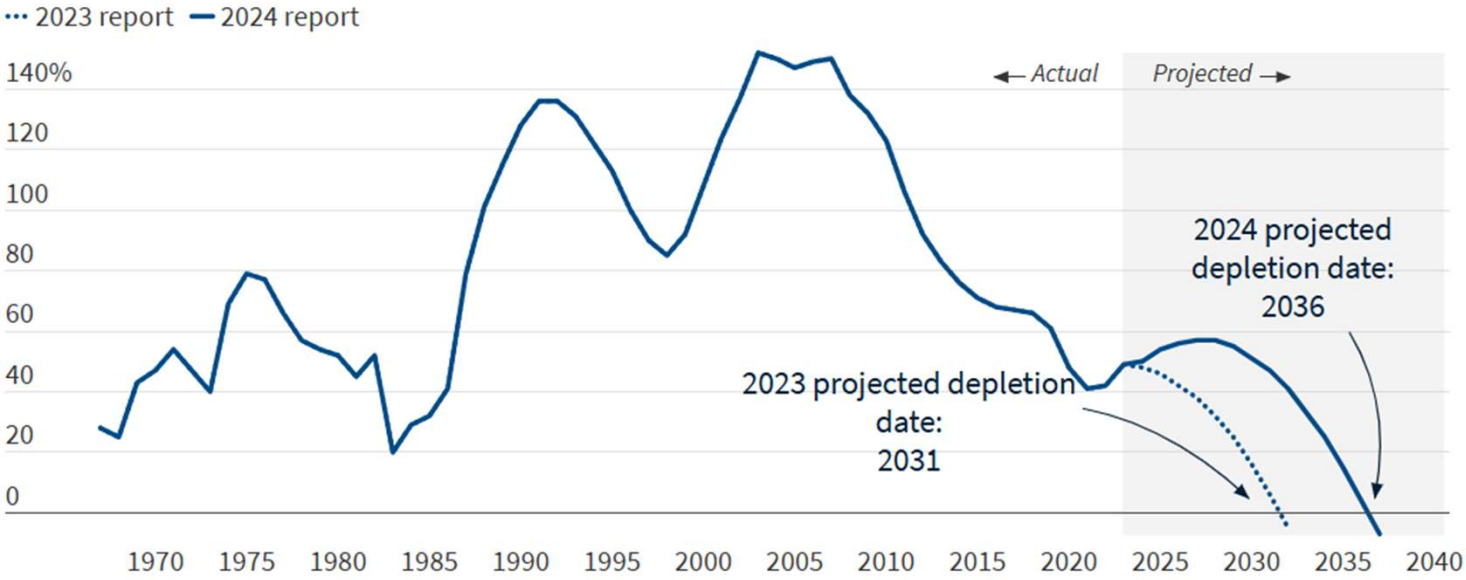


Medicare Trust Fund

Figure 2

The Medicare Trustees Currently Project Depletion of the Medicare Hospital Insurance Trust Fund in 2036, 5 Years Later than Their 2023 Projection

Ratio of assets at the beginning of the year to spending during the year for the HI trust fund



Note: Actual data through 2023.

Source: KFF analysis of data from the 2024 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, May 2024. • Get the data • Download PNG

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Medicare Trust Fund

Figure 21

The Medicare Hospital Insurance Trust Fund Reserves Are Projected to Be Depleted in 2033, Based on a Projection by Medicare's Actuaries

Report year	Year of depletion	Number of years to depletion
2010	2029	19
2011	2024	13
2012	2024	12
2013	2026	13
2014	2030	16
2015	2030	15
2016	2028	12
2017	2029	12
2018	2026	8
2019	2026	7
2020	2026	6
2021	2026	5
2022	2028	6
2023	2031	8
2024	2036	12
2025	2033	8

Source: KFF based on Part A trust fund depletion date projections from the 2010-2025 annual reports of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. • Get the data • Download PNG

KFF

Medicare Trust Fund

Market Insights – U.S.

	2019	2020	2021	2022	2023	2024	2025
Number of Certified SNFs	15,471	15,348	15,264	15,137	14,924	14,807	14,769
Licensed SNF Beds	1,643,567	1,634,737	1,624,102	1,610,957	1,603,952	1,581,039	1,576,551
SNF Occupancy %	80.70%	72.70%	69.80%	73.20%	75.70%	-	-
Relative Occupancy	79.80%	71.50%	68.20%	71.00%	73.10%	-	-
Medicare Part A Share	11.60%	12.80%	12.40%	12.50%	11.60%	-	-
Medicaid Share	58.40%	58.60%	58.70%	57.80%	59.30%	-	-
Other Share	30.00%	28.50%	28.70%	29.30%	29.10%	-	-
Medicare ALOS (days)	25.4	28.5	29.6	26.3	29.6	30.8	-
Medicare Advantage Enrollment %	38.10%	40.70%	44.00%	46.70%	49.20%	50.80%	-
Medicare Advantage Growth Rate	5.00%	6.80%	8.10%	6.10%	5.40%	3.30%	-
Total ISNP Enrollment	97,620	92,059	94,872	105,878	119,425	126,473	122,083
SNF Ownership Changes	637	478	666	773	858	154	-

Source: CMS
Contextualized by ZHSG for:

z-INTEL

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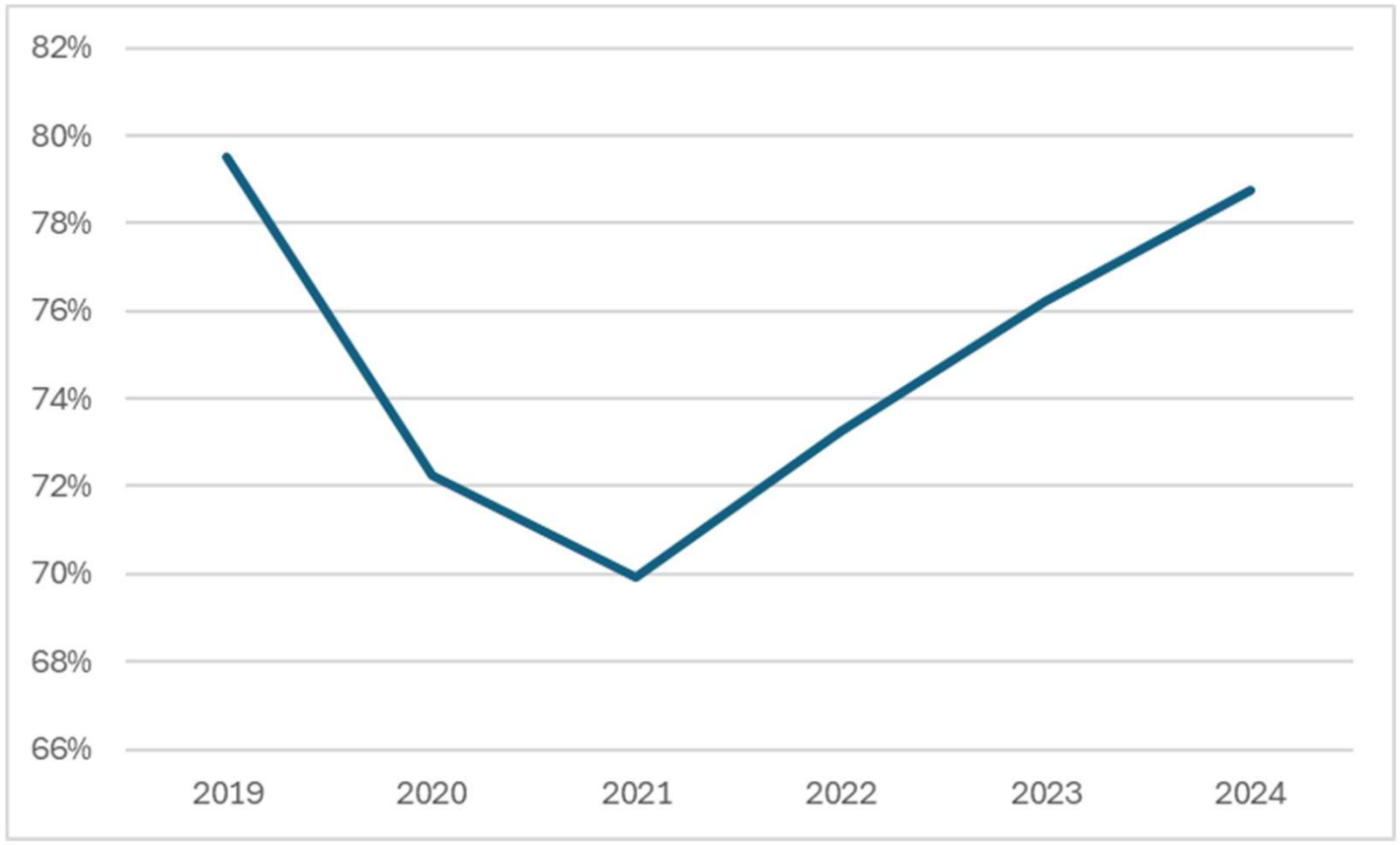
US SNF OCCUPANCY- Cost Report



Source: CMS
Contextualized by ZHSG for:

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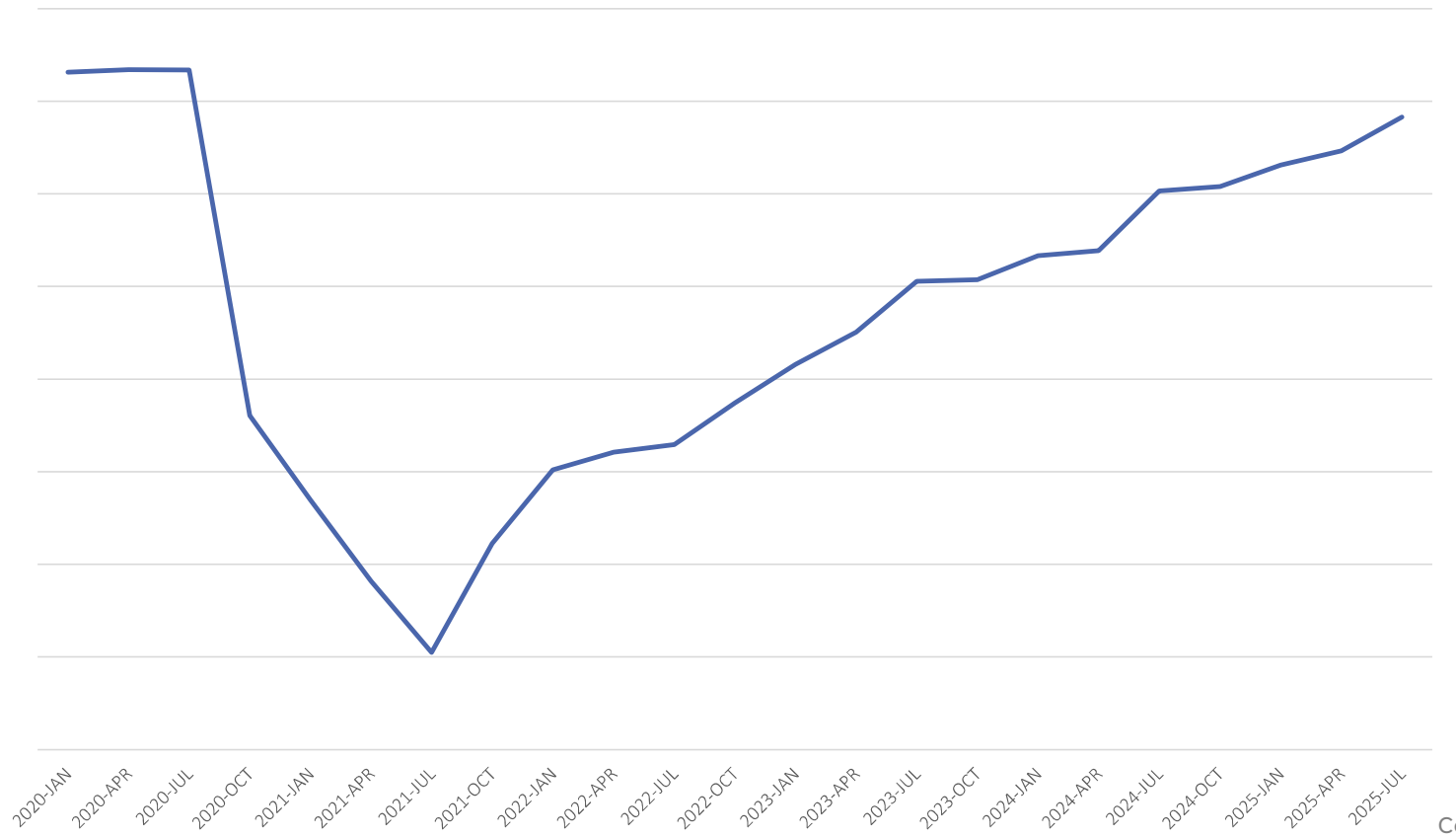
US SNF OCCUPANCY- PBJ& Provider Info Files



Source: CMS
Contextualized by ZHSG for:

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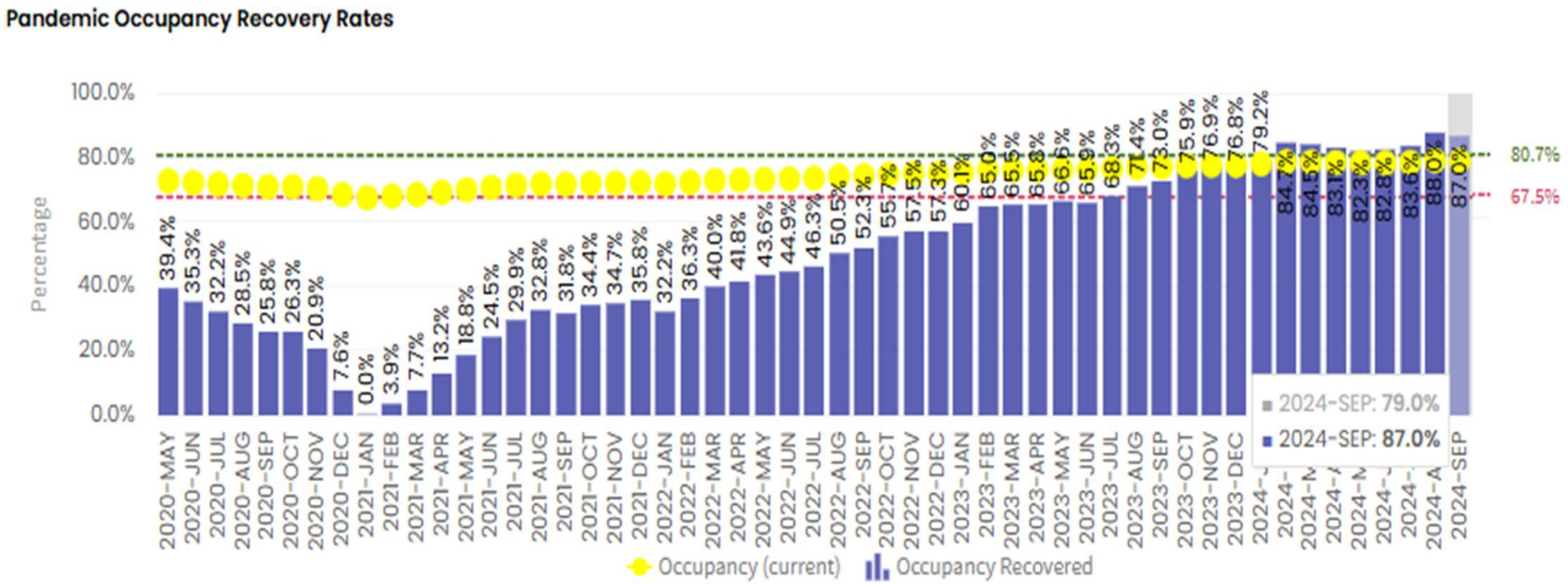
US SNF OCCUPANCY Recovery 5/20 to 9/24 CDC Data



CMS
Contextualized by ZHSG for:

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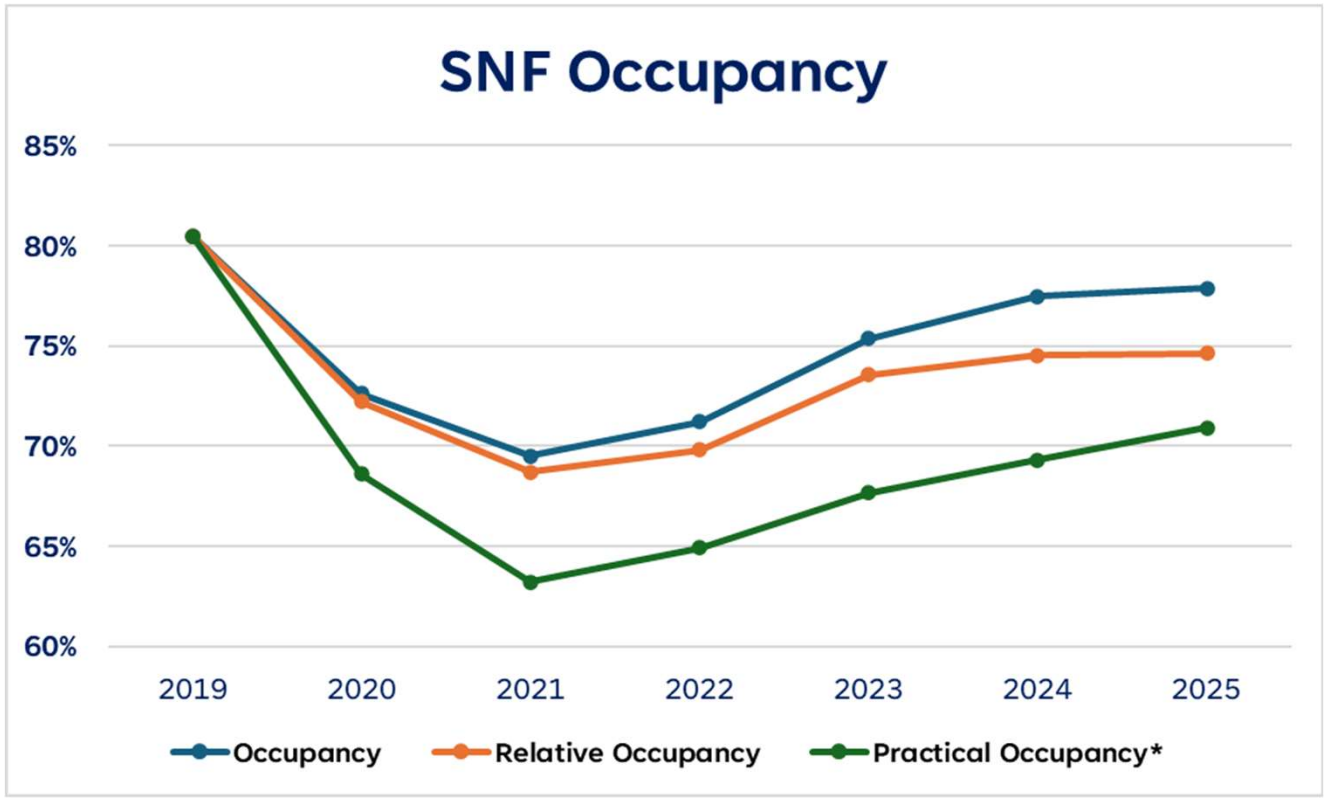
Nominal vs. Relative vs. Practical Occupancy



* estimate based on informal analysis

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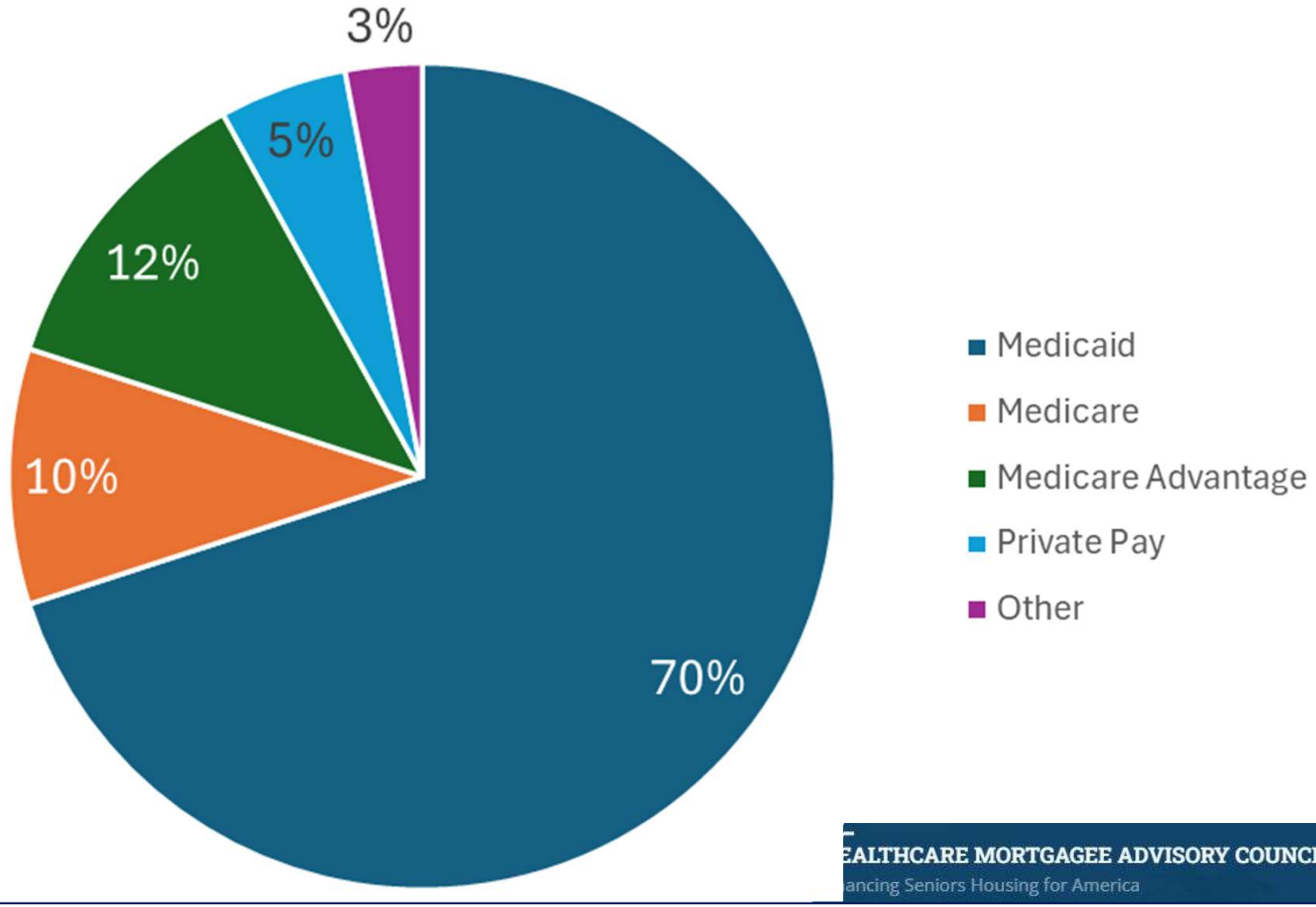
Typical Nursing Home Payer Mix – By Day of Care

We don't use "average" here because of data distortion. Typical is more Illustrative



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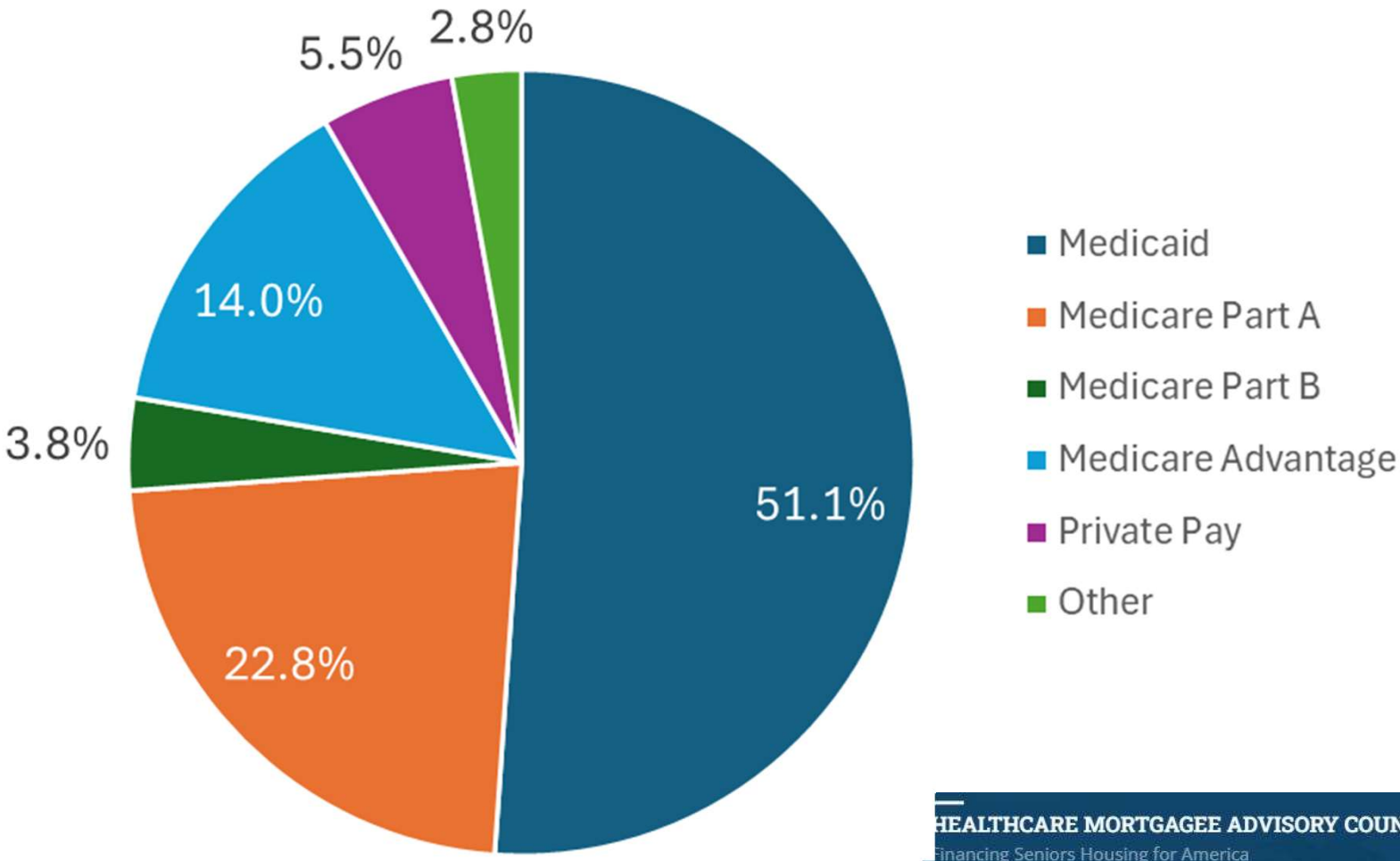
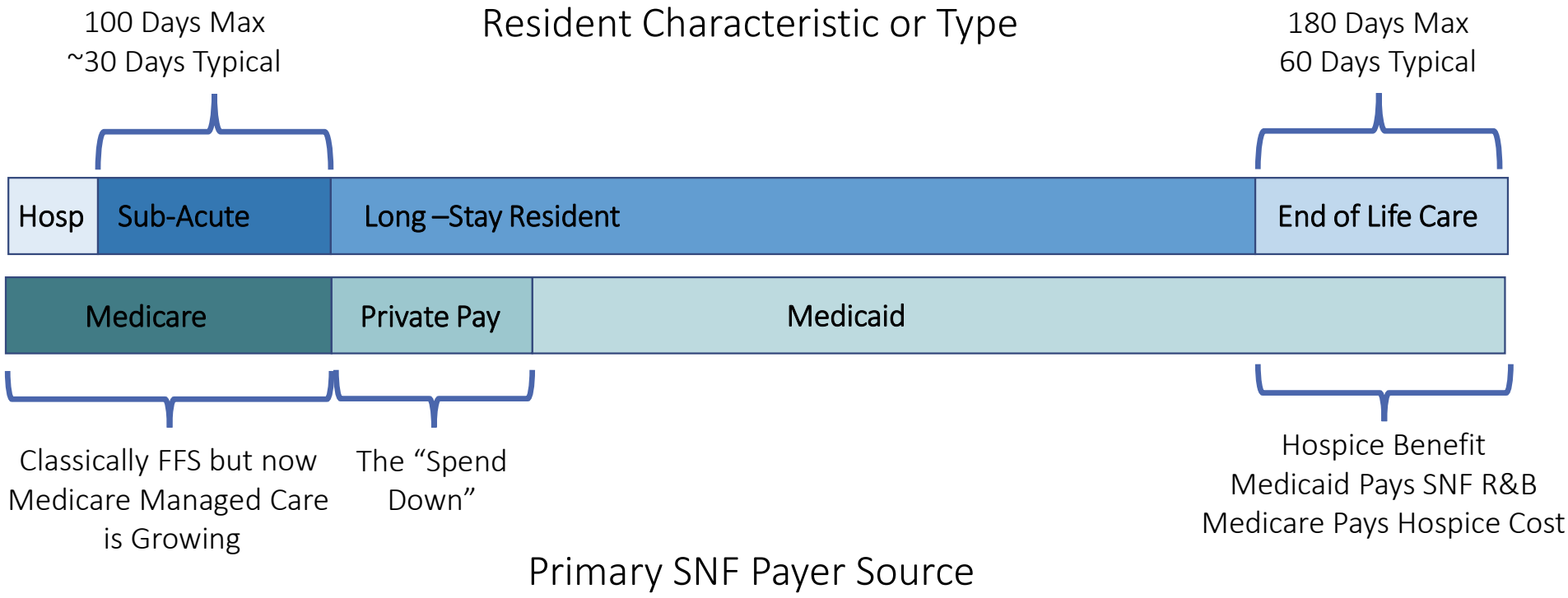
Typical Nursing Home Payer Mix – By $

We don't use "average" here because of data distortion. Typical is more Illustrative

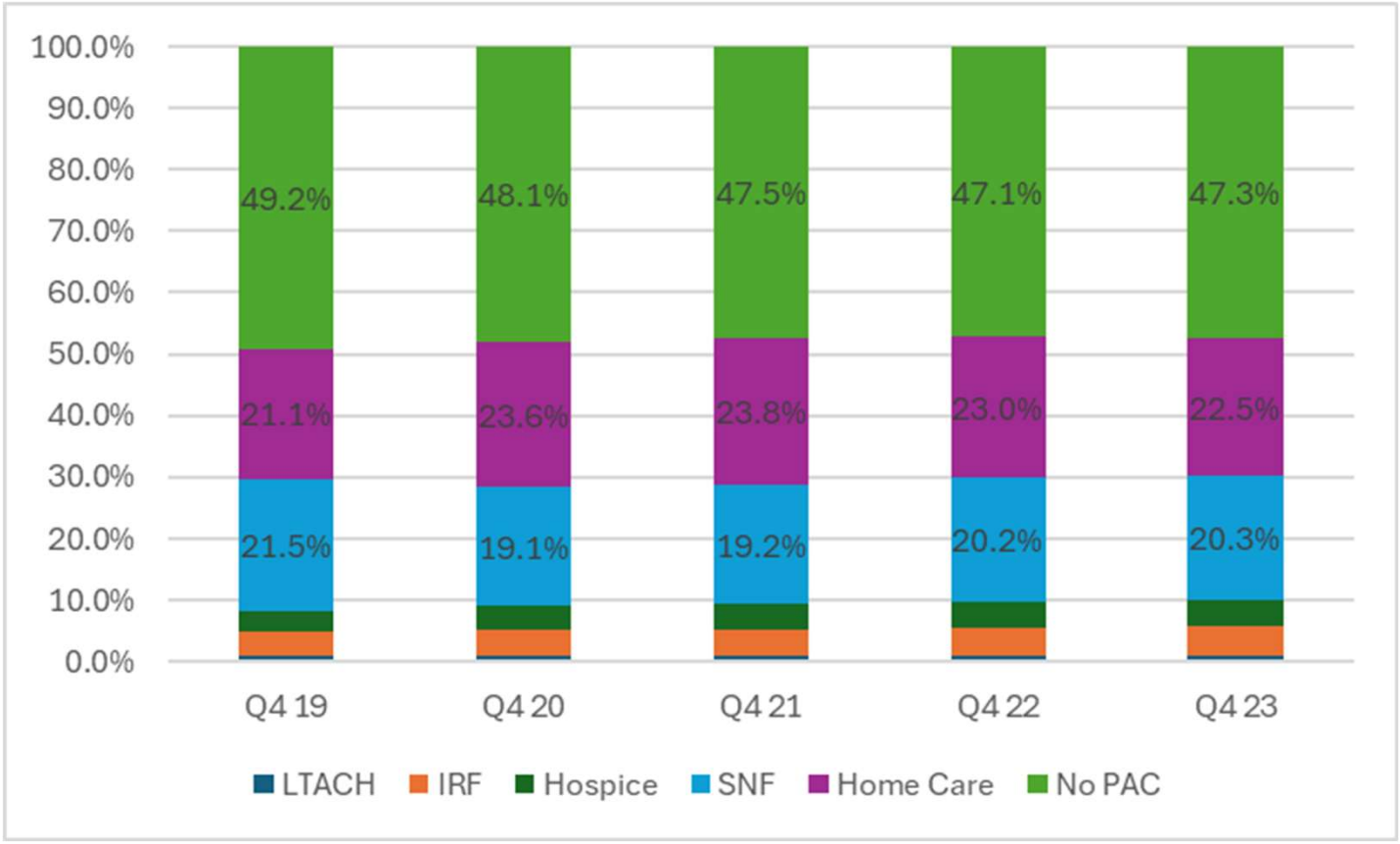


The “Traditional” or Classic Resident Progression*

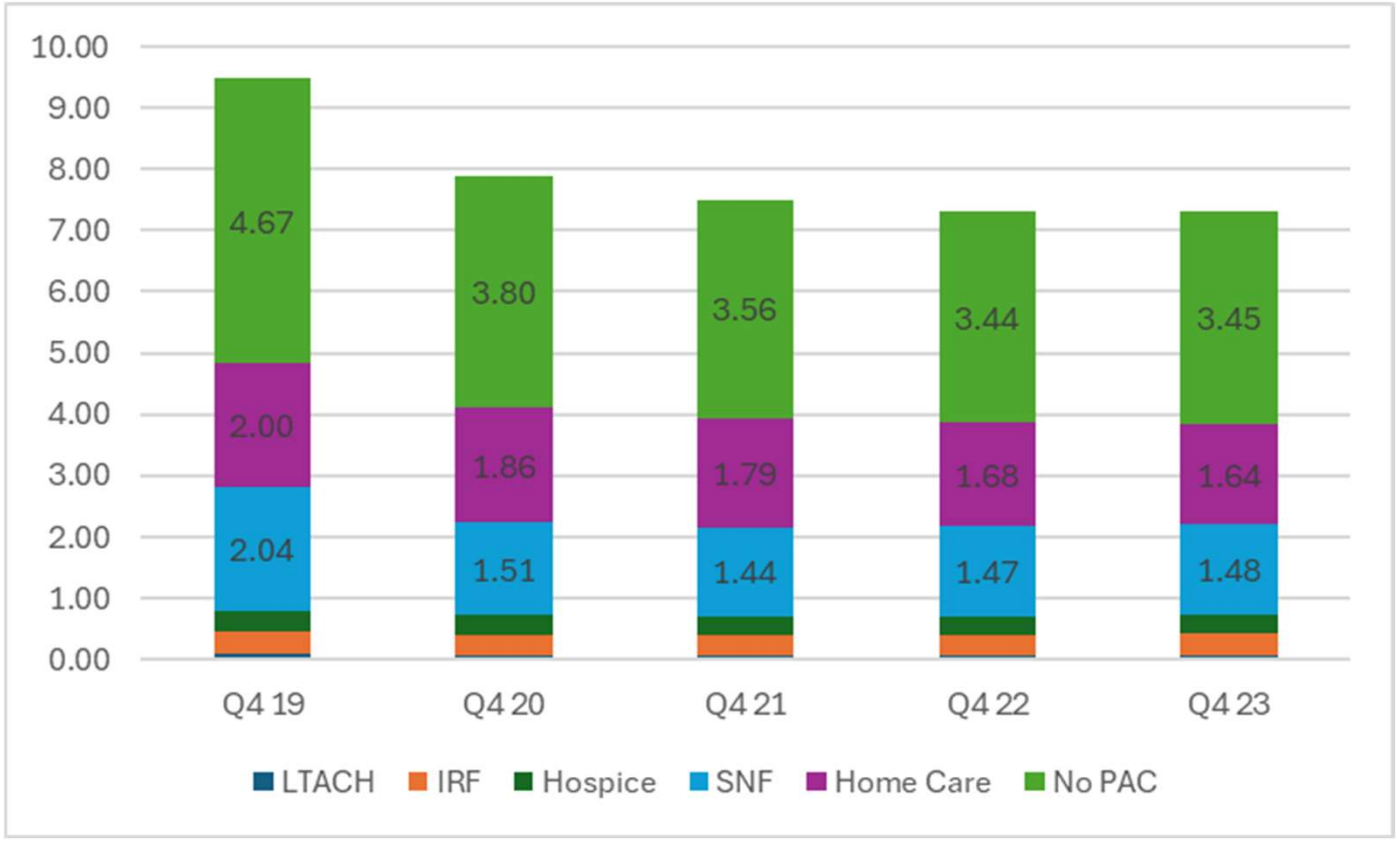
***not to scale**



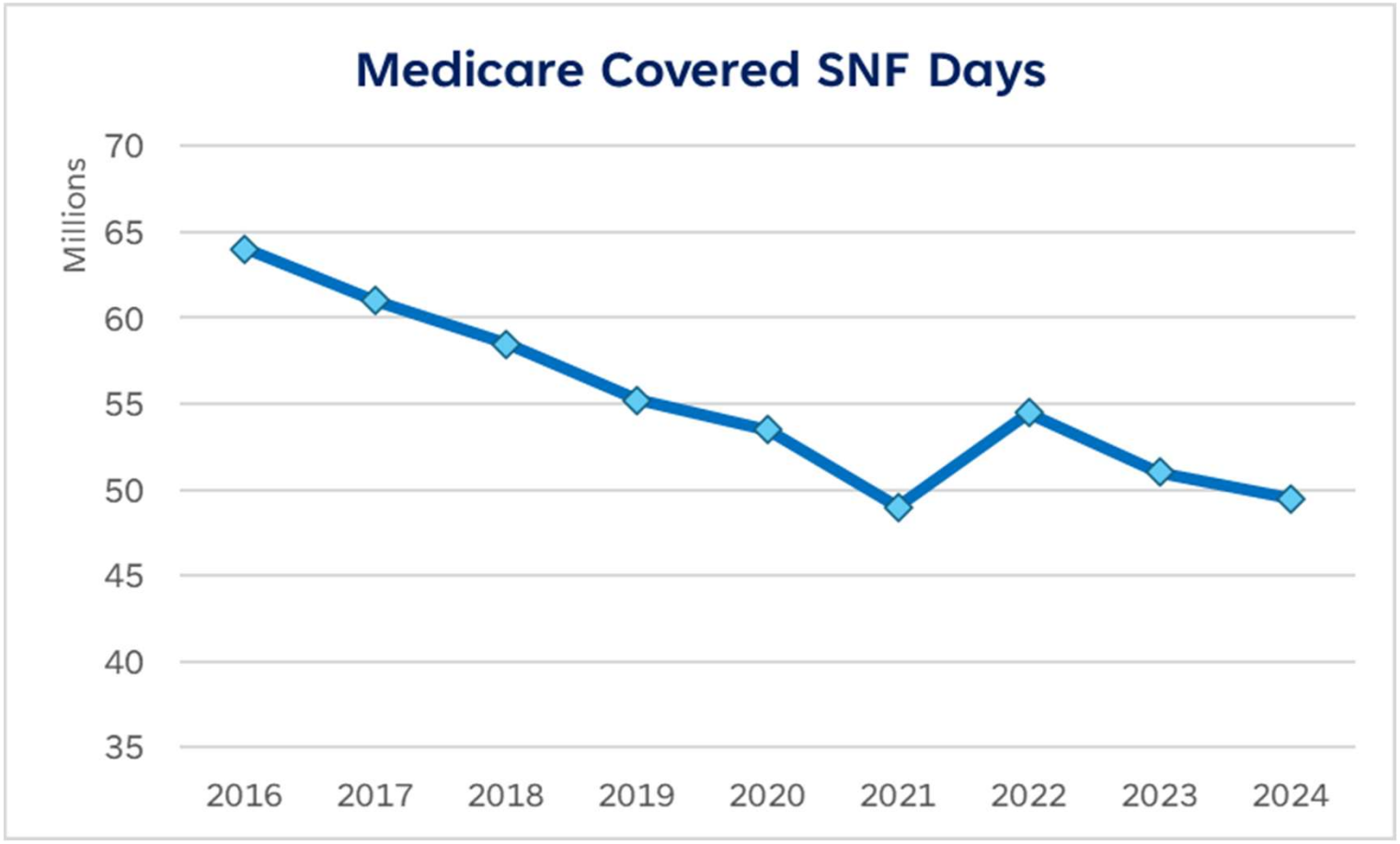
Medicare Discharges



Medicare Discharges – In Millions



Declining Medicare Utilization



Source: HCRIS

Medicare Rate Estimation – Chester County PA

Medicare Trailing 12 Utilization

Month	Revenue	Days	Avg. Rate
9/2024	$329,477	475	$693.64
10/2024	$379,916	551	$689.50
11/2024	$276,669	376	$735.82
12/2024	$225,887	298	$758.01
1/2025	$207,888	304	$683.84
2/2025	$188,603	260	$725.40
3/2025	$417,536	568	$735.10
4/2025	$402,111	559	$719.34
5/2025	$423,391	603	$702.14
6/2025	$417,392	612	$682.01
7/2025	$530,088	721	$735.21
8/2025	$504,475	692	$729.01
Trailing 12 Months	$4,303,435	6,019	$714.98
Trailing 6 Months	$2,694,994	3,755	$717.71
Trailing 3 Months	$1,451,955	2,025	$717.02

Source: Compiled by JLL

Conversion of 2024 to 2025

Weighted Avg Rate Prior to 9/30/24		$693.64
Non Labor Portion (29%)		$201.15
Labor Portion (71%)		$492.48
2024 Wage Index	0.9851	
2025 Wage Index	0.9722	
Difference	0.9869	
Adjusted Labor		$486.03
Adjusted 24 Rate to 25 For Wage Index		$687.19
2025 Rate Increase		1.042
Adjusted 2024 Rate to 2025		$716.05
2024 Days		475
2024 Adj Revenue to 2025		$340,123

Source: Compiled by JLL

Estimated FY 2026 Medicare Rate

Adjusted 2024 Revenue		$340,123
2025 Revenue		$3,973,958
Total Trailing 12 Adj to 25		$4,314,081
Total Days		6,019
2025 Adjusted Rate		$716.74
Non Labor Portion (29%)		$207.86
Labor Portion (71%)		$508.89
2025 Wage Index	0.9722	
2026 Wage Index	0.9618	
Difference	0.9893	
Adjusted Labor		$503.44
Adjusted 25 Rate to 26 For Wage Index		$711.30
2026 Rate Increase		1.032
Adjusted 2025 Rate to 2026		**734.06**

Source: Compiled by JLL

Wage Index Change	-1.1%
Percentage Increase over T12	2.7%

Medicare Rate Estimation – Kent County, DE

Medicare Trailing 12 Utilization

Month	Revenue	Days	Avg. Rate
8/2024	$316,771	430	$736.68
9/2024	$266,812	360	$741.14
10/2024	$301,749	385	$783.76
11/2024	$306,499	403	$760.54
12/2024	$255,730	351	$728.58
1/2025	$277,984	372	$747.27
2/2025	$321,327	417	$770.57
3/2025	$348,568	456	$764.40
4/2025	$471,518	608	$775.52
5/2025	$529,493	700	$756.42
6/2025	$296,042	386	$766.95
7/2025	$470,323	612	$768.50
Trailing 12 Months	$4,162,816	5,480	$759.64
Trailing 6 Months	$2,437,271	3,179	$766.68
Trailing 3 Months	$1,295,858	1,698	$763.17

Source: Compiled by JLL

Conversion of 2024 to 2025

Weighted Avg Rate Prior to 9/30/24		$738.71
Non Labor Portion (29%)		$214.23
Labor Portion (71%)		$524.49
2024 Wage Index	1.0899	
2025 Wage Index	1.1154	
Difference	1.0234	
Adjusted Labor		$536.76
Adjusted 24 Rate to 25 For Wage Index		$750.98
2025 Rate Increase		1.042
Adjusted 2024 Rate to 2025		$782.53
2024 Days		790
2024 Adj Revenue to 2025		$618,195

Source: Compiled by JLL

Estimated FY 2026 Medicare Rate

Adjusted 2024 Revenue		$618,195
2025 Revenue		$3,579,233
Total Trailing 12 Adj to 25		$4,197,428
Total Days		5,480
2025 Adjusted Rate		$765.95
Non Labor Portion (29%)		$222.13
Labor Portion (71%)		$543.83
2025 Wage Index	1.1154	
2026 Wage Index	1.1673	
Difference	1.0465	
Adjusted Labor		$569.13
Adjusted 25 Rate to 26 For Wage Index		$791.26
2026 Rate Increase		1.032
Adjusted 2025 Rate to 2026		**816.58**

Source: Compiled by JLL

Wage Index Change	4.7%
Percentage Increase over T12	7.5%

Medicare Cost Reports

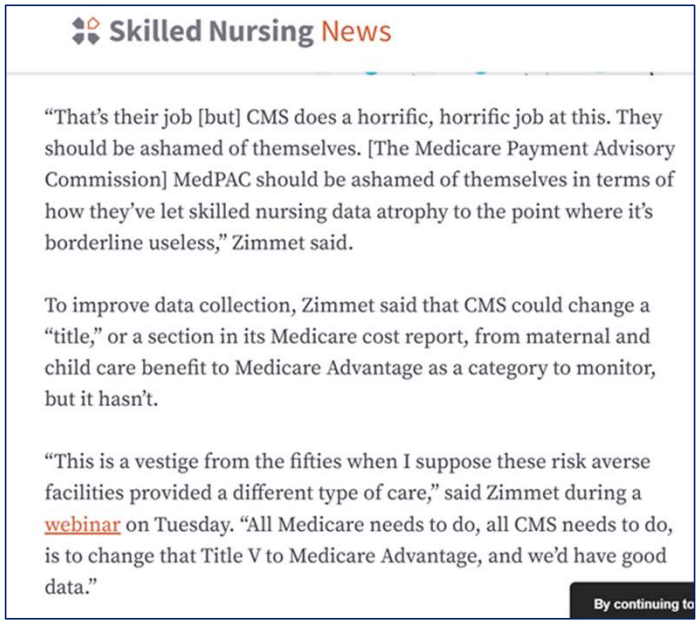
- Changes after 9/30/25 may improve financial reporting and your ability to model.
- Success depends on Providers compliance with the new rules.
- Timing for new data will be 2026-2027.

• Cost Reporting

- Basis for all rate setting (facility-specific until 1999).
- Medicare 2540-10 (“MCR”) required annually; State reporting varies.
- Accuracy and consistency are essential.
- CMS uses cost reports for policy and rate development

Skilled Nursing has a cost reporting problem.

- Inconsistent, non-comparable, inaccurate but not irrelevant
- Unsuitable in form for modern healthcare dynamics.
- SNF is a singular certification; profile does not matter.
- Cost allocations distorted by non-SNF programs.
- State regs differ; trickles down to the MCR.
- Unaudited except for Medicare Reimbursable Bad Debt.



Skilled Nursing News

“That’s their job [but] CMS does a horrific, horrific job at this. They should be ashamed of themselves. [The Medicare Payment Advisory Commission] MedPAC should be ashamed of themselves in terms of how they’ve let skilled nursing data atrophy to the point where it’s borderline useless,” Zimmet said.

To improve data collection, Zimmet said that CMS could change a “title,” or a section in its Medicare cost report, from maternal and child care benefit to Medicare Advantage as a category to monitor, but it hasn’t.

“This is a vestige from the fifties when I suppose these risk averse facilities provided a different type of care,” said Zimmet during a webinar on Tuesday. “All Medicare needs to do, all CMS needs to do, is to change that Title V to Medicare Advantage, and we’d have good data.”

By continuing to

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Medicare Cost Report: CMS 2540-10

PERIOD:
FROM 01/01/2024
TO 12/31/2024

WORKSHEET S-3 PART I

PART I - STATISTICAL DATA

	Component	Number of Beds	Bed Days Available	Inpatient Days / Visits: Title V	Title XVIII	Title XIX	Other	Total
		1	2	3	4	5	6	7
1	Skilled Nursing Facility	120	43,920		2,340	31,491	7,195	41,026

Title V Days

2020	2021	2022	2023	2024
128,279	516,107	1,557,845	6,977	7,018
-26.6%	302.3%	201.8%	-99.6%	0.6%

Medicare: Title XVIII
Medicaid: Title XIX

Occupancy:	93.4%
ADC:	112.1
Medicare Share:	5.7%
Medicaid Share:	76.7%

Other:
- Private Pay
- Medicare Advantage
- Commercial, No-Fault
- LTC Insurance
- ISNP replacement
- VA, Hospice GIP, BL

Medicare Advantage: *Other*

Managed Medicaid: *Medicaid*

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Medicare Cost Report: CMS 2540-10

PERIOD:
FROM 01/01/2024
TO 12/31/2024

WORKSHEET S-3 PART I

PART I - STATISTICAL DATA

Component		Number of Beds	Bed Days Available	Inpatient Days / Visits					Discharges					Average Length of Stay				Admissions				
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	Skilled Nursing Facility	120	43,920		2,340	31,491	7,195	41,026		60	29	144	233		39	1,086	176		71	13	148	232

Component		Number of Beds	Bed Days Available	Inpatient Days / Visits					Discharges					Average Length of Stay				Admissions				
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	Skilled Nursing Facility	29,111	10,654,626		4,452	38,558	8,787	51,797		161	85	325	571		28	454	91		238	49	301	588

Medicare ALOS (Cost Report)	39.0
Medicare ALOS (Claims)	22.3

Medicare Cost Report Changes

- CMS has updated the SNF Medicare Cost Report for the first time in 15 years.
- The new form is to be used for reporting periods ending on or after 9/30/25.
- SNFs should now capture this information in their revenue cycle and financial systems.
- CMS intends the cost report changes to give them:
  - SNF Market Basket modeling (yes)
  - SNF wage index (not likely)
  - Payer specific data for Medicare Advantage and Managed Medicaid (yes).

Medicare Cost Report Changes

To do this, CMS has made substantial modifications:

- Separate reporting of Medicare Advantage/Medicare HMO days, Medicaid HMO days, admissions, and discharges.

- Reporting of room and ancillary revenue separately for Medicaid HMO and Medicare Advantage separately.

Medicare Cost Report Content:

- Facility characteristics
- Utilization data
- Financial Statement Data
- Cost and charges by cost center
  - In Total
  - For Medicare
  - **And now for Medicare Advantage**

Medicare Cost Report Changes

The following will be reported separately (on their own lines):

- Quality Assurance and Performance Improvement (QAPI) costs.
- Training and In-Service Education including Nurse Aide Training and Competency Evaluation Program (NATCEP).
- Patient Transportation for Part A .
- IV therapy costs for administering IV fluids, drugs, or blood products will be reported separately from drug and supply costs .
- IV solutions costs will be separated from other drug or supply costs.
- Preventative (not therapeutic) pneumococcal, influenza, or COVID-19 vaccines and monoclonal antibody products for treating residents will be reported in a new Preventative Vaccines line.

Key Worksheet Changes – Old to New

Form CMS-2540-10	Form CMS-2540-24	Summary of Changes
Worksheet S-3, Parts I, II, III, IV, & V	Worksheet S-3, Parts I, II, III, IV, & V	• Revised Worksheet S-3. Part I to collect Medicare and Medicaid HMO inpatient days and discharges. • Revised S-3, Part V, to reflect previous iteration but added data collection for Home Office/Chain Organization direct care expenditures.
Worksheet S-4	Worksheet S-4 Parts I, II, III, and IV	• Revised form for reporting HHA data consistent with the freestanding HHA, Form CMS-1728-20.
Worksheet S-5	• Eliminated obsolete worksheet – Not SNF related	
Worksheet S-6	• Eliminated obsolete worksheet – Not SNF related	

Medicare Cost Report – New S-3 Part I

HEALTHCARE MORTGAGEE ADVISORY COUNCIL
Financing Seniors Housing for America

10-24 FORM CMS-2540-24 4995 (CONT.)

STATISTICAL DATA | PROVIDER CCN: | PERIOD: FROM: _____ TO: _____ | WORKSHEET S-3 PART I

PART I - VISITS AND CENSUS DATA

		NUMBER OF BEDS	BED DAYS AVAILABLE	INPATIENT DAYS					DISCHARGES					
				TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	5	6	7	8	9	10	11	12	
1	SNF - FFS													1
2	SNF - HMO													2
3	NF - FFS													3
4	NF - HMO													4
5	ICF/IID													5
6	HOSPICE													6
7	TOTAL													7

		AVERAGE LENGTH OF STAY					ADMISSIONS					FTE		
		TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	EMPLOYEE	NON-PAID	
		13	14	15	16	17	18	19	20	21	22	23	24	
1	SNF - FFS													1
2	SNF - HMO													2
3	NF - FFS													3
4	NF - HMO													4
5	ICF/IID													5
6	HOSPICE													6
7	TOTAL													7

RECLASSIFICATION AND ADJUSTMENT
OF TRIAL BALANCE OF EXPENSES-

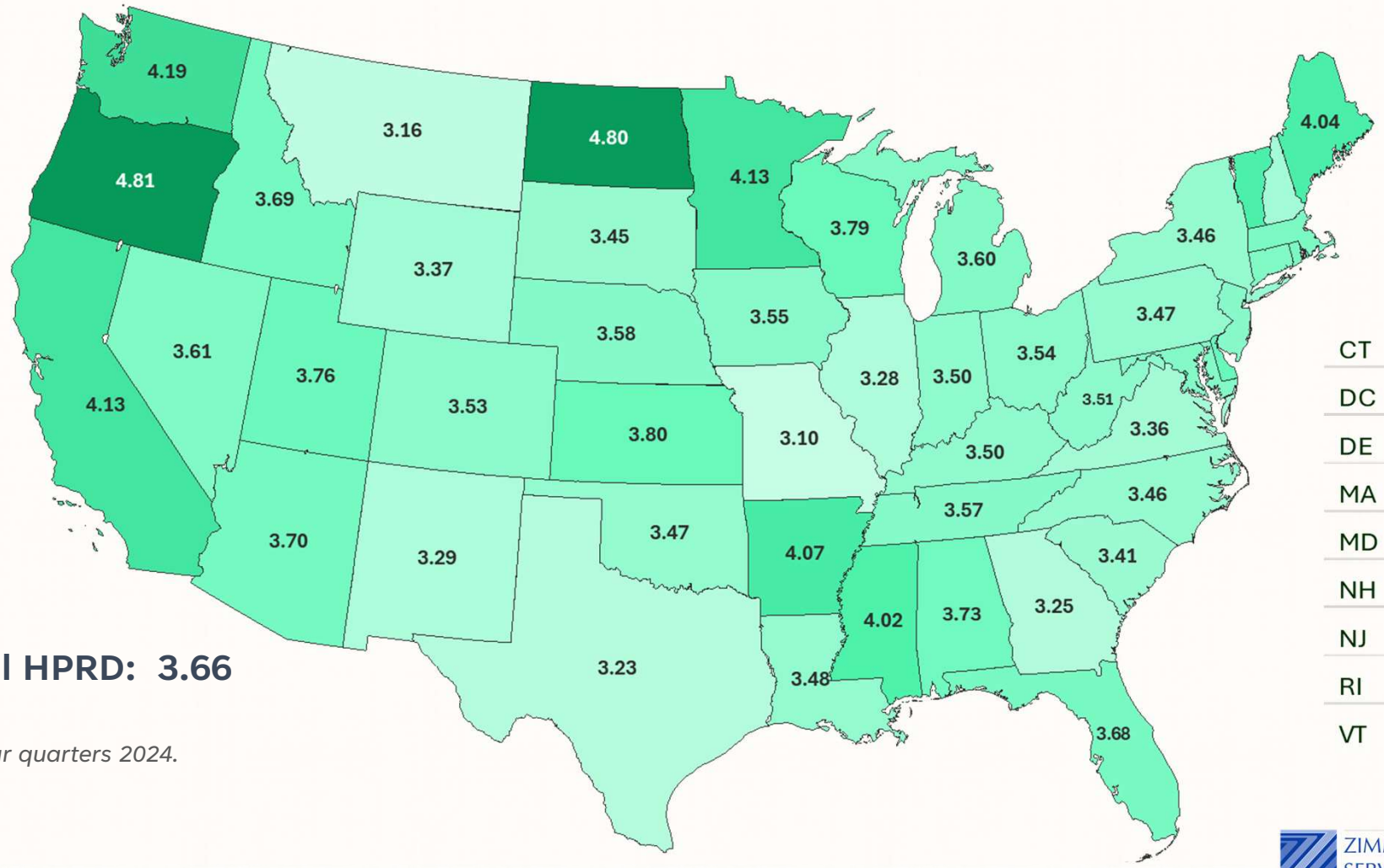
		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)
A	B	C	1	2	3
GENERAL SERVICE COST CENTERS					
1	0100	Capital-Related Costs - Buildings & Fixtures		5,844,995	5,844,995
2	0200	Capital-Related Costs - Moveable Equipment			
3	0300	Employee Benefits		5,454,112	5,454,112
4	0400	Administrative and General	294,219	6,635,810	6,930,029
5	0500	Plant Operation, Maintenance and Repairs	256,999	1,282,457	1,539,456
6	0600	Laundry and Linen Service		360,456	360,456
7	0700	Housekeeping	876,941	217,825	1,094,766
8	0800	Dietary	1,137,152	1,279,313	2,416,465
9	0900	Nursing Administration			
10	1000	Central Services and Supply			
11	1100	Pharmacy			
12	1200	Medical Records and Library			
13	1300	Social Service	403,733	532,592	936,325
14	1400	Nursing and Allied Health Education			
15		Other General Service Cost			
INPATIENT ROUTINE SERVICE COST CENTERS					
30	3000	Skilled Nursing Facility	7,391,053	4,205,282	11,596,335

SNF REPORTING OF DIRECT CARE EXPENDITURES

	OCCUPATIONAL CATEGORY	Amount Reported
		1
Direct Salaries		
	Nursing Occupations	
1	Registered Nurses (RNs)	1,231,152
2	Licensed Practical Nurses (LPNs)	1,655,895
3	Certified Nursing Assistants/Nursing Assistants/Aides	3,552,184
4	Total Nursing (sum of lines 1 through 3)	6,439,231
Contract Labor		
	Nursing Occupations	
14	Registered Nurses (RNs)	18,060
15	Licensed Practical Nurses (LPNs)	1,425,904
16	Certified Nursing Assistants/Nursing Assistants/Aides	1,873,446
17	Total Nursing (sum of lines 14 through 16)	3,317,410

Direct Care Differential: 99.1% **11,596,335** **9,756,641**

2024 PBJ HPRD



CT	3.62
DC	4.14
DE	3.80
MA	3.65
MD	3.59
NH	3.35
NJ	3.57
RI	3.65
VT	4.03

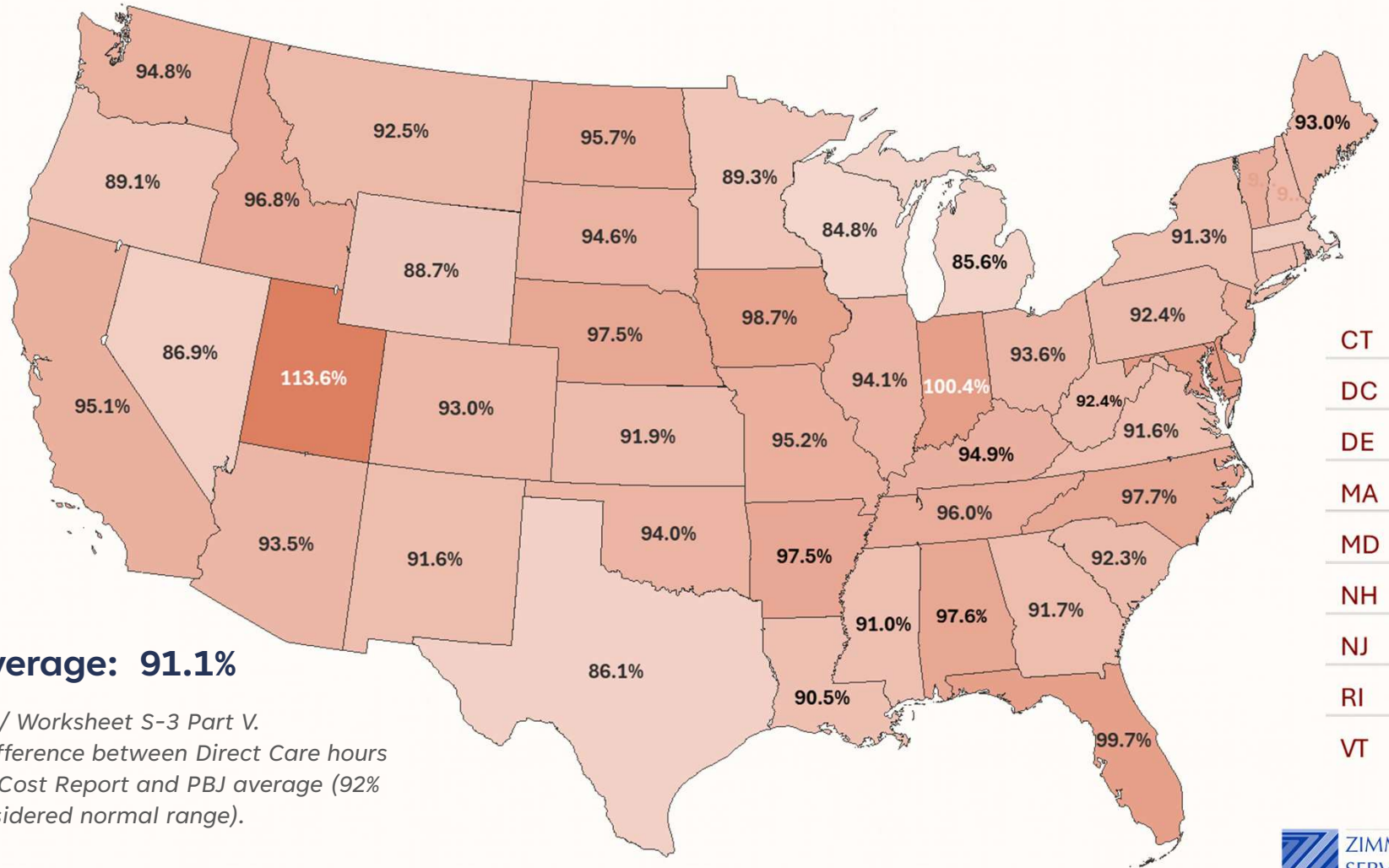
National HPRD: 3.66

Average four quarters 2024.

Source: CMS PBJ ; Contextualized by ZHSG

ZIMMET HEALTHCARE SERVICES GROUP, LLC

2024 Direct Care Differential



CT	92.0%
DC	96.4%
DE	104.0%
MA	88.0%
MD	101.5%
NH	92.4%
NJ	95.5%
RI	91.3%
VT	95.6%

State Average: 91.1%

= PBJ HPRD / Worksheet S-3 Part V. Measures difference between Direct Care hours reported on Cost Report and PBJ average (92% - 95% is considered normal range).

Source: HCRIS & PBJ Contextualized by ZHSG

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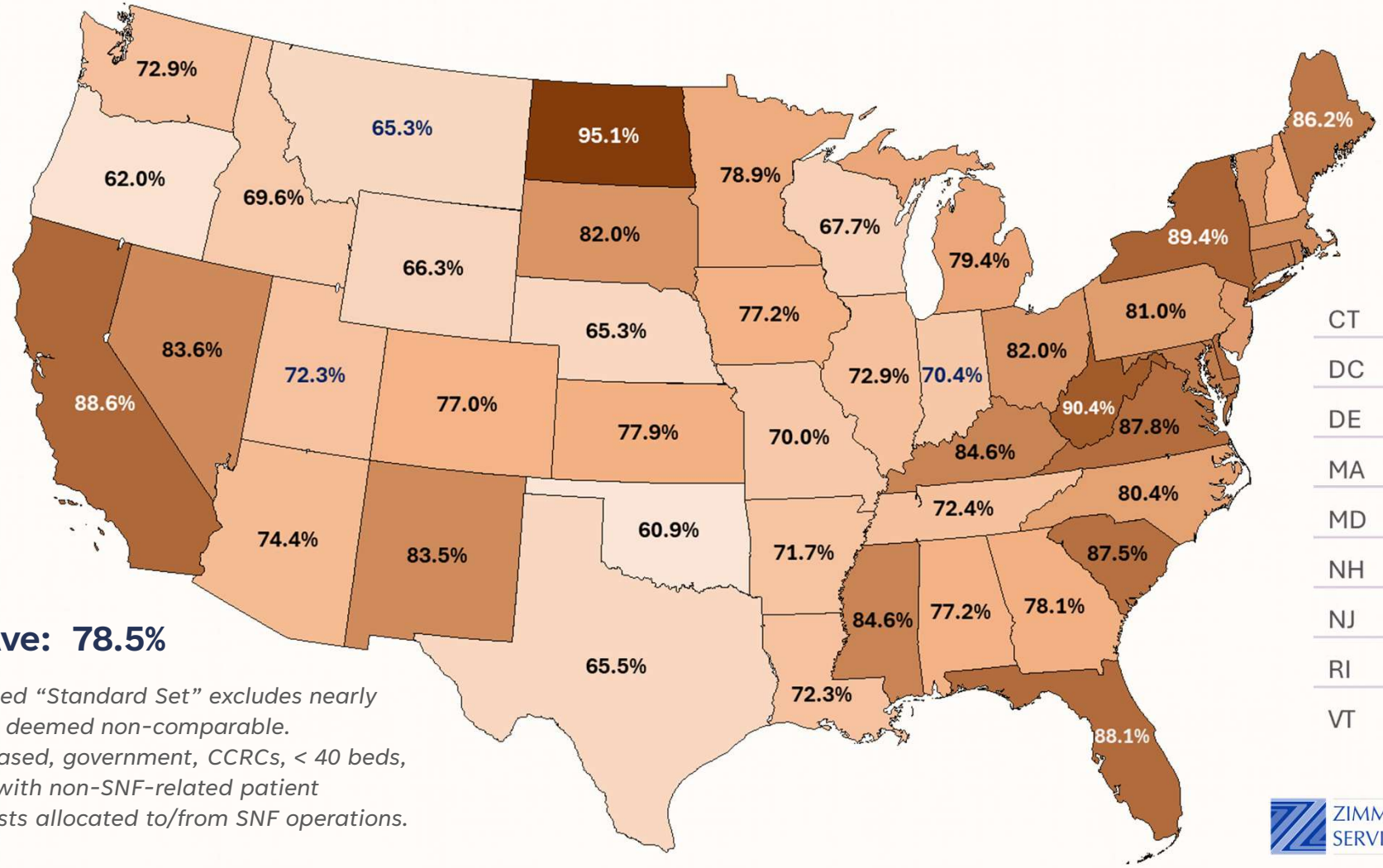
2024 "Standard Set" SNF Occupancy



CT	85.6%
DC	85.3%
DE	87.8%
MA	83.4%
MD	85.8%
NH	77.7%
NJ	81.2%
RI	85.2%
VT	82.6%

State Ave: 78.5%

ZHSG defined "Standard Set" excludes nearly 4,000 SNFs deemed non-comparable. Hospital-based, government, CCRCs, < 40 beds, and those with non-SNF-related patient revenue/costs allocated to/from SNF operations.

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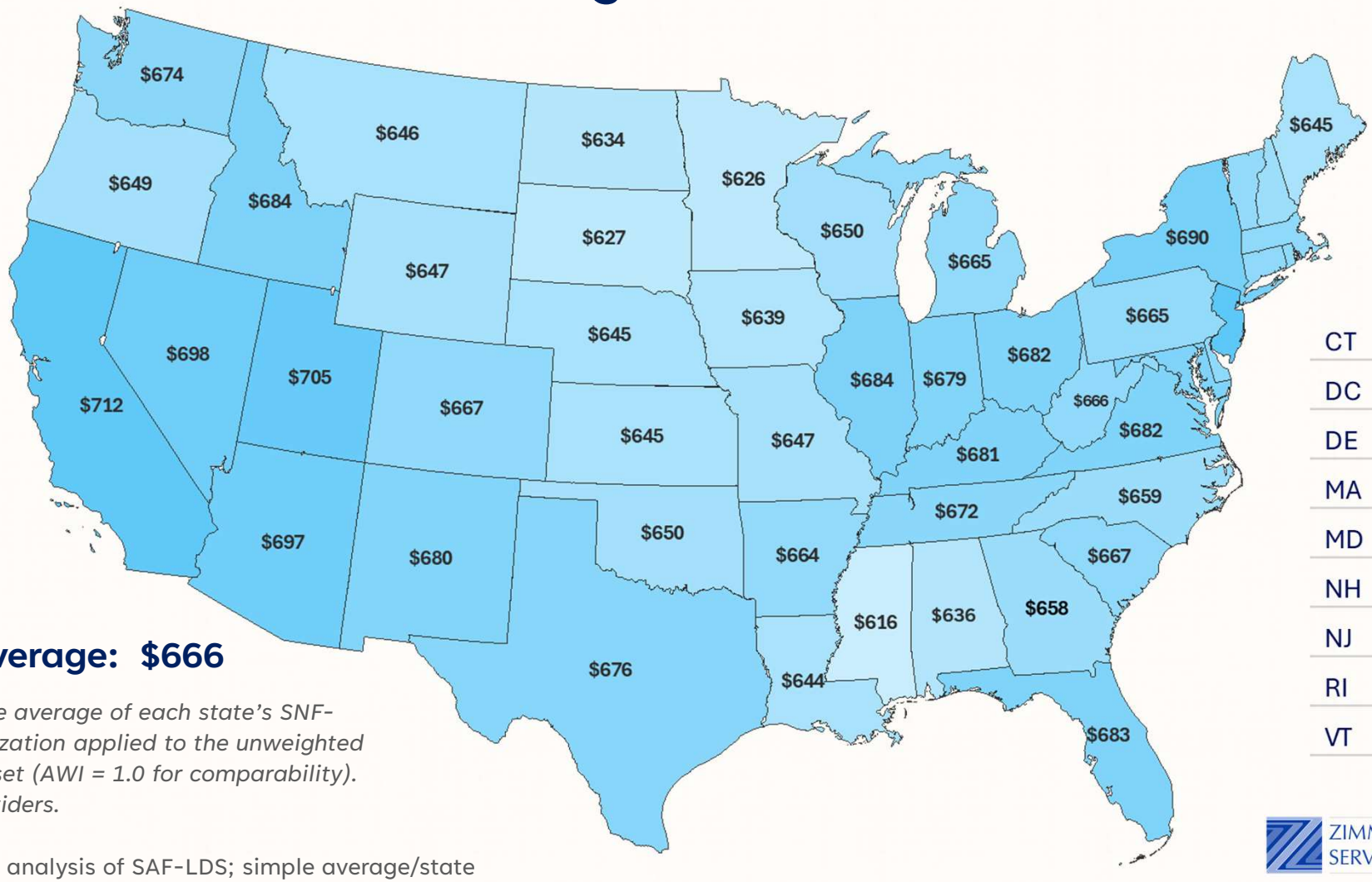
2024 Average Medicare Rates



CT	$669
DC	$688
DE	$669
MA	$670
MD	$683
NH	$656
NJ	$715
RI	$670
VT	$665

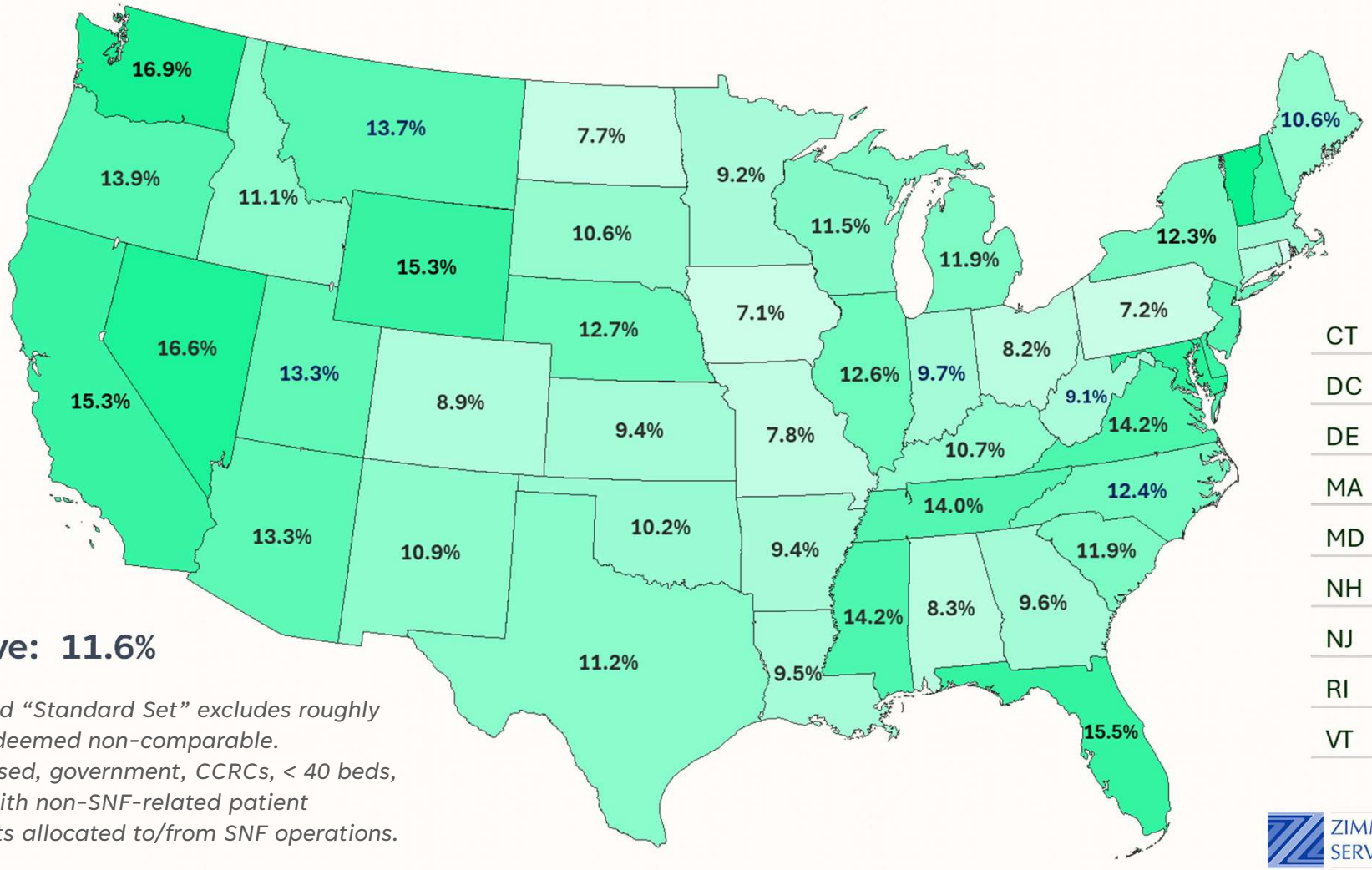
State Average: $666

Note: Simple average of each state's SNF-specific utilization applied to the unweighted Urban rate set (AWI = 1.0 for comparability). All SNF providers.

Source: ZHSG analysis of SAF-LDS; simple average/state

ZIMMET HEALTHCARE SERVICES GROUP, LLC

2019 Medicare Share



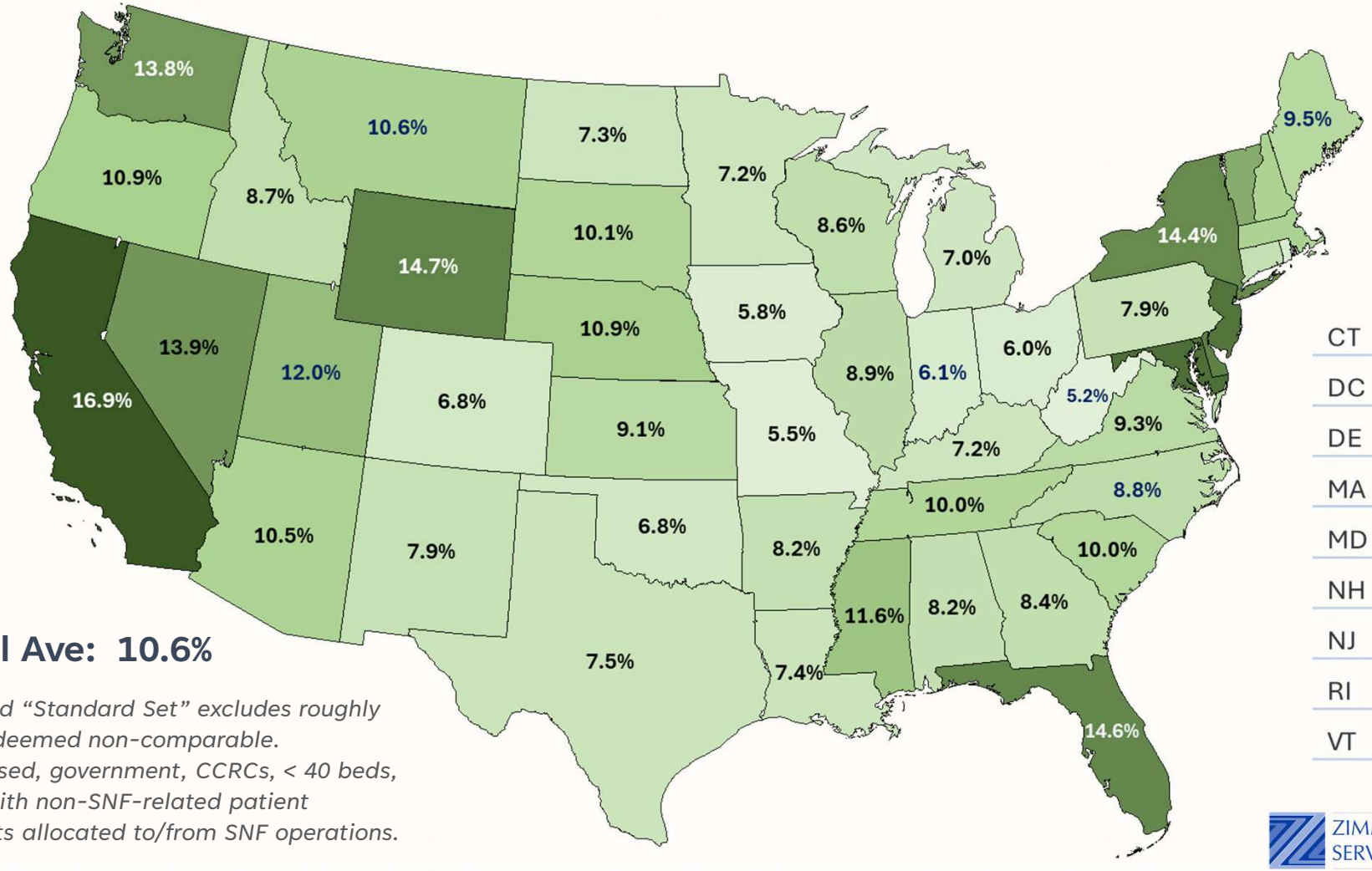
State Ave: 11.6%

ZHSG defined "Standard Set" excludes roughly 4,000 SNFs deemed non-comparable. Hospital-based, government, CCRCs, < 40 beds, and those with non-SNF-related patient revenue/costs allocated to/from SNF operations.

CT	8.9%
DC	10.4%
DE	15.3%
MA	10.3%
MD	16.1%
NH	15.0%
NJ	14.1%
RI	6.3%
VT	17.6%

ZIMMET HEALTHCARE SERVICES GROUP, LLC

2024 Medicare Share



CT	8.1%
DC	8.1%
DE	14.8%
MA	10.6%
MD	15.7%
NH	10.7%
NJ	15.4%
RI	6.0%
VT	12.8%

National Ave: 10.6%

ZHSG defined "Standard Set" excludes roughly 4,000 SNFs deemed non-comparable. Hospital-based, government, CCRCs, < 40 beds, and those with non-SNF-related patient revenue/costs allocated to/from SNF operations.

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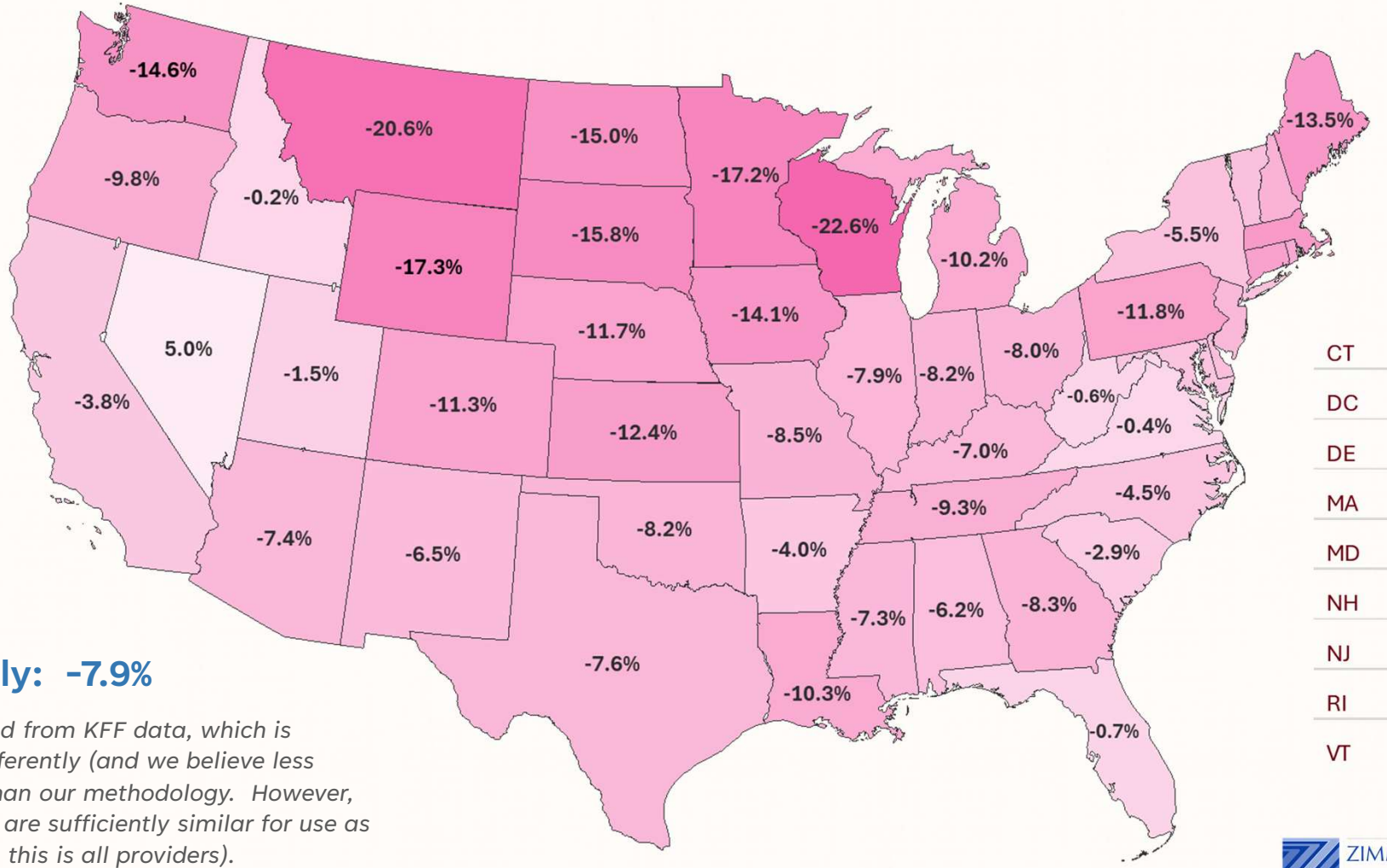
KFF

KFF: Total Resident Days 2019 – 2024



CT	-11.9%
DC	-13.6%
DE	-6.0%
MA	-13.2%
MD	-4.7%
NH	-8.9%
NJ	-7.3%
RI	-10.5%
VT	-5.6%

Nationally: -7.9%

Contextualized from KFF data, which is measured differently (and we believe less accurately) than our methodology. However, the trend line are sufficiently similar for use as proxies (note: this is all providers).

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2026 Medicare SNF coinsurance for Days 21 – 100: $214.50/day

- Medicaid “covers” Dual-Eligible resident copayments.
- Policy varies by state ($0 – 100%). Lessor of” policies.
- Cost Report: Medicare reimburses 65% if supported.
- $75/day * 80 days = $6000 write-off.
- Max loss on Medicare ADC of 15 = $328K
- Typical loss on Medicare ADC of 15 =$162K
- Cash Hit on Typical Medicare ADC= $431K
- On a 120 bed home that’s almost the entire NOI

The Daily Provider

ECAP INTEL eCapIntel.com

October 19, 2022 TODAY'S EDITION 0,50 c

Medicare SNF Rate Cut: **$56/day**!
Disadvantaged Communities Hit Hardest

CMS announced significant reductions in Medicare SNF daily rates, but not all providers will feel the pain. Wealthy areas are spared, while underserved, disadvantaged communities bear the brunt of the payment reductions. MedPAC supports this action.

When asked for justification about unfairly penalizing Skilled Nursing Facilities in struggling areas that need help the most, one official is on record saying, “It’s not Medicare’s job to subsidize providers based on demographics in their neighborhood.” *Ouch…*

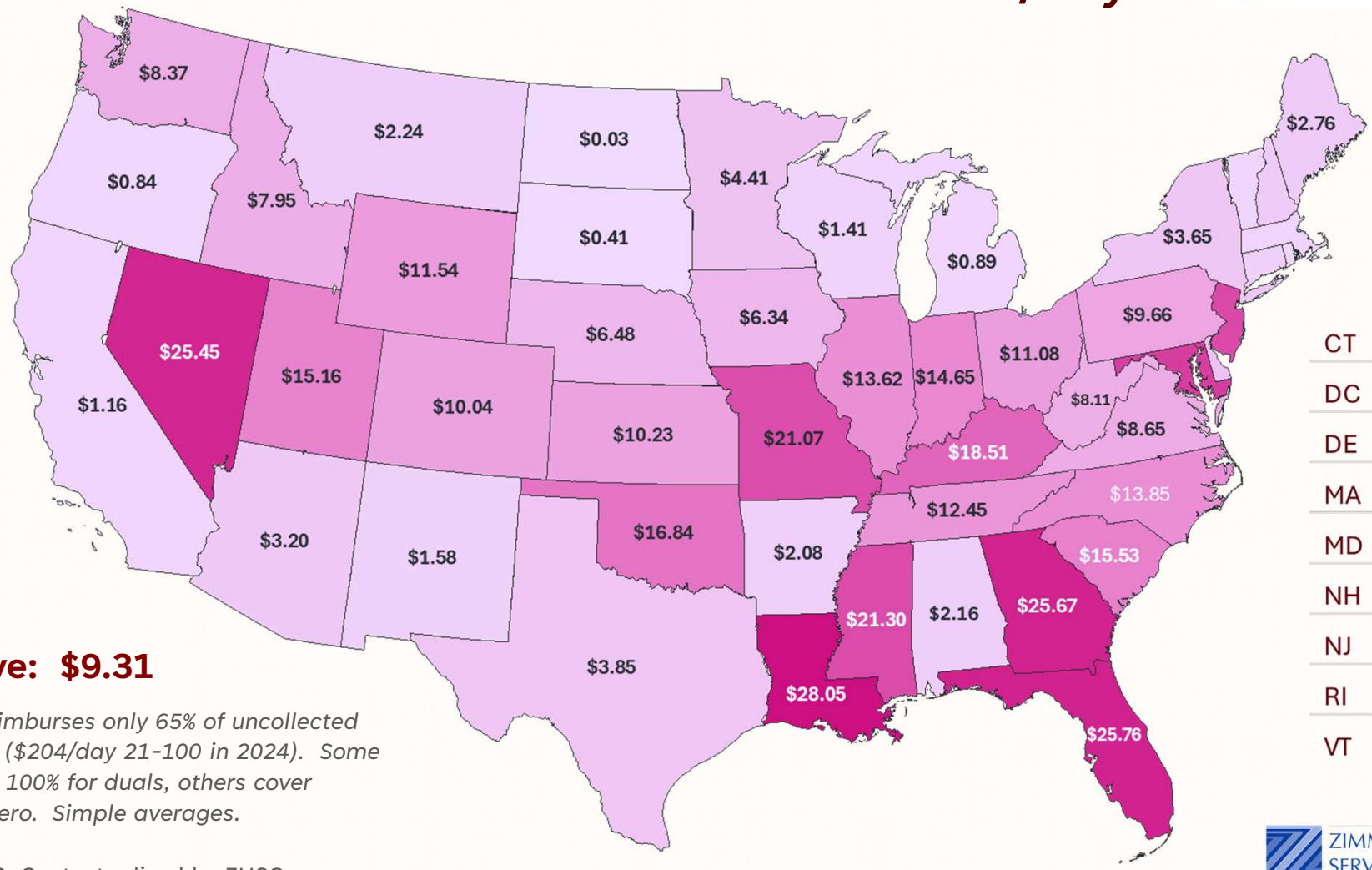
https://myzpax.com/commentary/cost-sharing

- Solano County, CA: AWI (1.9102); Ave rate $1,202
- Belmont, OH: AWI = 0.6742; Ave rate = $552

All SNFs subject to the same nominal loss

2024 Medicare Bad Debt Write-off/Day

Commentary



CT	$1.77
DC	$2.12
DE	$4.64
MA	$1.22
MD	$22.85
NH	$2.91
NJ	$21.50
RI	$1.07
VT	$0.98

State Ave: $9.31

Medicare reimburses only 65% of uncollected coinsurance ($204/day 21-100 in 2024). Some states cover 100% for duals, others cover effectively zero. Simple averages.

Source: HCRIS; Contextualized by ZHSG

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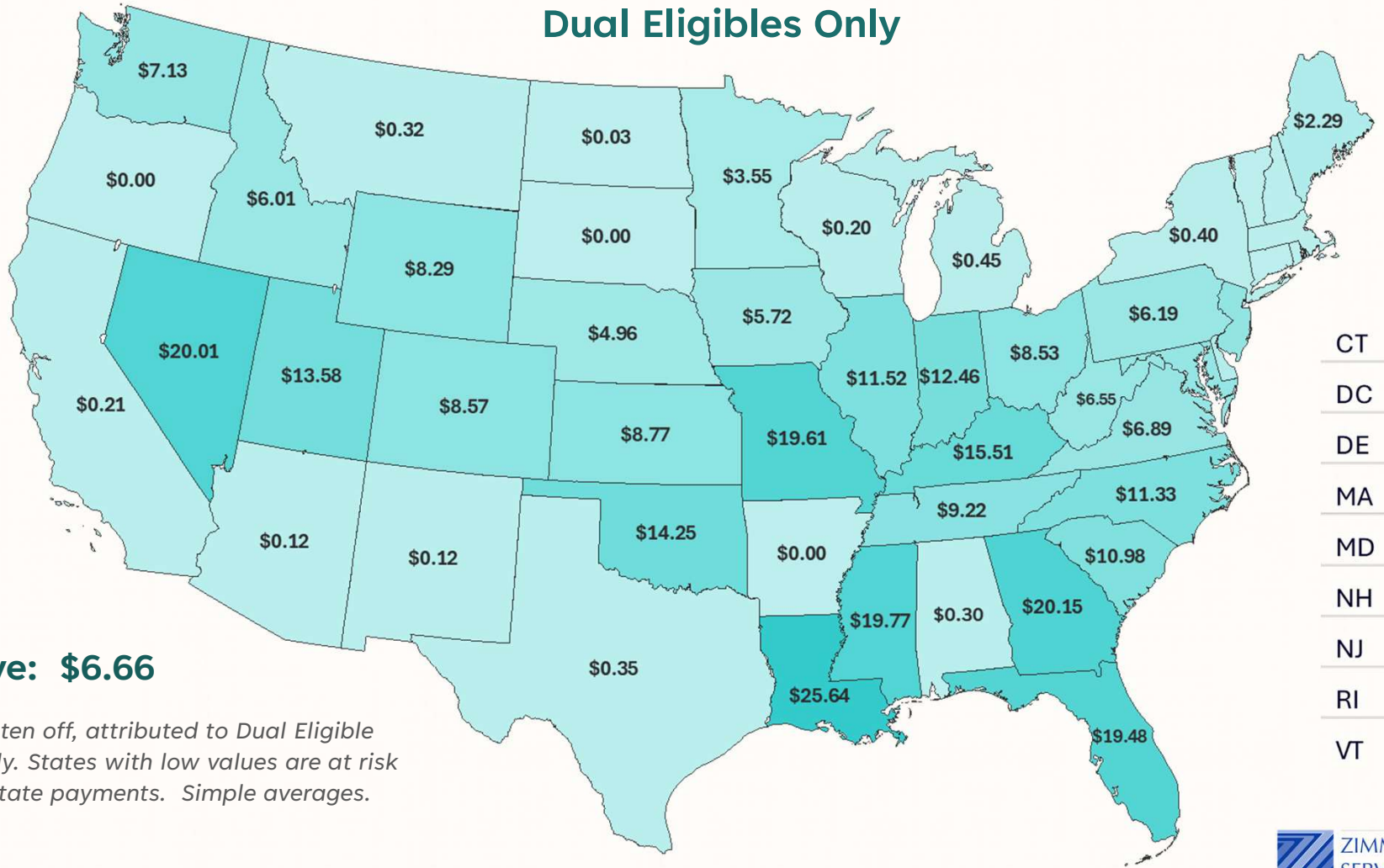
2024 Medicare Bad Debt Write-off/Day: Dual Eligibles Only



CT	$0.00
DC	$0.00
DE	$1.49
MA	$0.10
MD	$7.24
NH	$0.25
NJ	$7.67
RI	$0.00
VT	$0.08

State Ave: $6.66

The 35% written off, attributed to Dual Eligible residents only. States with low values are at risk of reduced state payments. Simple averages.

Source: HCRIS; Contextualized by ZHSG

ZIMMET HEALTHCARE SERVICES GROUP, LLC

Medicare: Area Wage Index

z-INTEL PDPM Rate Simulator app

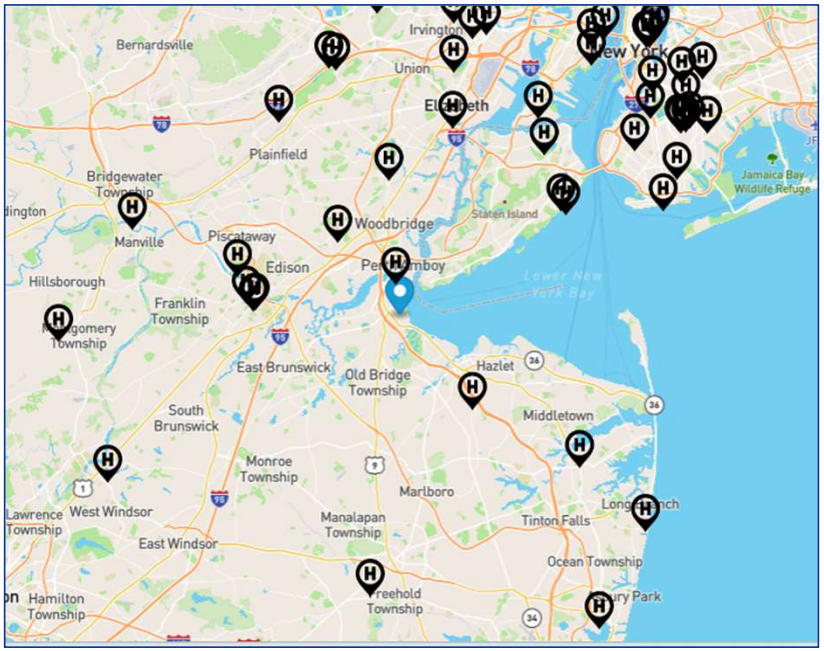
The Medicare Geographic Classification Review Board must approve geographic reclassification requests for "IPPS“ hospitals (individual or group).

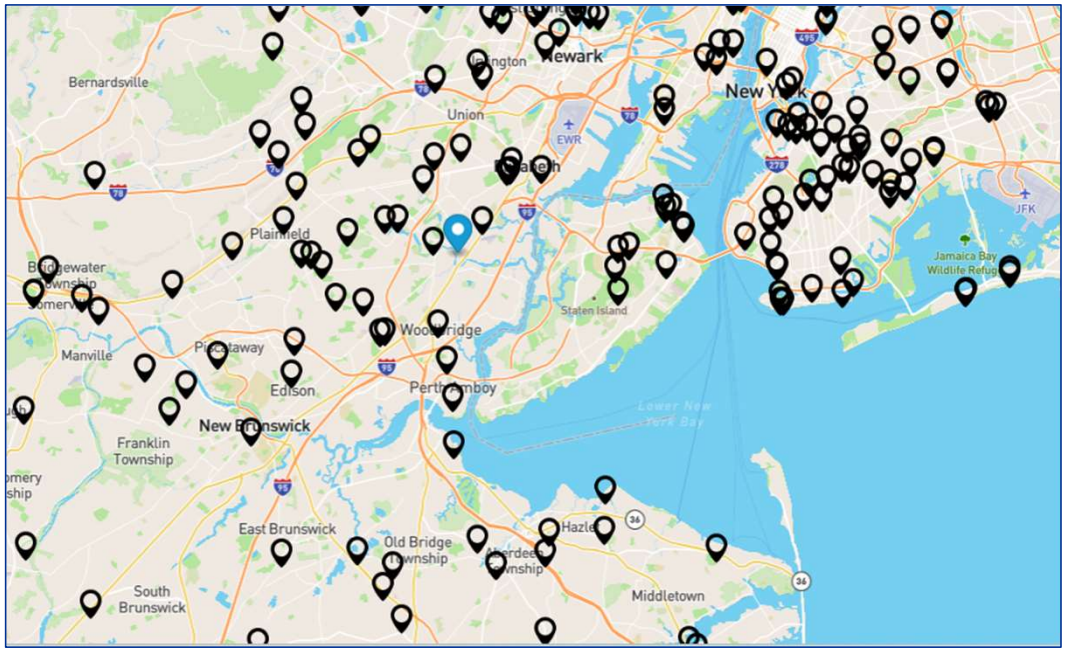
Applied as Group	CBSA Code	CBSA Code	Status	SNF $PPD
Monmouth County (NJ)	29484	35614	Approved	$110
Dutchess County (NY)	28880	35614	Approved	$70
Morris County (NJ)	35084	35614	Approved	$110
Sussex County (NJ)	35084	28880	Approved	$25
Essex County (NJ)	35084	35614	Approved	$115

https://www.cms.gov/files/document/mgcrb-ffy-2026-individual-decision-listing.pdf

Medicare: Area Wage Index

SNF $ impact of "tag along" rights = $300M – $500M





Medicare FY 26 Final Rule

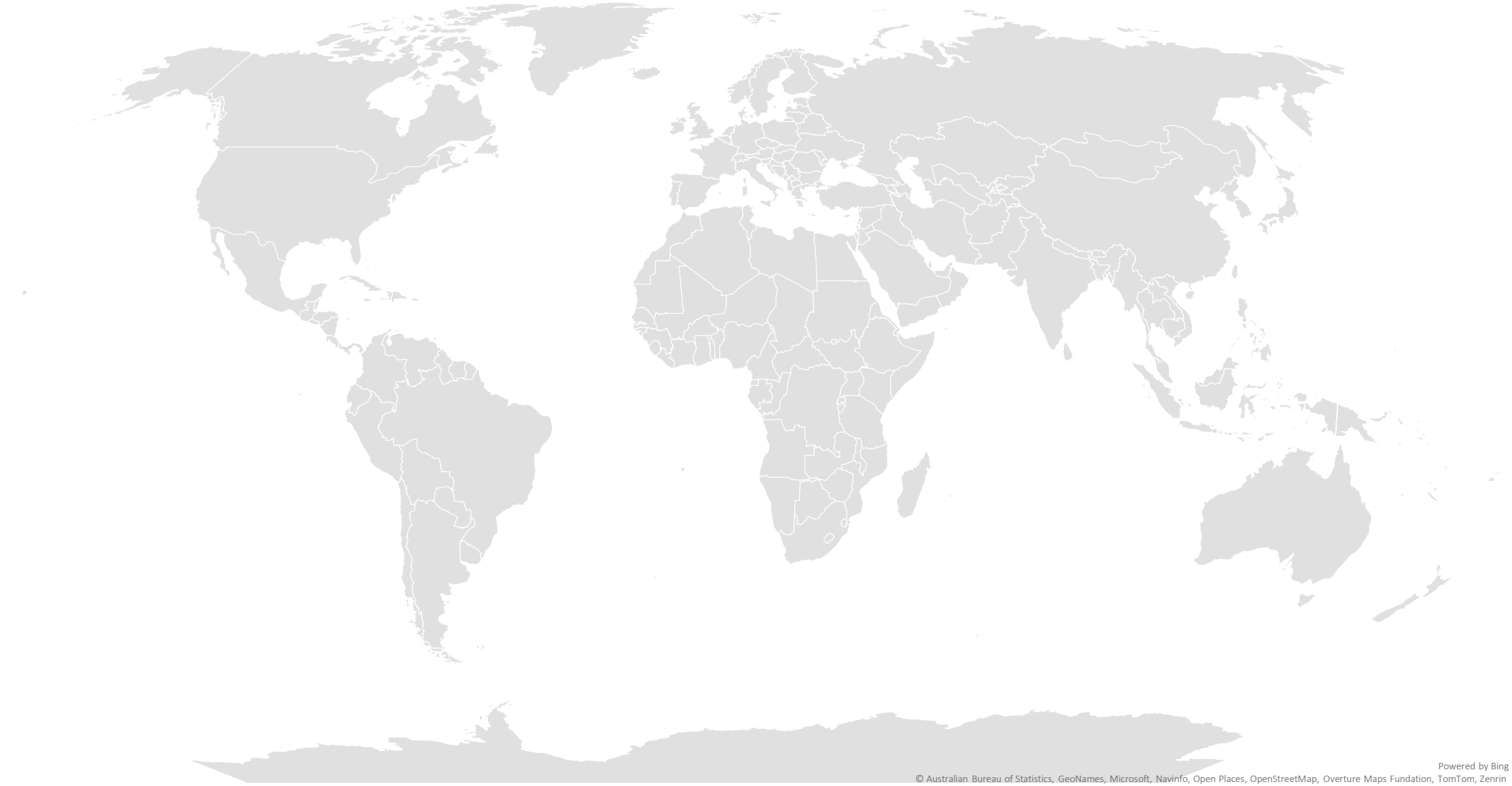
- Overall SNF PPS Increase: 3.2%
- CMS finalized a 3.2% update to SNF payment rates for FY 2026, effective October 1, 2025, calculated as follows:
  - Market basket increase: 3.3%
  - Forecast error adjustment: +0.6%
  - Productivity adjustment: –0.7%
  - Net effect → 3.2% increase in SNF PPS rates, equating to approximately $1.16 billion more than FY 2025
- ICD-10 Changes
- SNF VBP Changes

Average Wage Index- FY26

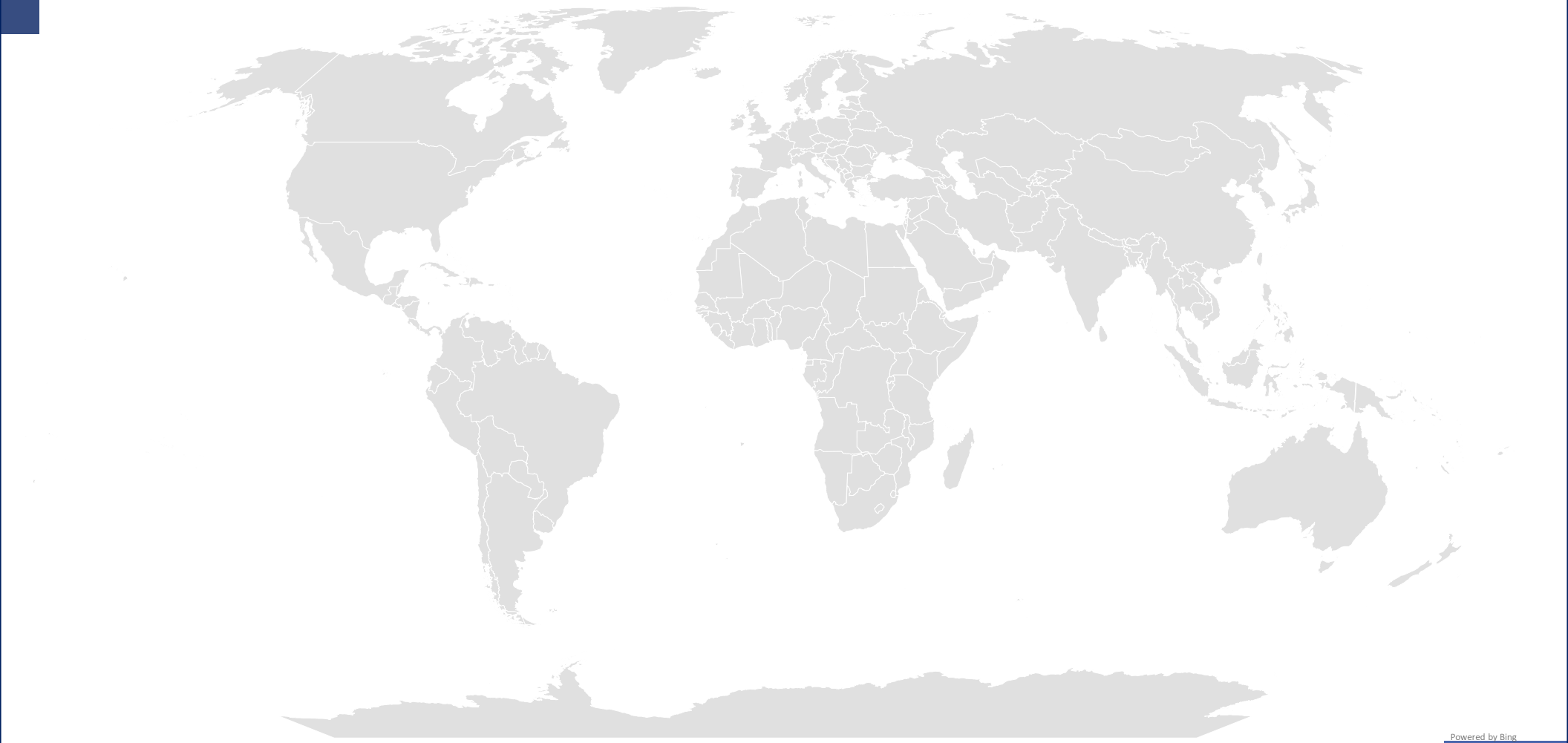
	FY 26 Proposed Rule		FY 26 Final Rule	
County	AWI Change	Medicare Rate Change	AWI Change	Medicare Rate Change
Barnstable	9.27%	$82.41	8.86%	$ 83.57
Berkshire	-1.24%	$15.17	-1.61%	$ 16.12
Bristol	0.98%	$27.10	0.84%	$ 29.46
Dukes	8.35%	$71.73	7.94%	$ 72.80
Essex	4.48%	$46.99	4.94%	$ 52.73
Franklin	8.35%	$71.73	7.94%	$ 72.80
Hampden	5.33%	$48.46	4.93%	$ 49.46
Hampshire	4.75%	$45.33	4.36%	$ 46.37
Middlesex	4.48%	$46.99	4.94%	$ 52.73
Nantucket	8.35%	$71.73	7.94%	$ 72.80
Norfolk	2.29%	$37.92	1.93%	$ 39.11
Plymouth	2.29%	$37.92	1.93%	$ 39.11
Suffolk	2.29%	$37.92	1.93%	$ 39.11
Wooster*	-8.61%	($28.22)	-8.96%	$ (27.18)

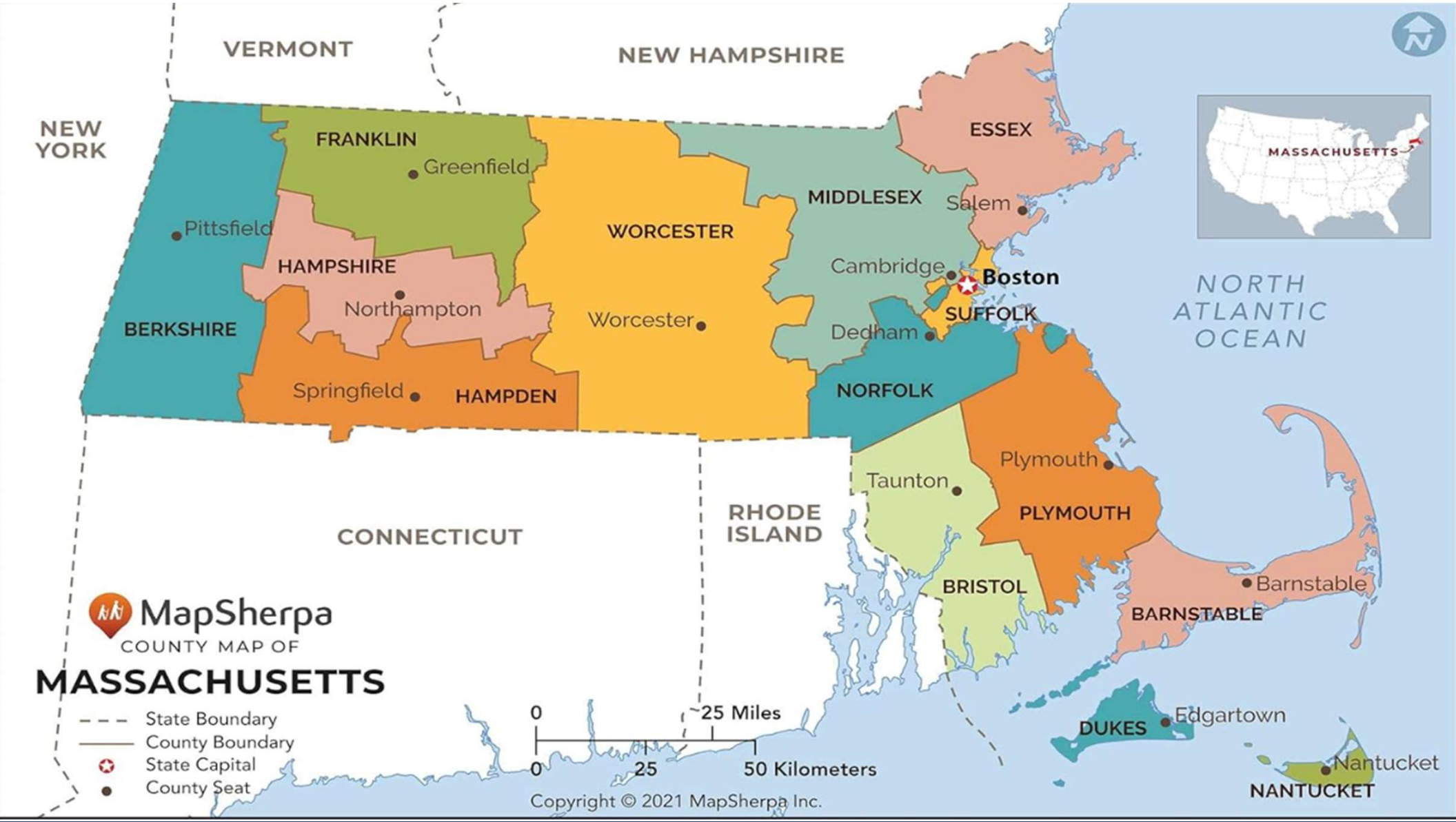
*Not Adjusted for the 5% downside cap

Medicare FY 2026 Rate Changes- Massachusetts



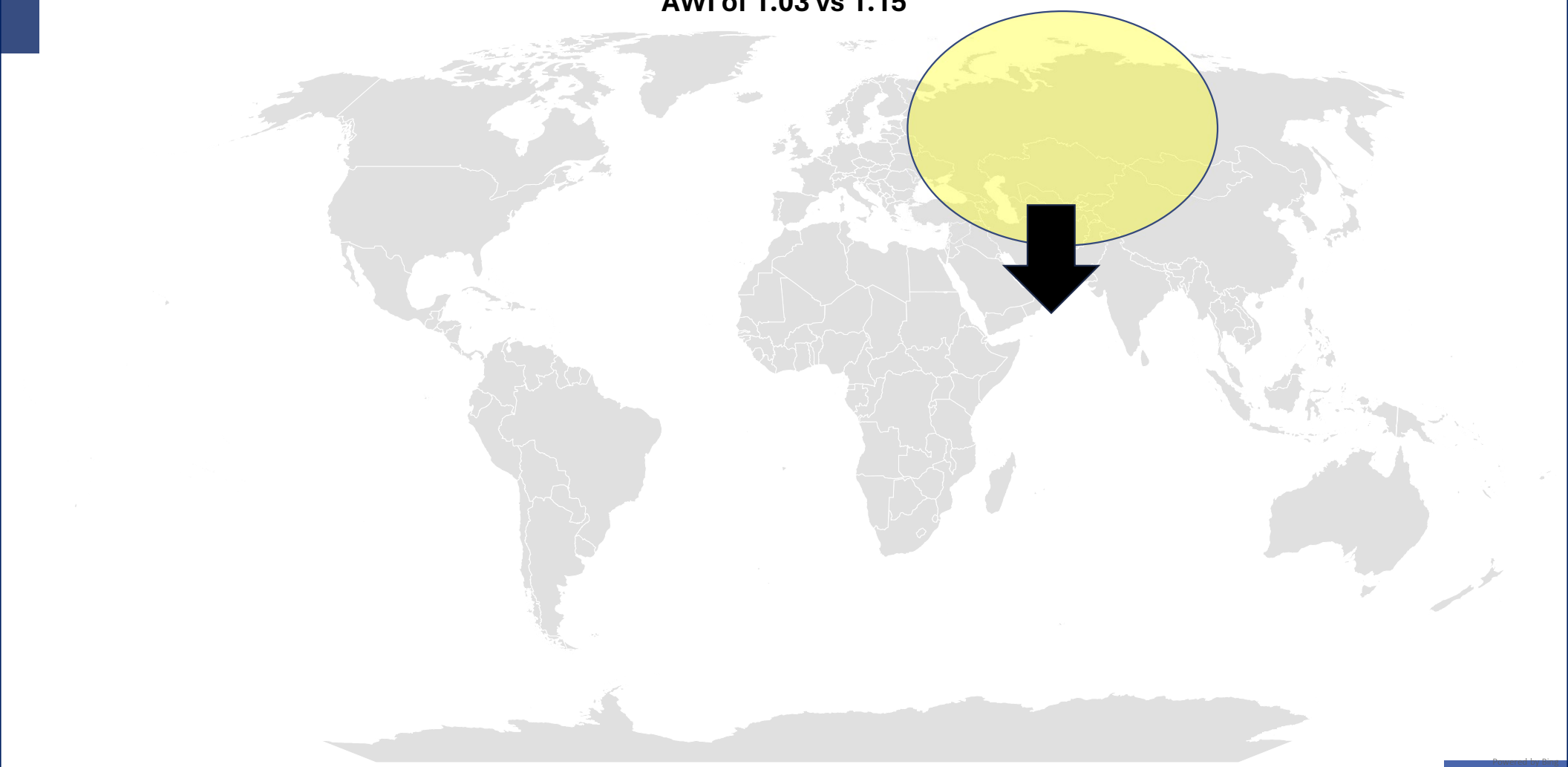
Medicare FY 2026 Rates

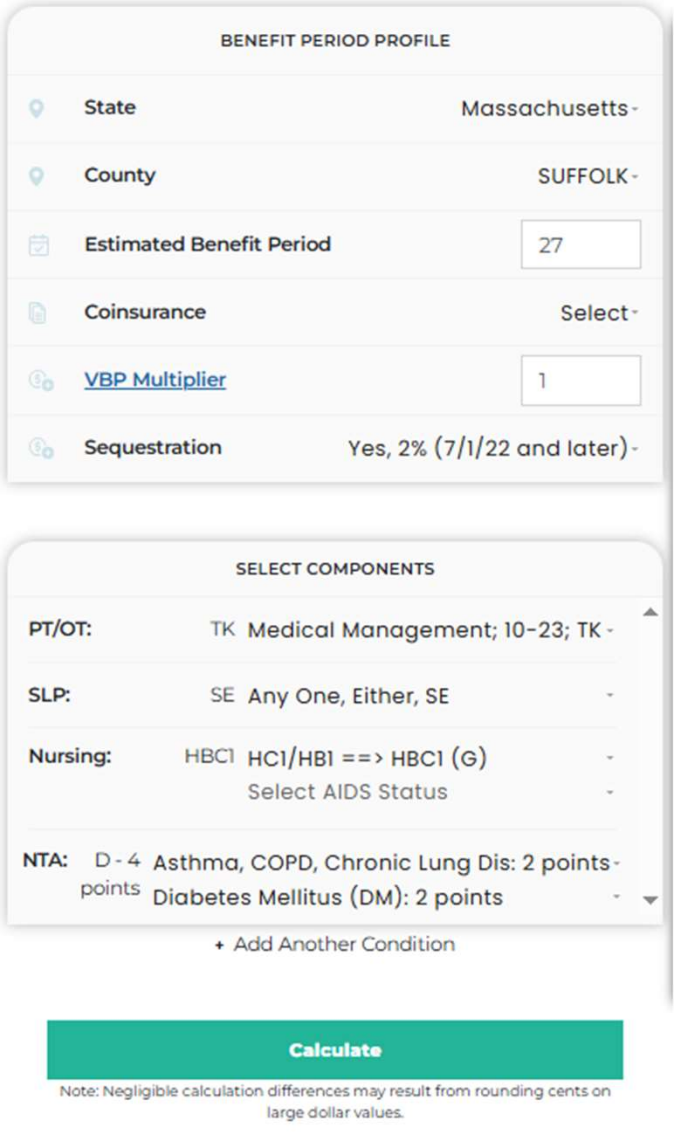



VERMONT
NEW HAMPSHIRE
NEW YORK
CONNECTICUT
RHODE ISLAND
NORTH ATLANTIC OCEAN
FRANKLIN
Greenfield
Pittsfield
HAMPSHIRE
Northampton
BERKSHIRE
Springfield
HAMPDEN
WORCESTER
Worcester
MIDDLESEX
Cambridge
Boston
SUFFOLK
Dedham
NORFOLK
ESSEX
Salem
Taunton
Plymouth
PLYMOUTH
BRISTOL
Barnstable
BARNSTABLE
DUKES
Edgartown
Nantucket
NANTUCKET
MASSACHUSETTS
MapSherpa
COUNTY MAP OF
MASSACHUSETTS
State Boundary
County Boundary
State Capital
County Seat
0
25 Miles
0
25
50 Kilometers
Copyright © 2021 MapSherpa Inc.

Medicare FY 2026 Geographic Classification

AWI of 1.03 vs 1.15




BENEFIT PERIOD PROFILE
State
Massachusetts
County
SUFFOLK
Estimated Benefit Period
27
Coinsurance
Select
VBP Multiplier
1
Sequestration
Yes, 2% (7/1/22 and later)
SELECT COMPONENTS
PT/OT:
TK
Medical Management; 10-23; TK
SLP:
SE
Any One, Either, SE
Nursing:
HBC1
HC1/HB1 ==> HBC1 (G)
Select AIDS Status
NTA:
D - 4 points
Asthma, COPD, Chronic Lung Dis: 2 points
Diabetes Mellitus (DM): 2 points
+ Add Another Condition
Calculate
Note: Negligible calculation differences may result from rounding cents on large dollar values.

FY 2026 CBSA #14454	FY 2025	FY 2026	Change
AREA WAGE INDEX	1.1301	1.1519	1.93%
DAYS 1-3: TOTAL	$3,178	$3,332	$154
DAYS 1-3: PER DIEM	$1,059	$1,111	$51
DAYS 4-20: TOTAL	$13,496	$14,151	$655
DAYS 4-20: PER DIEM	$794	$832	$39
DAY 21 - D/C: TOTAL	$5,526	$5,794	$268
DAY 21 - D/C: WEIGHTED PER DIEM	$789	$828	$38
TOTAL ADMISSION $ (GROSS)	$22,200	$23,278	$1,077
AVERAGE PER DAY (GROSS)	**$822.23**	**$862.14**	**$39.90**
COINSURANCE	($1,467)	($1,467)	$0
COPAYMENT TOTAL	$0	$0	$0
TOTAL ADMISSION $ (NET)	$20,319	$21,375	$1,056
AVERAGE PER DAY (NET)	**$752.56**	**$791.67**	**$39.11**

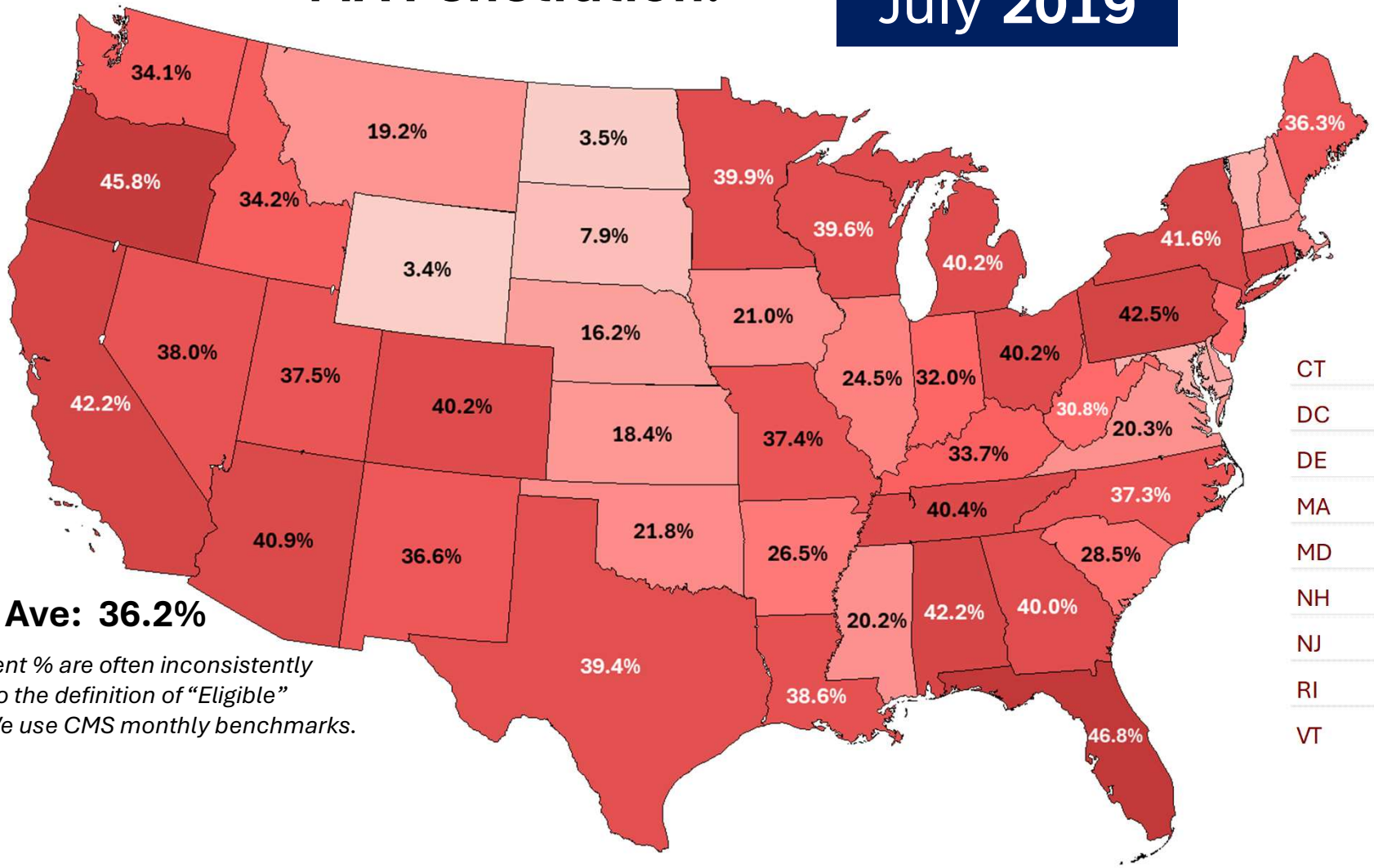
“Medicare Advantage”

- MA was always required to cover all FFS benefits.
- New protections, but Authorizations will not solve the SNF problem.
- ZHSG data: MA SNF utilization and $PPD rates are up to 50% below FFS:
  - **$12B - $13B per year**
- Medicare FFS Attrition Rate
  - **Lessons learned from 2003**
- MA costs the federal government more than FFS per beneficiary.
- The SNF problem is a state problem.
- MA rate < Medicaid dual is a potential crisis.
- SNFs need “Rate Floor” or states must take action.

https://debt-clock.z-pax.com/

as of August 11, 2025

MA Penetration: July 2019



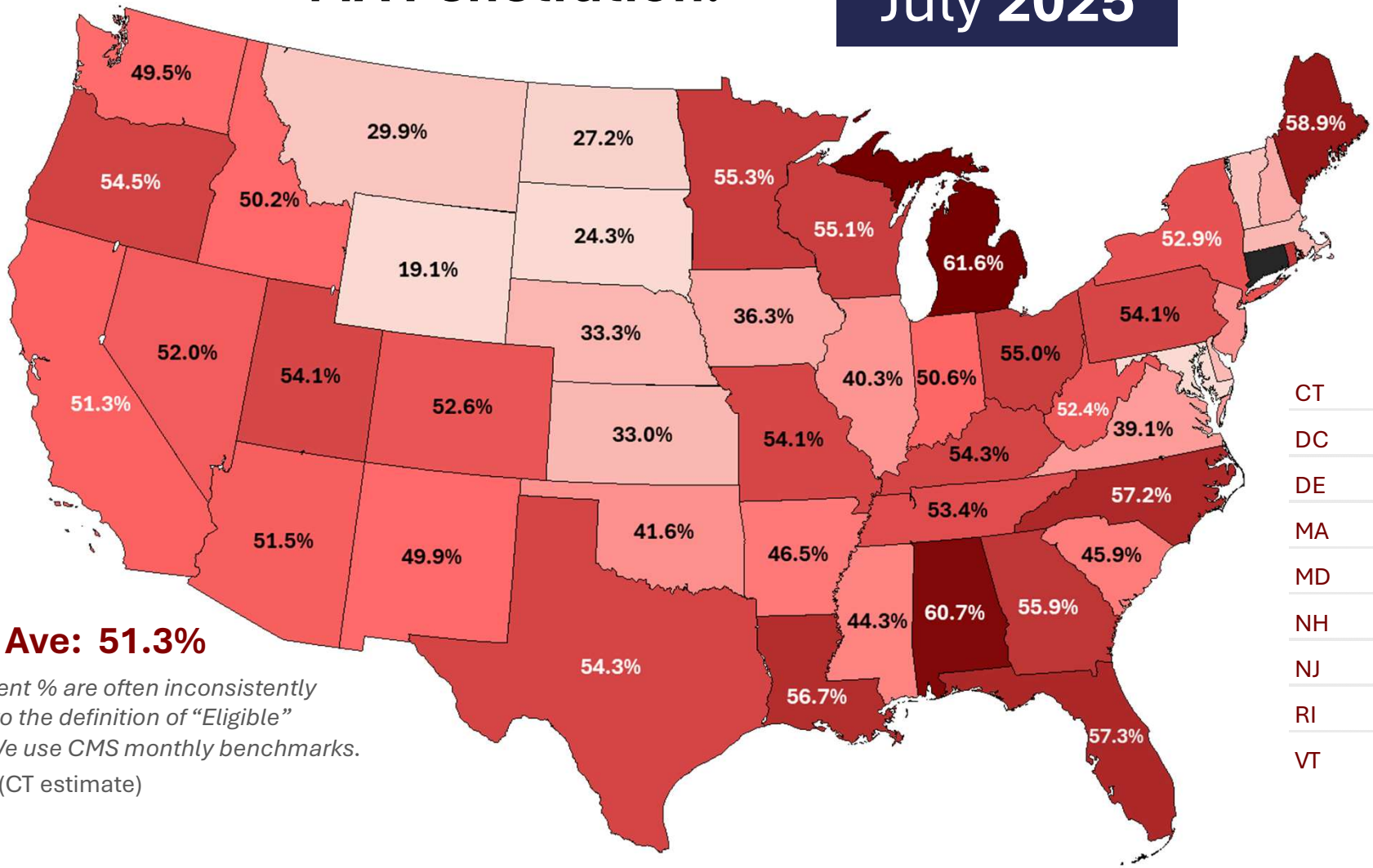
CT	41.8%
DC	19.7%
DE	15.9%
MA	23.0%
MD	11.9%
NH	18.4%
NJ	29.9%
RI	39.1%
VT	11.9%

National Ave: 36.2%

Note: enrollment % are often inconsistently reported due to the definition of "Eligible" beneficiary. We use CMS monthly benchmarks.

Source: CMS

MA Penetration: July 2025



National Ave: 51.3%

Note: enrollment % are often inconsistently reported due to the definition of "Eligible" beneficiary. We use CMS monthly benchmarks.

Source: CMS (CT estimate)

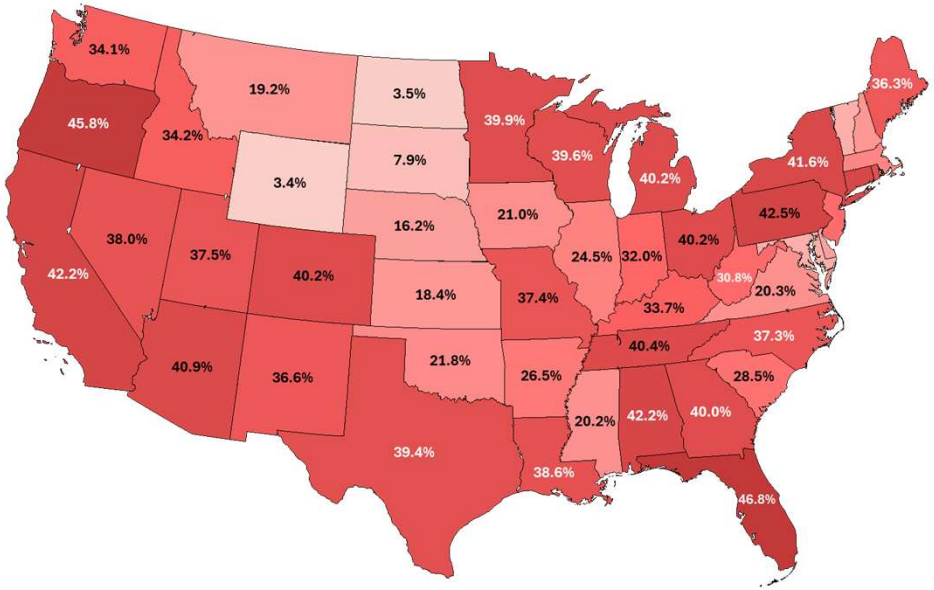
CT	57.0%
DC	34.4%
DE	32.7%
MA	33.1%
MD	25.4%
NH	35.5%
NJ	41.0%
RI	55.5%
VT	30.7%

MA Penetration: July 2019 – July 2025

Using same color-coding calibration

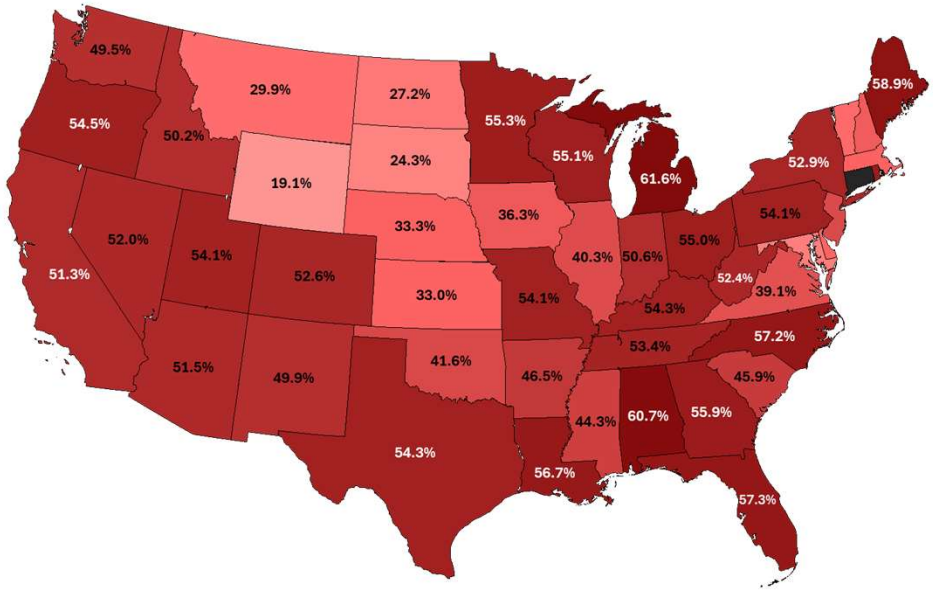
July 2019:

National Benchmark: 36.2%
(21.5 million enrolled)



July 2025:

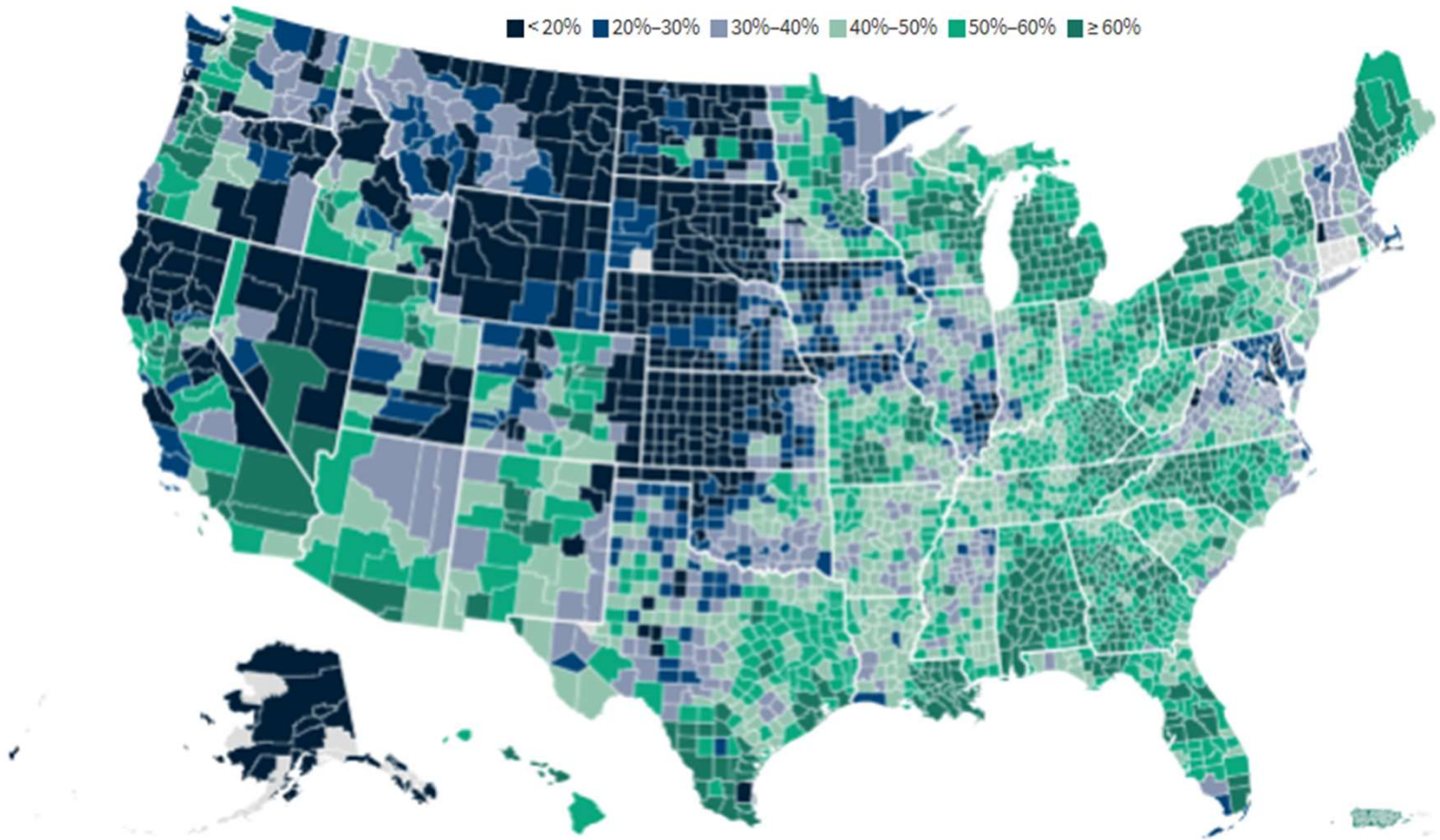
National Benchmark: 51.3%
(34.2 million enrolled)



Source: CMS

MA Penetration By County:

2024 Avg



National Ave: 50.1%

Source: CMS/KFF

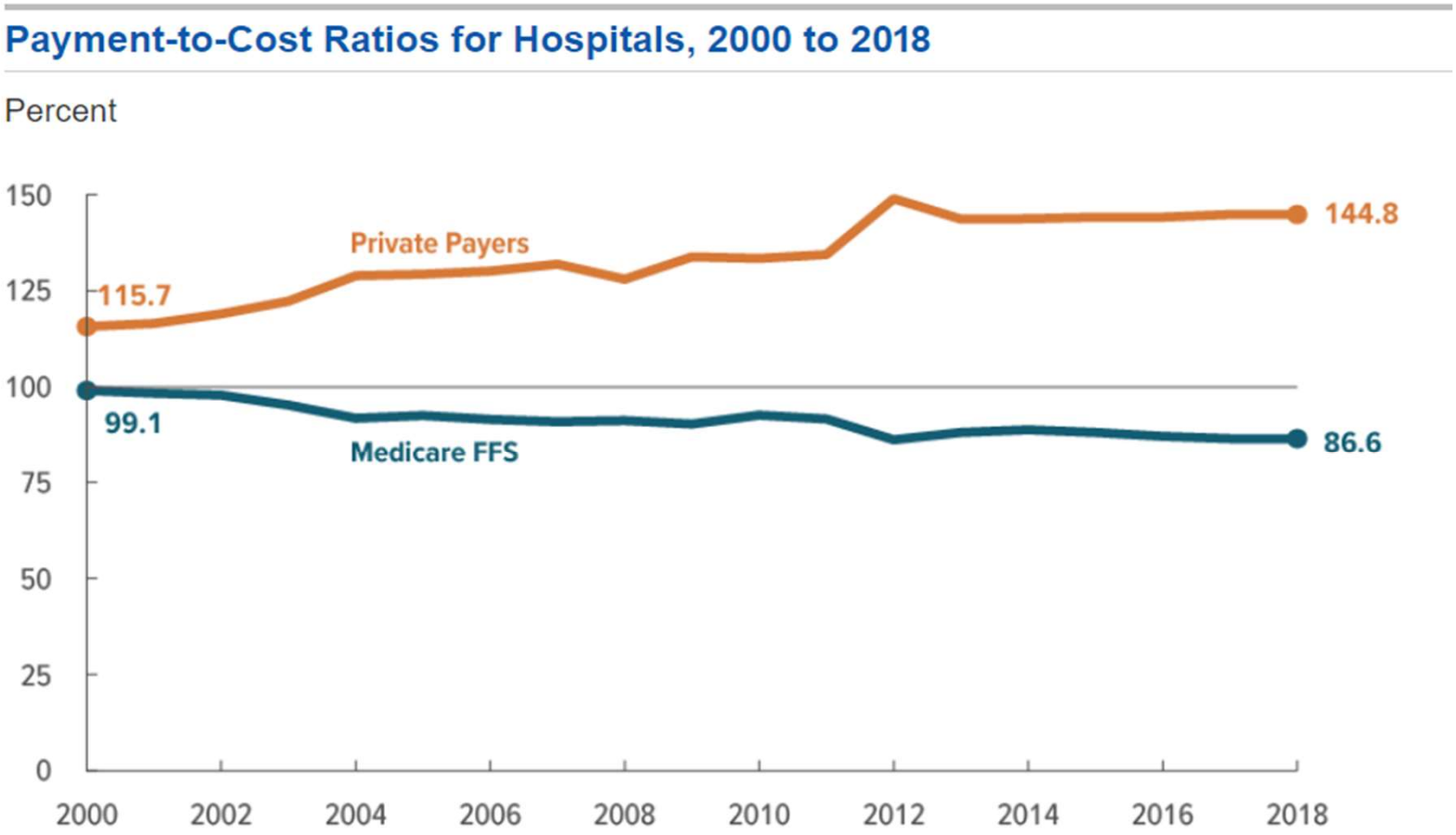
Medicare Advantage $PPD Relative to FFS

Urban Area	FFS	MA	MA/FFS Ratio	30-Day Re-H	ALOS
Nassau County-Suffolk County, NY	$796	$412	51.8%	18.6%	17.6
NYC-Jersey City-White Plains, NY-NJ	$810	$441	54.5%	21.8%	15.2
Miami-Miami Beach-Kendall, FL	$619	$342	55.2%	26.8%	17.5
Boston, MA	$740	$418	56.5%	6.6%	16.4
Cambridge-Newton-Framingham, MA	$681	$418	61.4%	12.6%	16.5
West Palm-Boca Raton-Delray, FL	$603	$374	62.1%	18.7%	16.9
Scranton-Wilkes-Barre-Hazleton, PA	$577	$360	62.4%	13.5%	17.0
Portland-South Portland, ME	$647	$564	87.2%	10.7%	17.2
Pittsburgh, PA	$577	$509	88.4%	21.1%	15.4
Manchester-Nashua, NH	$631	$560	88.8%	14.7%	17.9
Detroit-Dearborn-Livonia, MI	$597	$546	91.5%	21.0%	15.0
Chicago-Arlington Heights, IL	$672	$620	92.3%	22.3%	16.8
Warren-Troy-Farmington Hills, MI	$605	$571	94.4%	16.6%	16.2
Shreveport-Bossier City, LA	$577	$556	96.4%	14.1%	17.7

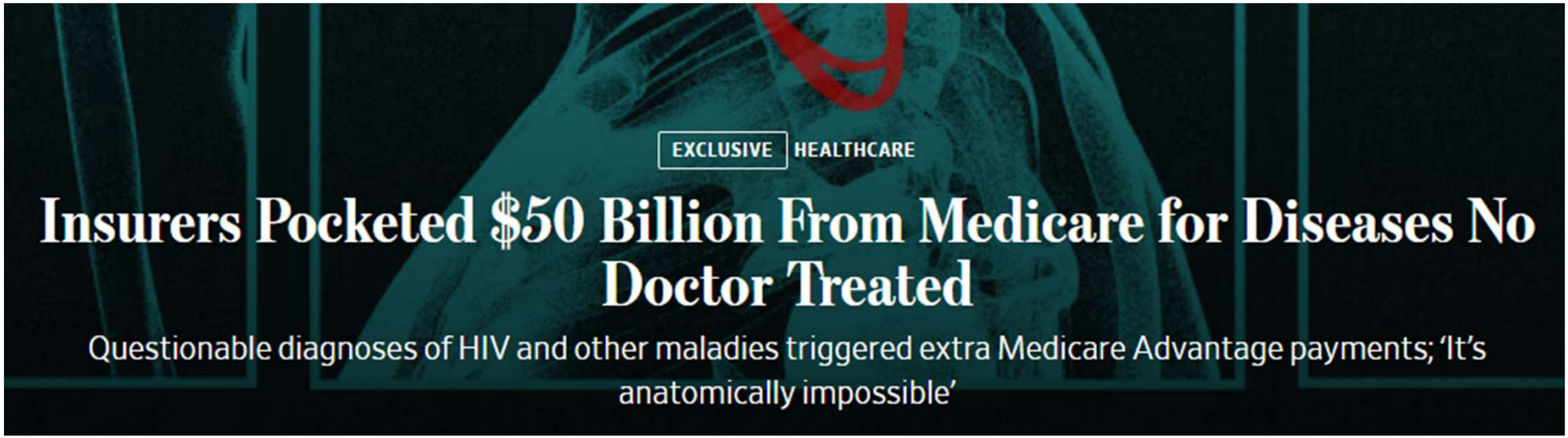
Source: CORE Analytics
Contextualized by ZHSG

simple.
a Netsmart solution

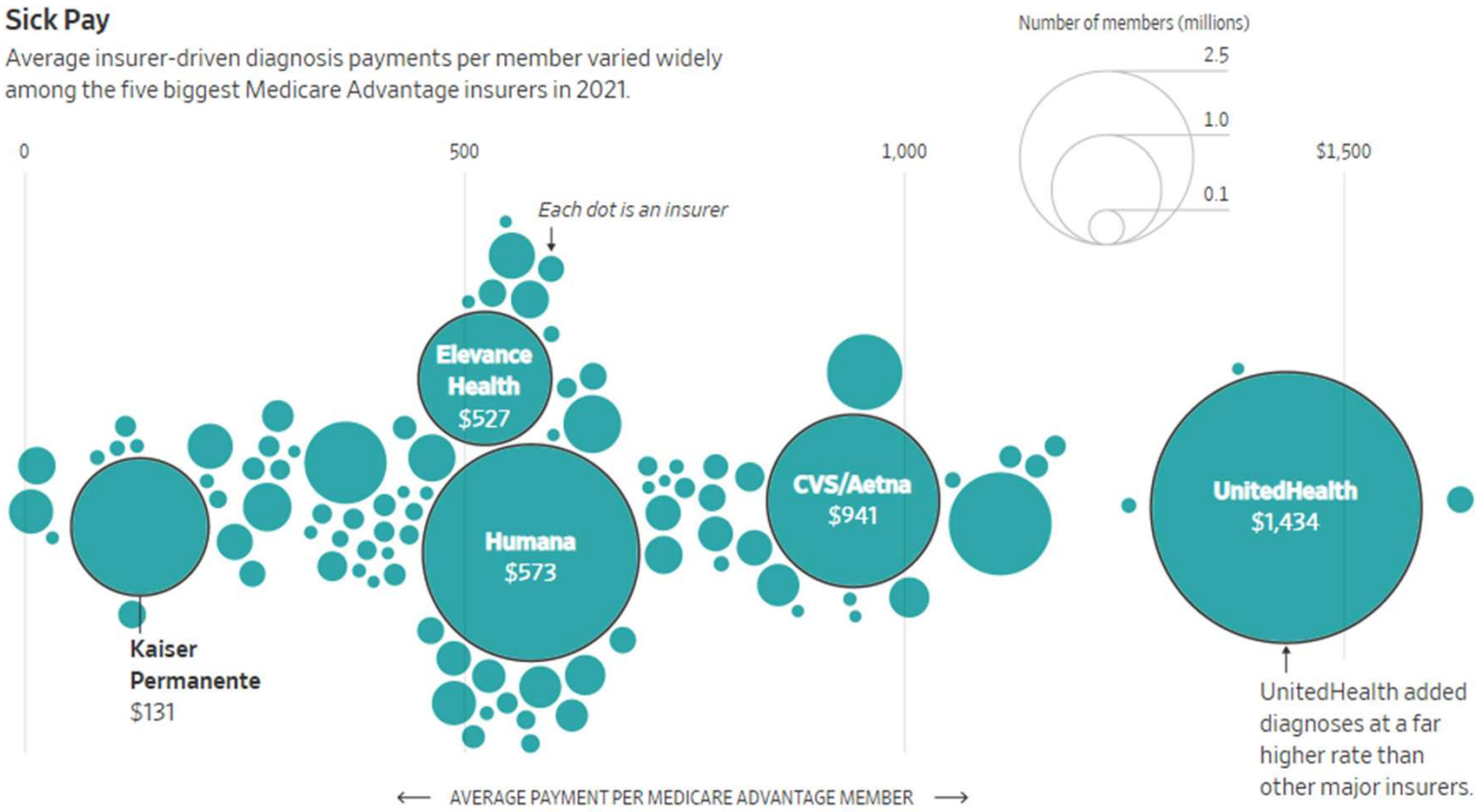
Medicare Advantage Hospital Cost Shifting



Medicare Advantage



Medicare Advantage



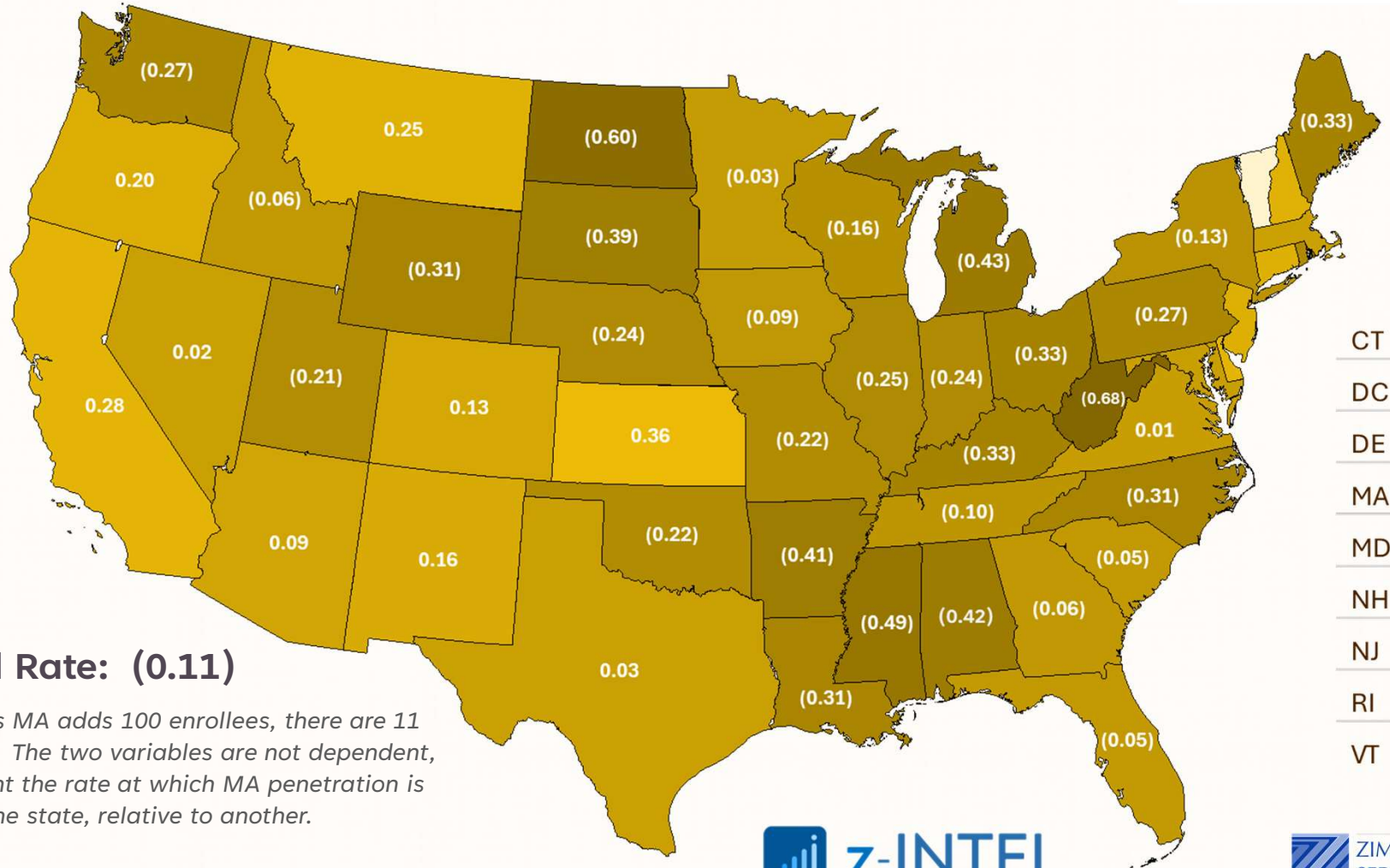
Medicare Advantage

UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud

Company's stock has declined over financial performance and sudden replacement of CEO

Medicare (FFS) Attrition Rate: July 2023 -2025

Commentary



CT	0.22
DC	(0.40)
DE	0.28
MA	0.03
MD	0.01
NH	0.23
NJ	0.22
RI	(0.24)
VT	1.76

National Rate: (0.11)

Nominally, as MA adds 100 enrollees, there are 11 fewer in FFS. The two variables are not dependent, they represent the rate at which MA penetration is growing in one state, relative to another.

Source: CMS; Contextualized by ZHSG

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Medicare Part B

Sample PA facility – 119 Beds

Medicare Part B Utilization & Reimbursement											
Revenue Codes	Ancillary Service	Q1 2024		Q2 2024		Q3 2024		Q4 2024		Total	
		Units	Amount	Units	Amount	Units	Amount	Units	Amount	Units	Amount
042X	Physical Therapy	1,450	$25,820	896	$17,293	966	$17,903	1,139	$21,376	4,451	$82,391
043X	Occupational Therapy	784	$14,083	556	$10,480	546	$10,825	797	$14,672	2,683	$50,060
044X	Speech Therapy Language Pathology	266	$16,080	177	$11,381	131	$8,353	238	$14,894	812	$50,708
063X	Pharmacy	5	$913	13	$2,608	3	$668	-	-	21	$4,189
077X	Preventive Services	4	$144	13	$492	3	$92	-	-	20	$728
Total		2,509	$57,039	1,655	$42,254	1,649	$37,841	2,174	$50,943	7,987	$188,076

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Medicare Part B

Sample NY facility – 120 Beds

Medicare Part B Utilization & Reimbursement											
Revenue Codes	Ancillary Service	Q1 2024		Q2 2024		Q3 2024		Q4 2024		Total	
		Units	Amount	Units	Amount	Units	Amount	Units	Amount	Units	Amount
042X	Physical Therapy	127	$2,924	120	$2,988	78	$1,977	20	$580	345	$8,469
043X	Occupational Therapy	30	$606	20	$469	15	$451	-	-	65	$1,526
044X	Speech Therapy Language Pathology	11	$773	11	$785	34	$2,410	13	$911	69	$4,879
Total		168	$4,303	151	$4,242	127	$4,838	33	$1,491	479	$14,875

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Medicare Part B

Sample CA facility – 120 Beds

Medicare Part B Utilization & Reimbursement											
Revenue Codes	Ancillary Service	Q1 2024		Q2 2024		Q3 2024		Q4 2024		Total	
		Units	Amount	Units	Amount	Units	Amount	Units	Amount	Units	Amount
027X	Medical/Surgical Supplies and Devices	122	$428	4,234	$1,812	5,726	$2,079	6,013	$1,934	16,095	$6,253
030X	Laboratory	5	$17	-	-	-	-	-	-	5	$17
042X	Physical Therapy	1,914	$39,110	2,409	$64,576	1,495	$53,235	1,290	$32,810	7,108	$189,731
043X	Occupational Therapy	2,624	$54,596	2,583	$54,548	1,804	$38,847	1,520	$32,046	8,531	$180,037
044X	Speech Therapy Language Pathology	211	$14,346	82	$5,703	95	$6,574	139	$9,425	527	$36,047
062X	Medical/Surgical Supplies	173	$1,273	1,914	$9,309	2,524	$7,289	2,808	$10,970	7,419	$28,840
063X	Pharmacy	7	$379	6	$351	4	$244	11	$386	28	$1,359
077X	Preventive Services	7	$255	6	$212	4	$148	11	$359	28	$974
Total		5,063	$110,403	11,234	$136,512	11,652	$108,415	11,792	$87,929	39,741	$443,259

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Medicare Part B

Sample CA facility – 132 Beds

Medicare Part B Utilization & Reimbursement											
Revenue Codes	Ancillary Service	Q1 2024		Q2 2024		Q3 2024		Q4 2024		Total	
		Units	Amount	Units	Amount	Units	Amount	Units	Amount	Units	Amount
042X	Physical Therapy	3,347	$67,287	3,884	$76,420	5,412	$103,036	7,056	$134,287	19,699	$381,029
043X	Occupational Therapy	4,023	$100,916	4,923	$138,939	7,325	$210,809	7,217	$193,819	23,488	$644,484
044X	Speech Therapy Language Pathology	196	$12,507	211	$12,852	304	$17,810	508	$32,468	1,219	$75,638
046X	Pulmonary Function	576	$10,671	12,646	$183,139	11,873	$236,642	10,130	$232,778	35,225	$663,230
Total		**8,142**	**$191,381**	**21,664**	**$411,351**	**24,914**	**$568,296**	**24,911**	**$593,352**	**79,631**	**$1,764,381**

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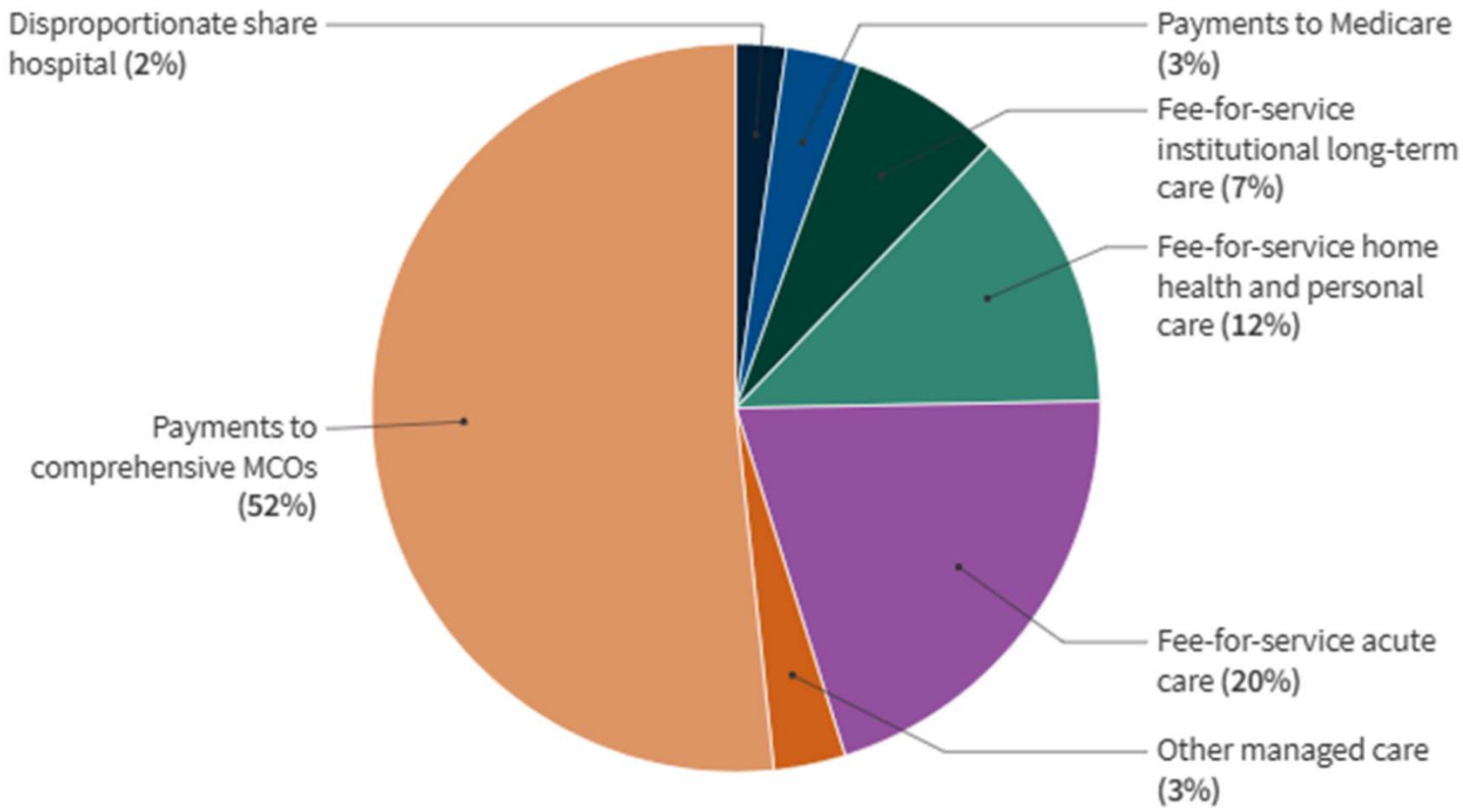
GREAT SCOTT!

Medicaid: The Great Transition

- **“CMI states” implementing significant changes to Medicaid SNF rate reimbursement:**
  - **Acuity adjustment (RUGs to PDPM)**
    - Most using Nursing Component only; others adding at least one other component.
    - In a fixed funding environment (Budget Neutral), changing only the CMI variable is a redistribution.
    - “Winners & Losers”: Contributing factors
  - **Rebasing**
    - Updated “Base Year” using cost reports.
    - Variations / misclassification of expenses can be extreme.
    - Occupancy during Base Year locks-in rates in a high fixed-cost environment (Allowable expenses / resident days).
    - Historical acuity capture patterns distort Direct Care calculations.
    - Strategies to manage distortions set providers up for greater distortion when rebased again.
  - **Restructuring**
    - Changes to Rate-Construction, primarily through Quality incentive payments and resident=specific add-ons based on characteristics poorly accounted for through case-mix adjustment.
    - Peer Grouping facilities based on profile, not position, remains the fundamental flaw in current rate setting processes.

What Does Medicaid Spend Money On?



Going “Managed Care”

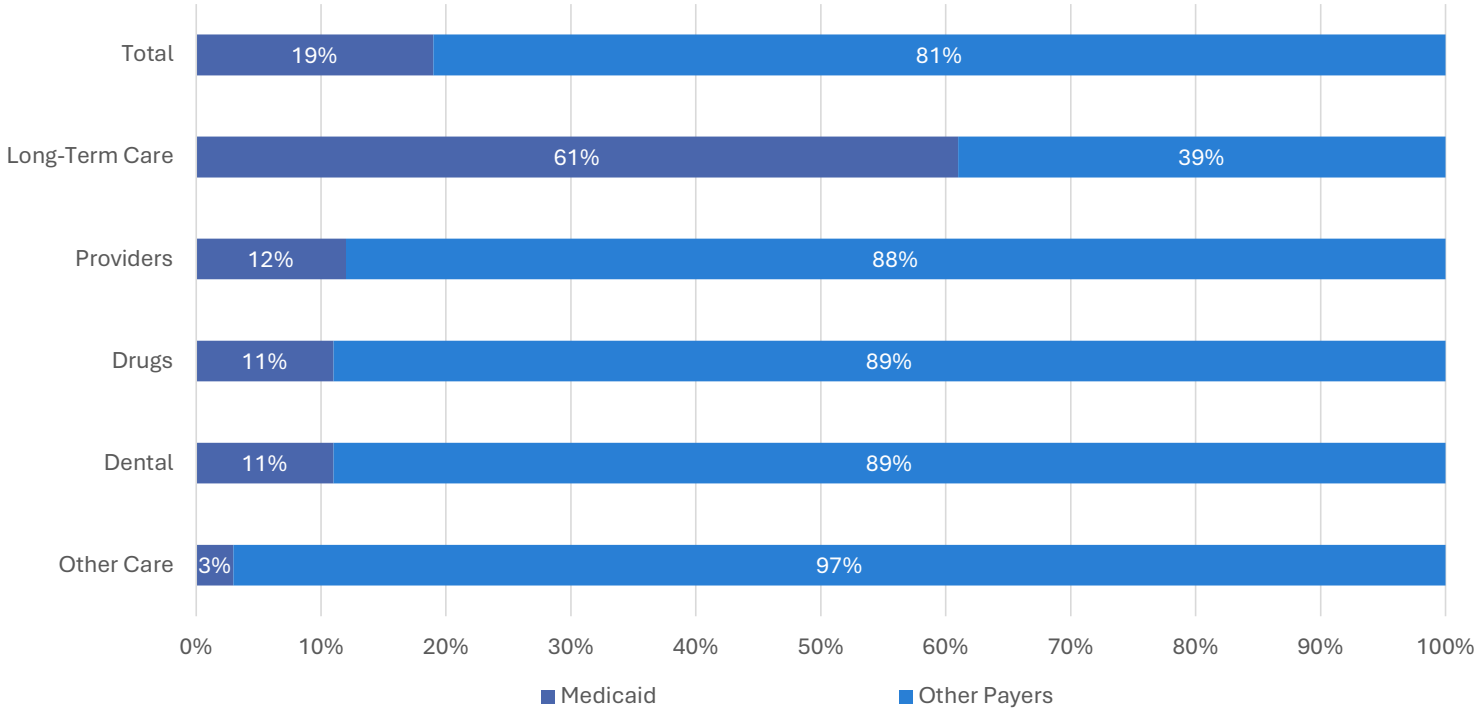
- Medicaid and Medicare Managed Care are very different

- Medicare Managed Care:
  - Has no price controls
  - Has national implications
  - Is designed (primarily) for a community-based market (I-SNP major exception)
  - Has diagnosis driven risk adjustment

- Medicaid Managed Care
  - Has price controls
  - Is state by state, but primarily is risk adjusted by setting and ADL evaluation
  - Is (at this point) designed for nursing homes primarily as a tool to ease the administration of the nursing home program
    - “You can’t manage a day of care”
  - State Directed Payments

What Does Medicaid Spend Money On- Nationally?

Medicaid Accounts for One Fifth of All Health Care Spending, and Over Half of Spending on Long-Term Care



Source: CMS, Office of the Actuary, National Health Statistics Group, 2023

KFF

How Much as a Percentage of Medicaid States Spending On SNF

NH	0.15%
VT	12.19%
MA	7.98%
CT	12.41%
RI	10.57%
NJ	7.83%
DE	7.20%
MD	8.55%
HI	1.09%

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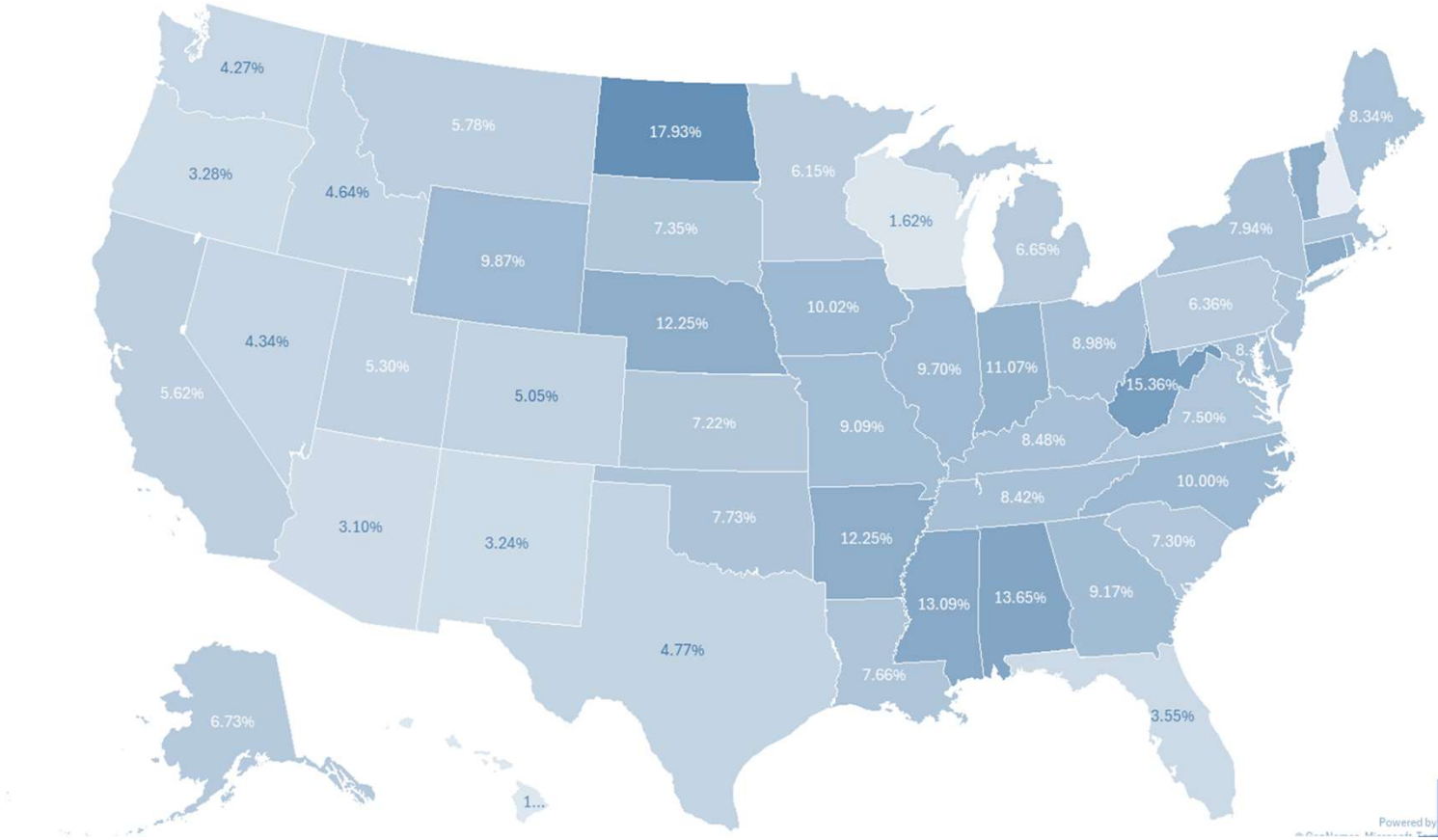
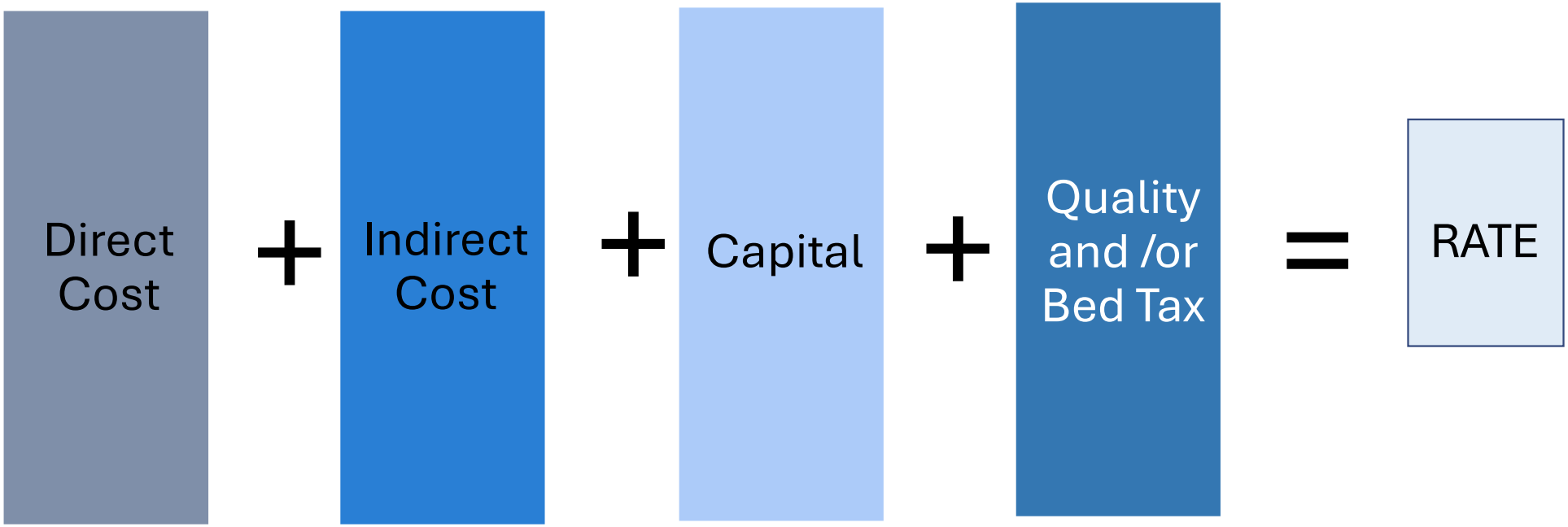


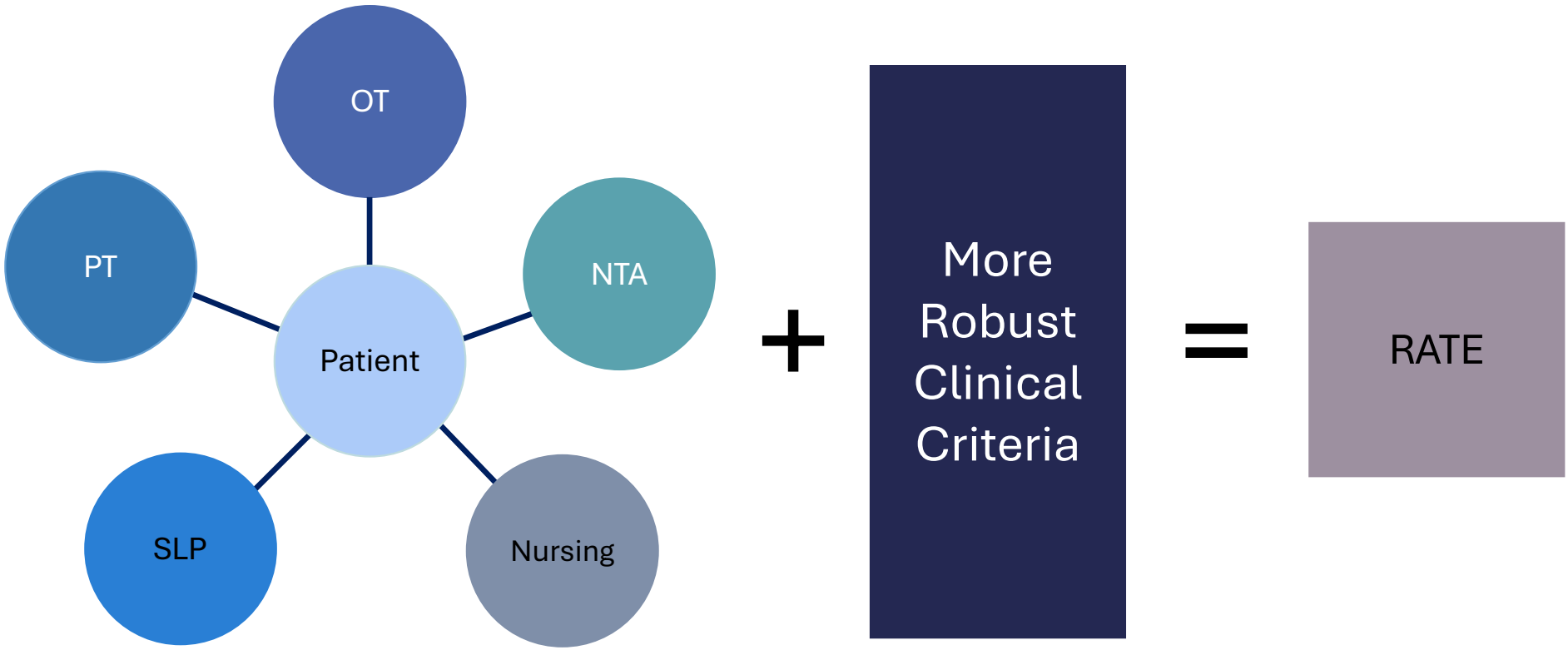
3 Ways to Decode Medicaid (Highly Variable State to State)

- Rate Elasticity
  - Ability for a provider to move the needle on rates, i.e., Case Mix
- Rate Construction
  - Does the underlying mechanics of the methodology capture information accurately?
- Underlying Funding Mechanism
  - Does the underlying mechanics of the methodology capture information accurately?

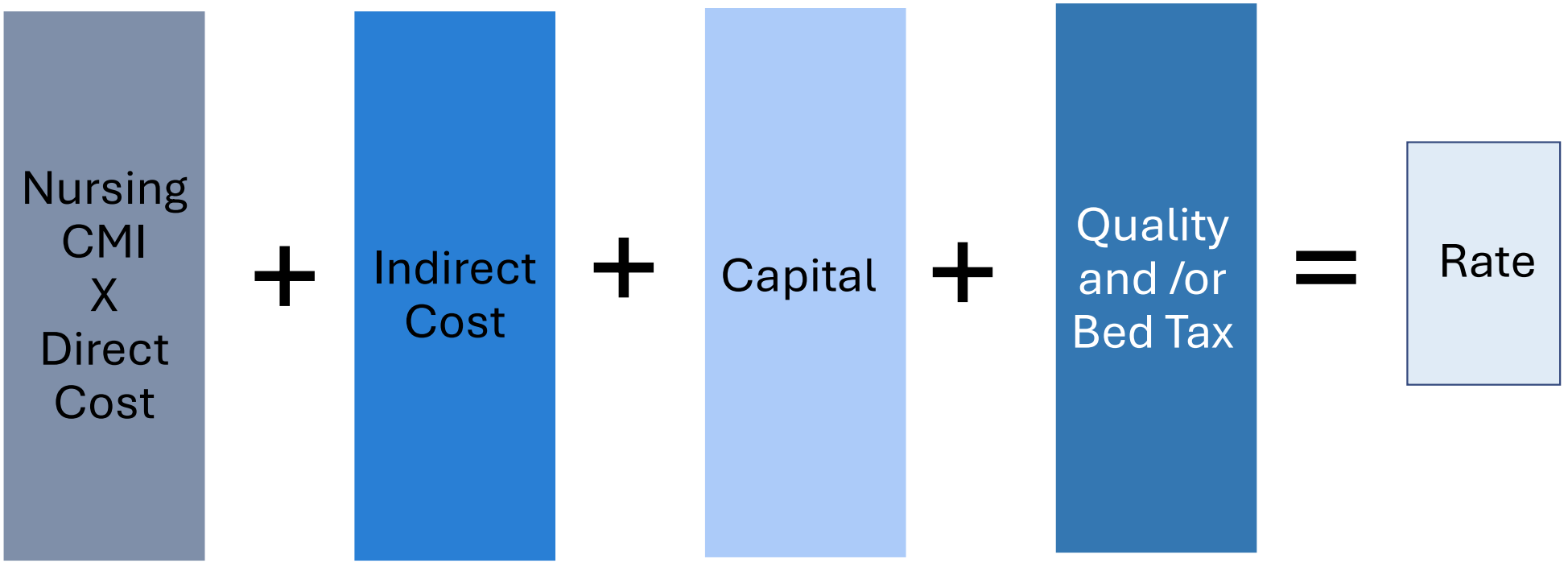
Most State Medicaid Systems



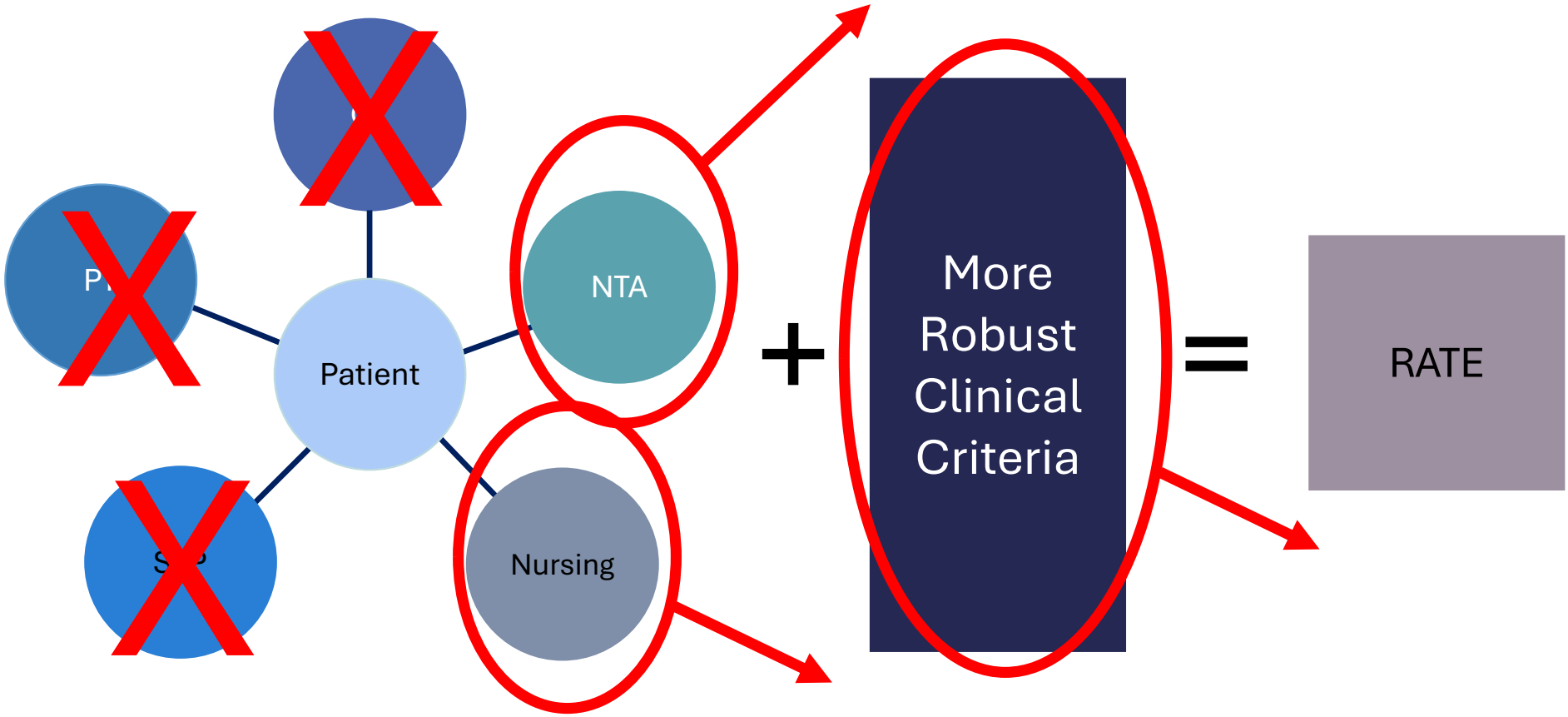
Medicare FFS Rates PDPM



Most State Medicaid PDPM Systems



Medicaid FFS Rates PDPM

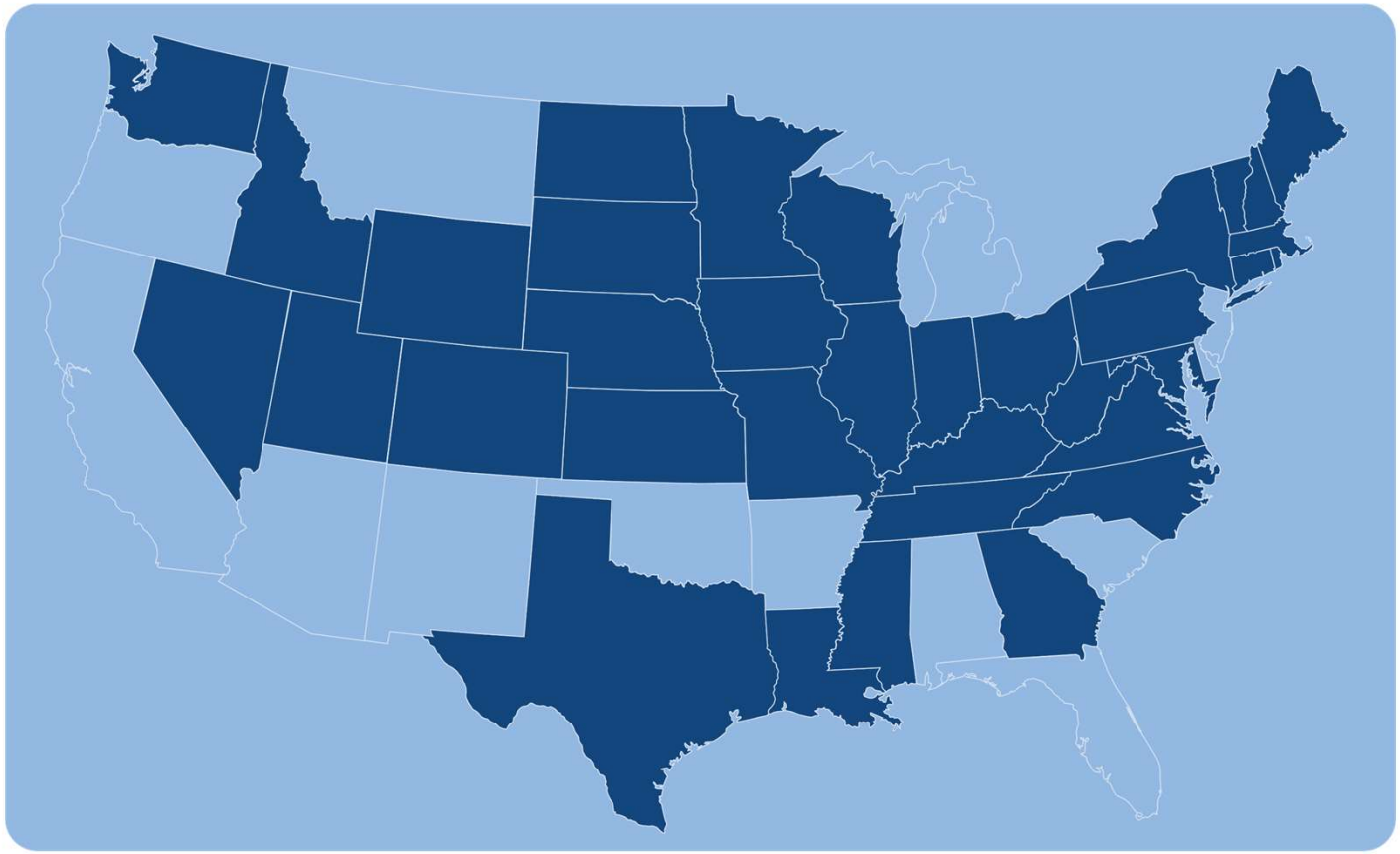


Transition to PDPM Medicaid

Case-Mix Index States

CONNECT

States that utilize any form of CMI system



Medicaid PDPM transition information contained within this map is not based on final state regulations in all cases. PDPM transition information is based on published state regulation or conversations with state officials, state association leadership or operators within the state. The goal of this map is to show National trends and the possible direction that states may take leading up to the October 2025 transition deadline. The information contained within is current as of April 2025, and the status for any state may change at any time. Prior to adoption of any reimbursement strategy, we advise SNF operators to confirm the transition status with your respective State.

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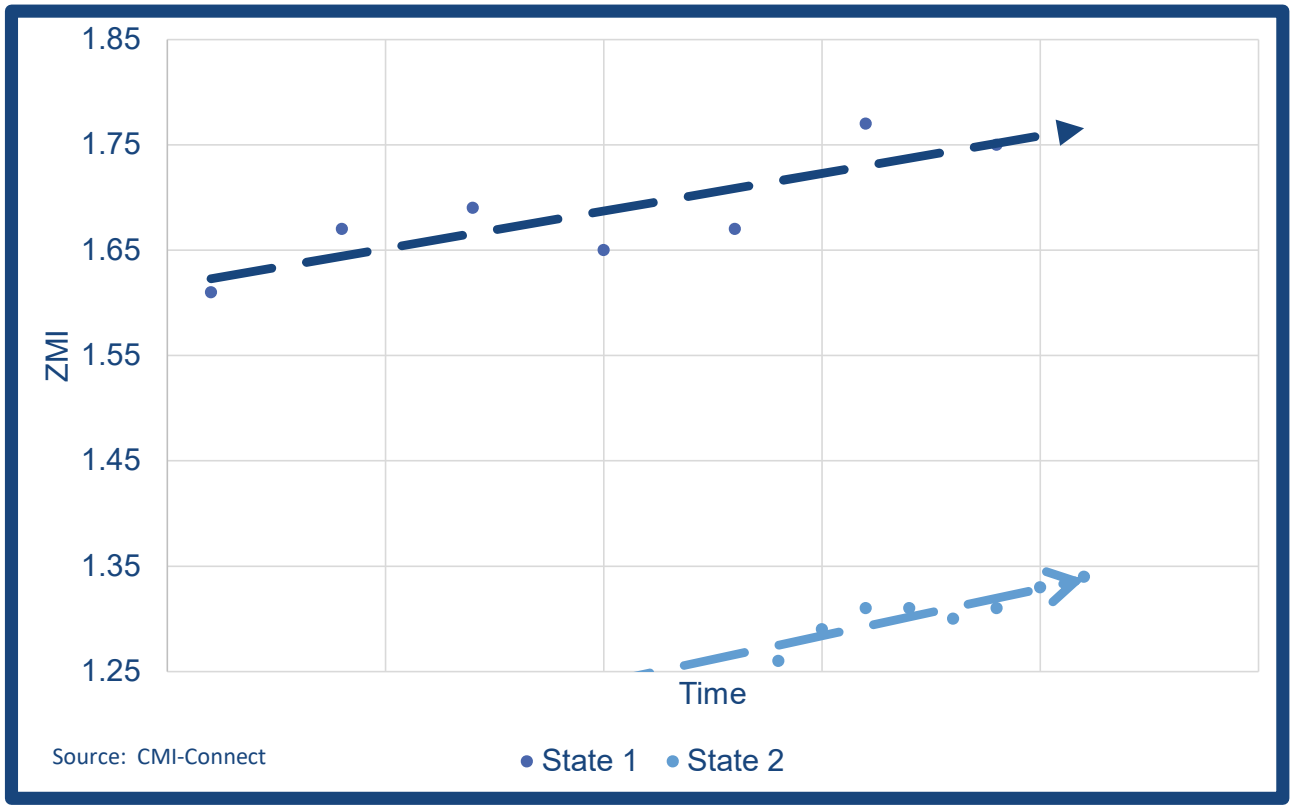
Not all State Transitions are Created Equal

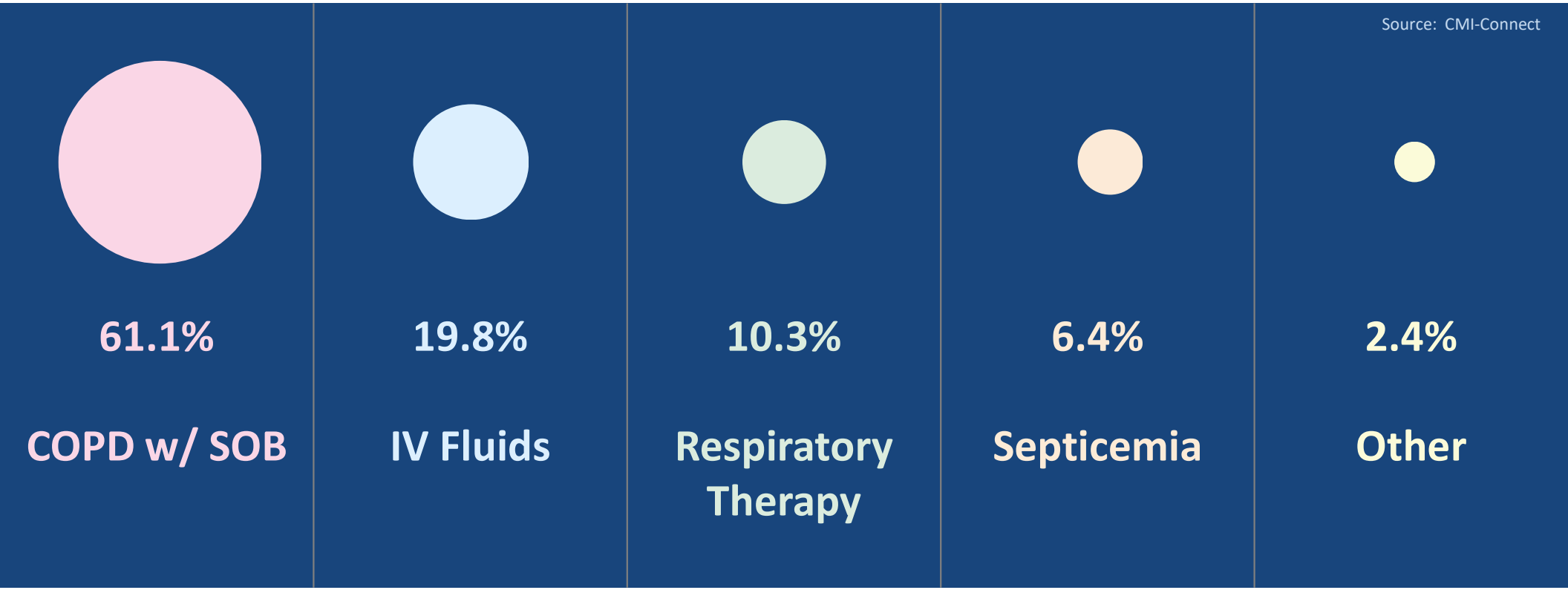


Early CMI Capture Trends in New York

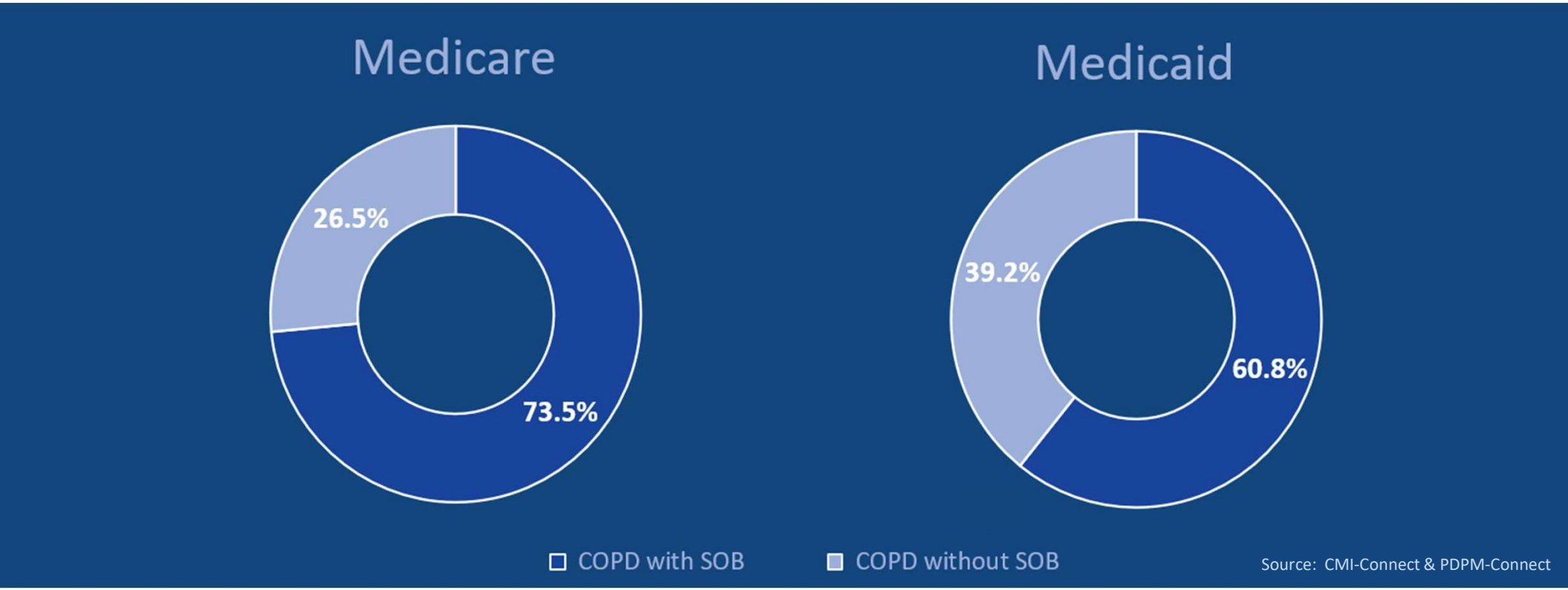
Category	9/30/24 Collection	3/31/25 Collection
CMI	**1.42**	**1.44**
Extensive Services	1.8%	2.2%
Special Care High	25.5%	26.8%
Special Care Low	11.0%	11.1%
Clinically Complex	13.9%	13.8%
Behavioral	11.3%	10.9%
Physical Function	36.5%	35.3%
Depression	25.5%	28.9%
Restorative Nursing	4.1%	3.6%
Function Score "A"	20.1%	19.8%

Source: CMI-Connect, 222 contributing New York skilled nursing facilities. Medicare PDPM Nursing CMI weights used as a proxy for CMI figures displayed above 9/30/24 Collection includes eligible NY Medicaid assessments from April 1 to September 30, 2024. 3/31/25 Collection includes eligible NY Medicaid assessments from October 1 to March 31, 2025

Special Care High Breakdown for Medicaid PDPM

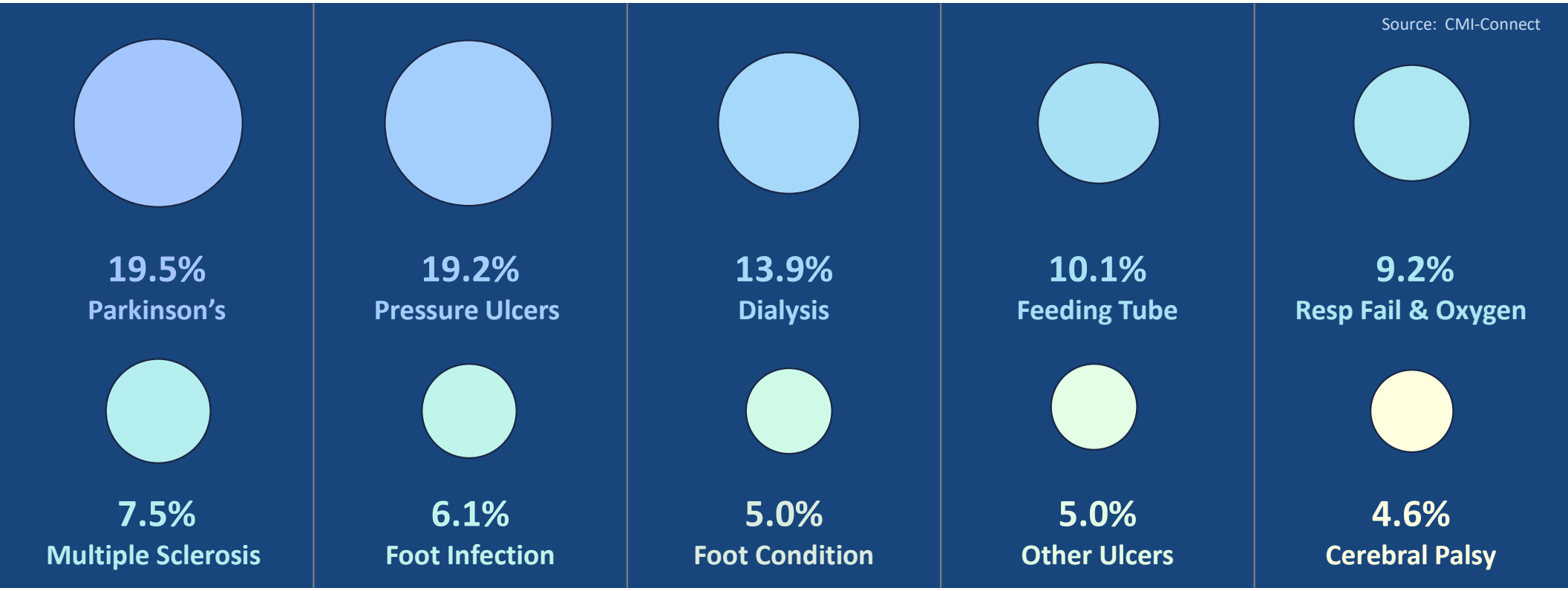


COPD Without SOB When Lying Flat

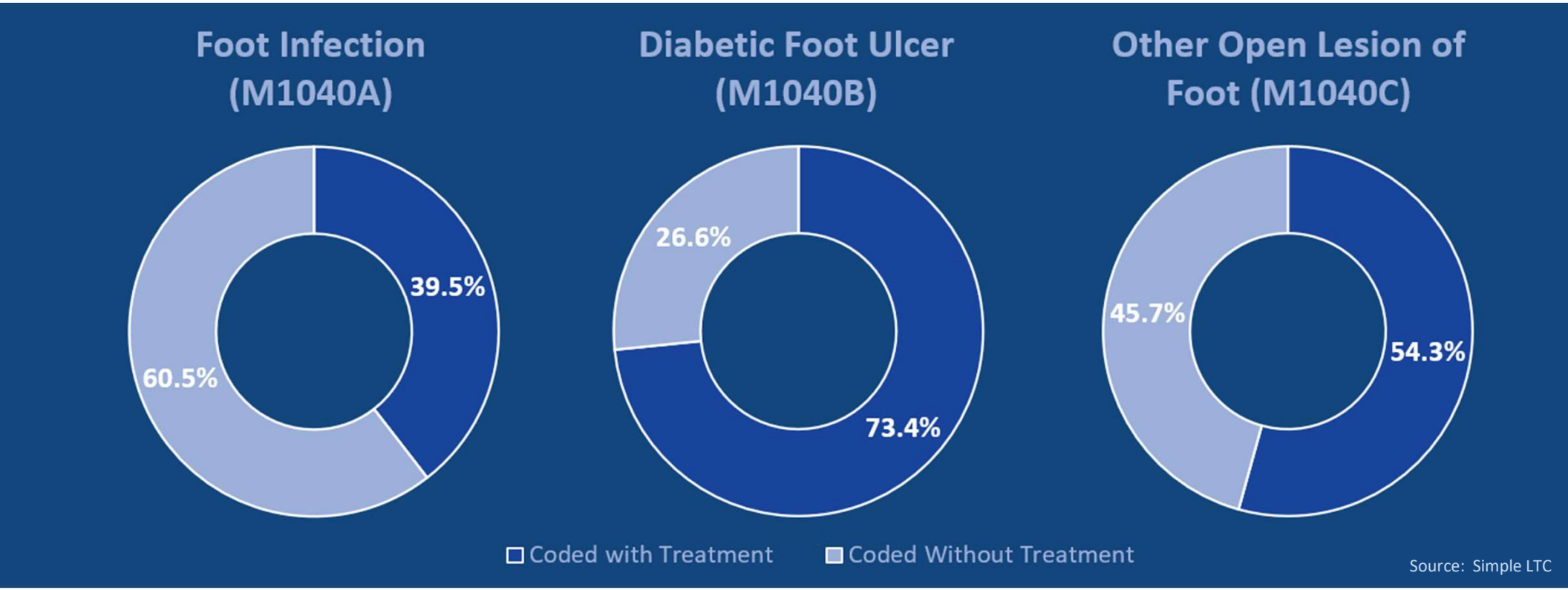


Source: CMI-Connect & PDPM-Connect

Special Care Low Breakdown for Medicaid PDPM

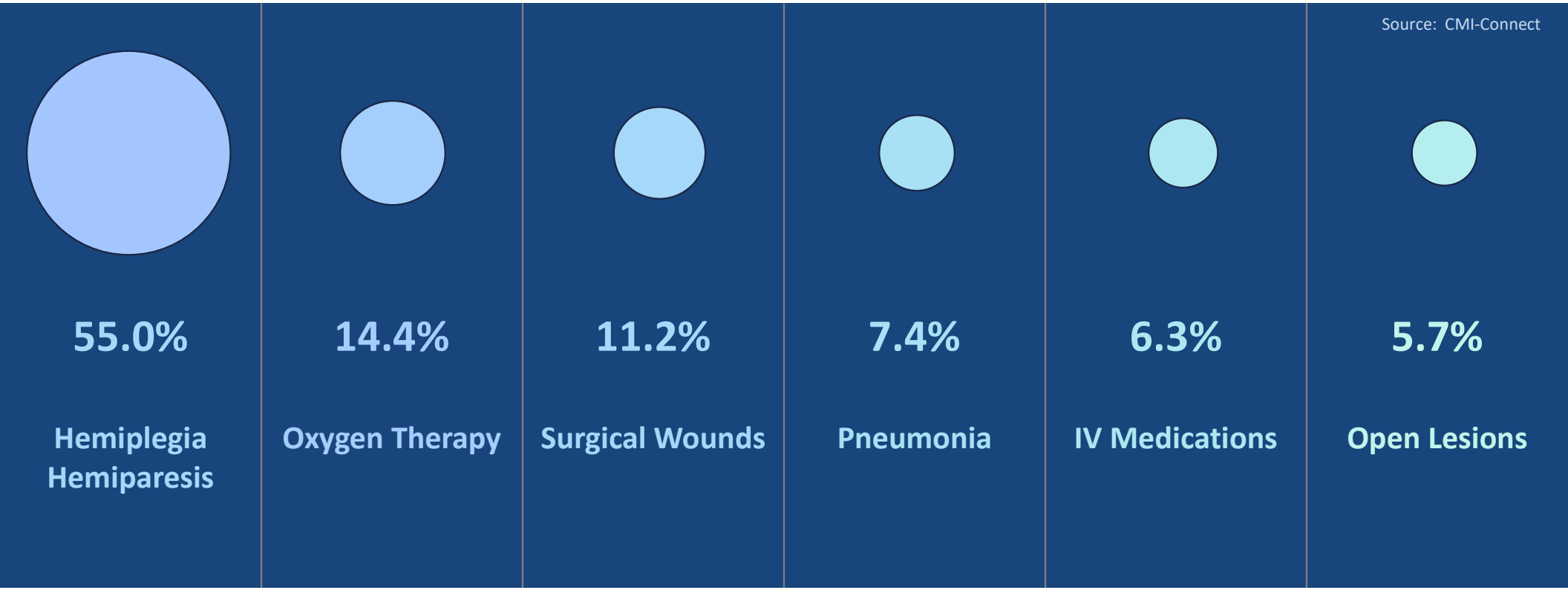


Skin Issues & Treatments

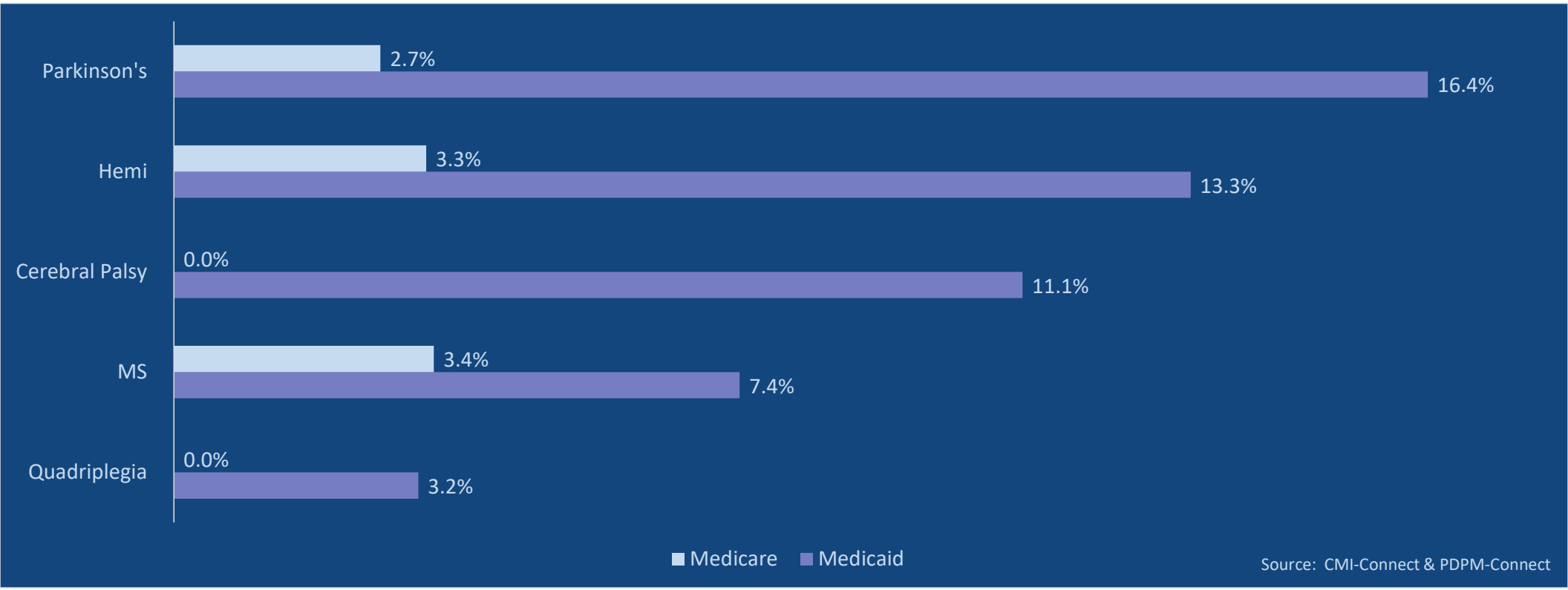


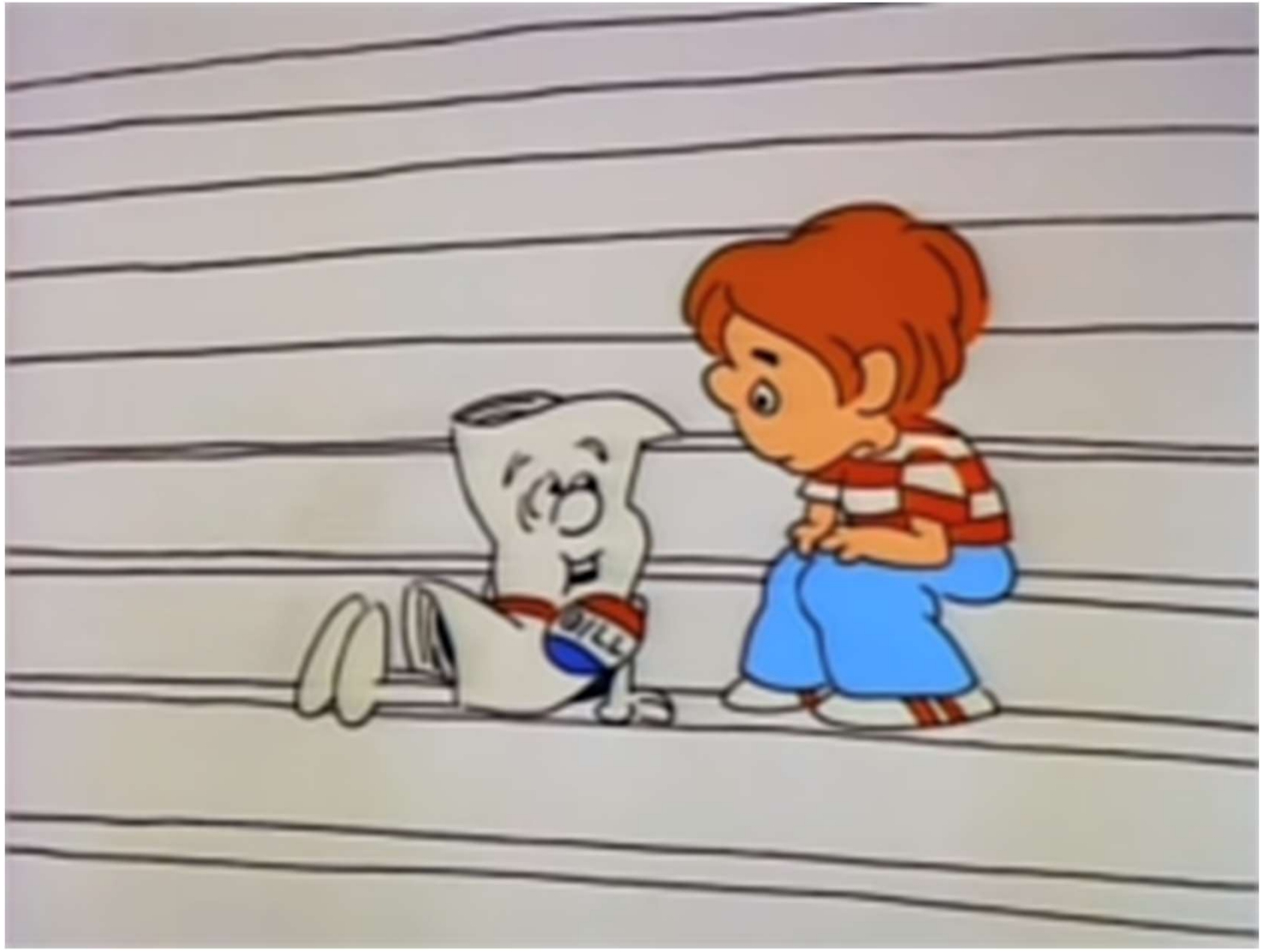
Source: Simple LTC

Clinically Complex Breakdown for Medicaid PDPM



Medicaid “Acuity Eliminator”




BILL

The OBBBA Decoded:

- The One Big Beautiful Bill Cut about $1T out of Medicaid over the next 10 years
- Most of those “cuts” are around reductions in enrollment and funding mechanisms, not mandatory rate or benefit changes
- SNFs came out better than most providers, with most of the population effected not big users of LTC– Biggest concerns are “halo” effects
- Savings of Federal Medicaid funding over 10 years do not directly translate into cuts to provider rates and any potential reductions to funding does not impact all programs equally

SNF's are Well Protected from Medicaid Changes

The government controls overall Medicaid spending through three primary levers:

- **Benefits**
  - Specifies what services are covered
    - Coverage differs from private insurance (e.g., includes long-term nursing home care)
- **Enrollment**
  - Defines who qualifies for Medicaid
    - Medicaid is a public assistance program, not traditional insurance
    - Designed to serve low-income individuals
- **Rates**
  - Sets how much is paid for each service
    - States primarily control rates
    - Federal government sets upper payment limits, typically tied to Medicare benchmarks

Lever 1 - Benefits

- No Viable Alternative:
  The government cannot cut the Medicaid SNF benefit without establishing a cost-effective alternative for delivering:
  - Meals
  - Nursing care
  - Housing
  - Medications
  - Preventive medical oversight

- Congregate Settings Are Most Efficient:
  Currently, nursing homes remain the most efficient and scalable model for meeting these needs

- High Financial & Moral Costs:
  Eliminating this benefit would leave vulnerable elderly individuals with no place to go, creating severe humanitarian and fiscal consequences

Lever 2 - Enrollment

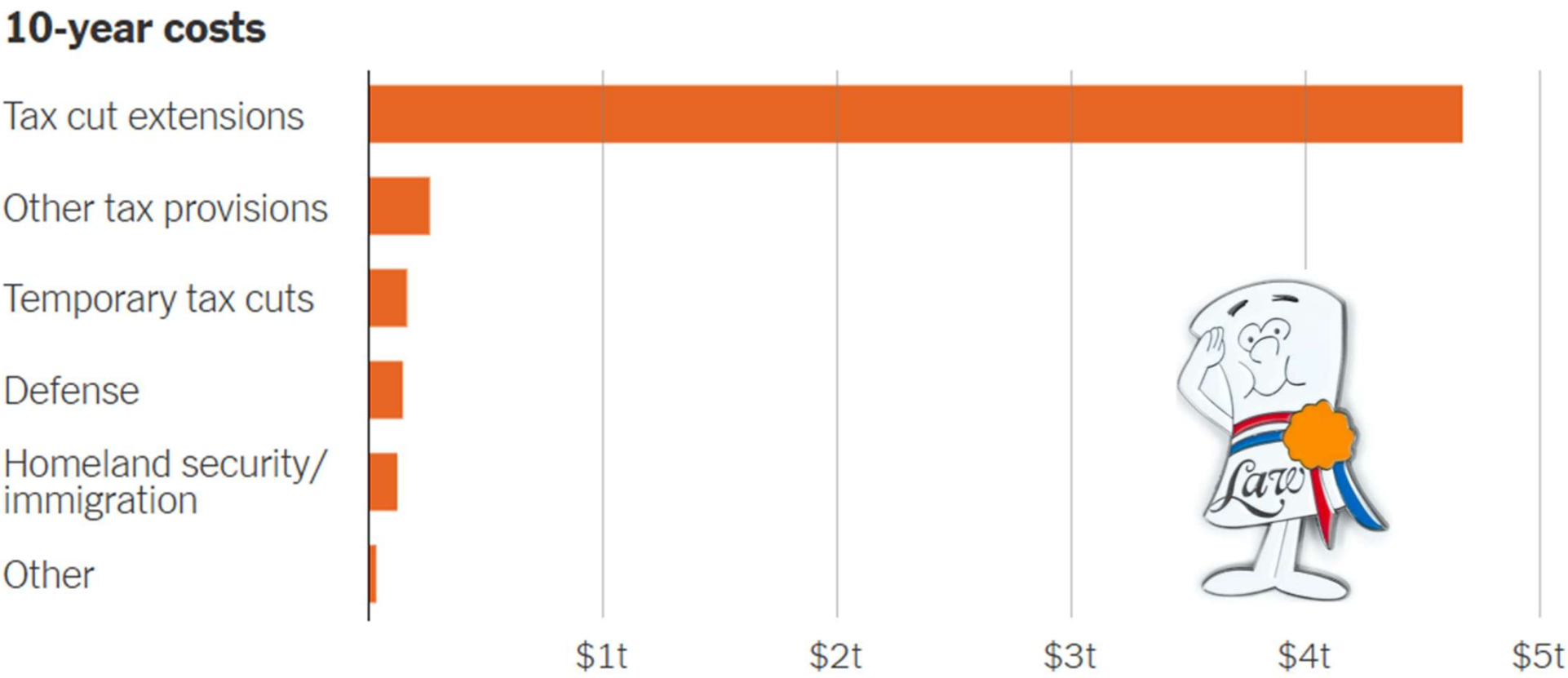
Why Institutional Medicaid Remains Relatively Protected

- Strictest Eligibility Standards in the Medicaid program:
  - Tighter definitions of “poor” or “indigent”
  - Includes five-year look-back, spousal refusal limits, and collection of Naturally Accruing Monthly Income
- These rules are stricter than community-based Medicaid, limiting access to only the most financially needy
- As a result, most proposed policy changes are unlikely to significantly impact long-term nursing home residents covered under Institutional Medicaid

Lever 3 - Rates

- SNF Rates Are Near the Lowest Sustainable Levels
  - Modest increases in some states, but no system can withstand major cuts
  - Significant reductions would lead to widespread facility closures
- Systemic Impact of Closures
  - Nursing Homes act as a critical release valve for hospitals
  - Without them, hospitals would face rapid overcrowding
  - Average hospital stay: ~5 days; backups would happen quickly
- Essential to Public Health Infrastructure
  - The necessity of nursing homes is well recognized across the healthcare system
  - This critical role insulates the sector from deep rate cuts

What's in the Law?



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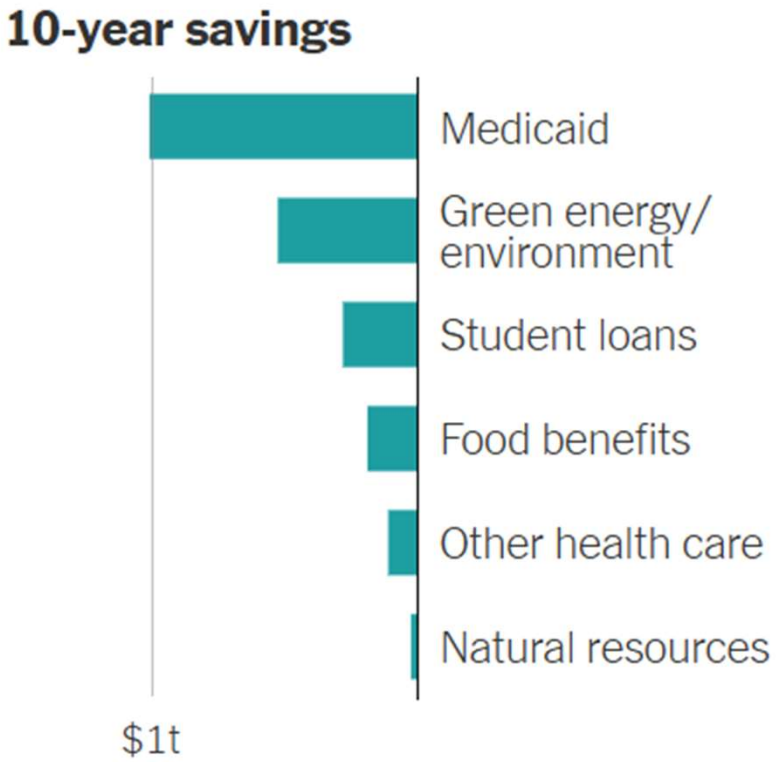
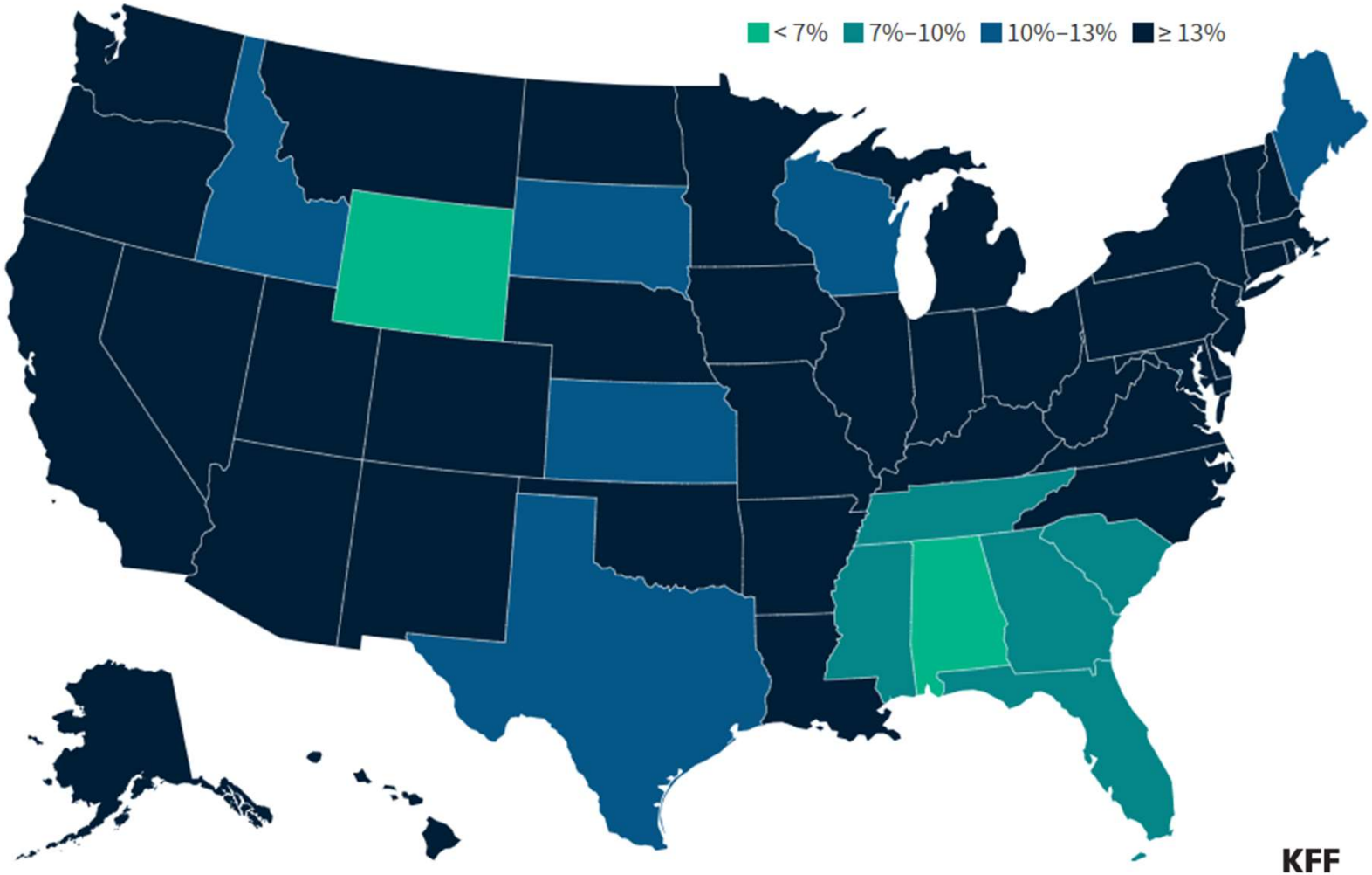


% Cuts By State



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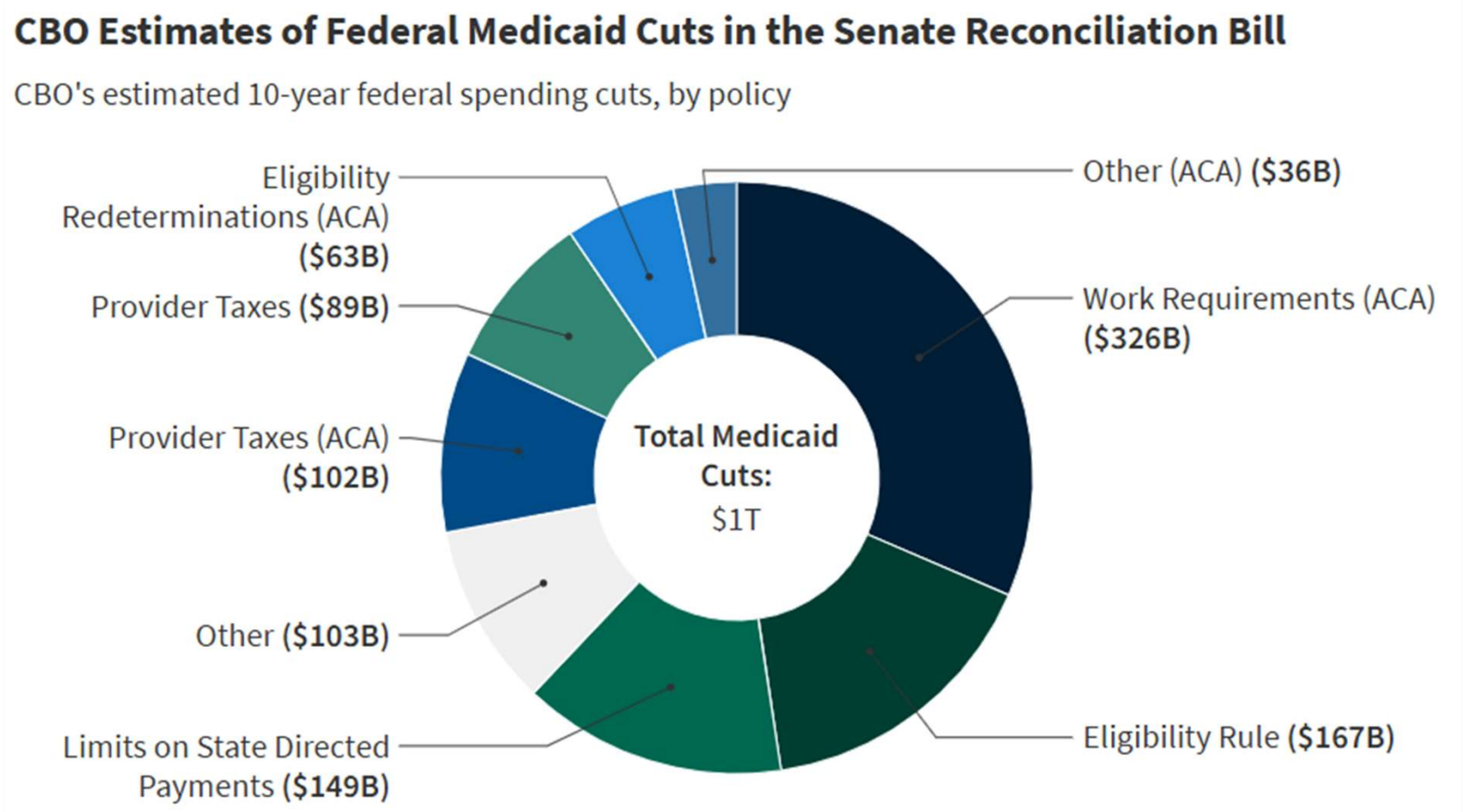

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Cap on Provider Taxes	**The House bill freezes all current provider taxes and imposes a moratorium on new provider taxes.** Under current Federal law, a state may finance the "local share" of Medicaid with a "provider tax"—a tax on health care providers—of up to 6% of a provider's net patient revenues. The freeze would prohibit states from increasing current taxes or imposing new taxes. The House bill also sunsets taxes that don't have a uniform tax structure, including New York's recently enacted Managed Care Organization (MCO) tax. The bill allows the Administration to provide up to a three-year transition period. **CBO score: $123.9 billion in savings over 10 years**	The Senate bill freezes all provider taxes and rates in effect as of May 1, 2025. Starting in fiscal year (FY) 2028, the Senate bill incrementally reduces the provider tax cap from 6% to 3.5% by reducing the cap by .5% per year until it reaches 3.5%. Nursing homes, intermediate care facilities, and non-expansion states would be exempt from the provider cap reduction. **The Senate provision is more restrictive and causes a larger financial impact than the House bill.** The Senate language essentially mirrors the House language in eliminating "broad-based and uniform" tax waivers, such as what New York has for its MCO tax.	Limits states' ability to generate Medicaid funding through provider taxes, potentially reducing Medicaid reimbursement rates for SNFs. Senate bill's stricter cap could disproportionately affect SNFs in states relying heavily on provider taxes.

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Provider Tax Issues?

Just because some fundings are cut, it doesn't mean that SNF rates will be.

State	Provider Taxes
AZ	Hospital Tax Over 5.5%
CA	No Hospital Tax Over 3.5%, but MCO tax
CO	Hospital Tax Over 5.5%
CT	Hospital Tax Over 5.5%
IL	Hospital Tax Over 3.5% But Not Over 5.5%, MCO Tax
IN	Hospital Tax Over 3.5% But Not Over 5.5%
IA	Hospital Tax Over 3.5% But Not Over 5.5%
MA	No Hospital Tax Over 3.5%, but MCO tax
MN	Hospital Tax Over 3.5% But Not Over 5.5%, MCO tax
MI	Hospital Tax Over 3.5% But Not Over 5.5%
OH	No Hospital Tax Over 3.5%, but MCO tax

State	Provider Taxes
MO	Hospital Tax Over 3.5% But Not Over 5.5%
NV	Hospital Tax Over 3.5% But Not Over 5.5%
NH	Hospital Tax Over 3.5% But Not Over 5.5%
NY	Hospital Tax Over 3.5% But Not Over 5.5%, MCO tax
OK	Hospital Tax Over 3.5% But Not Over 5.5%
OR	Hospital Tax Over 5.5%
RI	Hospital Tax Over 5.5%
UT	Hospital Tax Over 3.5% But Not Over 5.5%
VT	Hospital Tax Over 5.5%
VA	Hospital Tax Over 5.5%
WV	No Hospital Tax Over 3.5%, but MCO tax

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Limits on State Directed Payments (SDPs)	**The House bill caps SDPs at the Medicare rate—a significantly lower limit than the current average commercial rate (ACR) ceiling.** The bill includes a grandfathering provision that would allow the ACR limit for any SDPs submitted (and ultimately approved) within the Medicaid managed care rating period (or State fiscal year for New York) as of the date of enactment. **CBO score: $72 billion in savings over 10 years**	Under the Senate bill "new" SDPs would be capped at 100% of the Medicare rate for Medicaid expansion states, and 110% of the Medicare rate for non-expansion states. While the House bill grandfathers "existing" SDPs at their current levels, the Senate bill gradually drops the allowed SDP amount. If the SDP was approved by May 1, 2025 (or there was a good faith effort to receive approval or if it was submitted prior to enactment), its rate will be reduced by 10% per year with the rating period beginning January 1, 2028, until it reaches the Medicare rate. **The Senate provision is more restrictive and causes a larger financial impact than the House bill.**	Minor Lower SDP caps could reduce supplemental Medicaid payments to SNFs, especially in non-expansion states. Senate bill's gradual reduction may lead to long-term funding instability for SNFs relying on SDPs But most programs are under Medicare caps.

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Federal Medical Assistance Percentage (FMAP) Penalty for Covering Undocumented Immigrants	The House bill reduces the ACA expansion population FMAP from 90% to 80% for states that cover undocumented immigrants with state-only funds. CBO score: $11 billion in savings over 10 years	Removed due to Byrd Rule.	

House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Work Requirements	**The House bill conditions Medicaid coverage on work status.** The bill imposes 80 hours per month of working or volunteering, with exemptions for disabled populations, students, and other vulnerable groups. **CBO score: $344 billion**	**The Senate bill is largely the same as the House bill** but restricts the exemption for "parents with dependents" to dependents aged 14 and below (down from 18 and below in the House bill).	Minimal

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Eligibility Checks and Restrictions	**The House bill requires ACA expansion enrollees (income between 100% and 138% of FPL) to recertify their eligibility for Medicaid every six months,** an increase from the current annual requirement. It would also limit retroactive coverage to one month prior to an individual's application date. **CBO Score: $59.6 billion in savings over 10 years**	Same as House bill.	Minimal

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Rescind Eligibility Rules	**The House bill eliminates rules that streamline Medicaid enrollment.** These rules limit burdensome paperwork requirements, decrease the frequency of enrollment checks, limit unnecessary in-person appointments, and prevent eligible beneficiaries from "churning" off and on the Medicaid program. **CBO Score: $167 billion in savings over 10 years**	Same as House bill.	Eliminating streamlined enrollment could increase churn and administrative complexity, potentially delaying Medicaid payments to SNFs and increasing uncompensated care.

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Rural Health Transformation Program	N/A	The Senate bill provides $10 billion annually in Federal funding over FYs 2026–2030 to enhance rural health care. States would be required to submit a rural health transformation plan to the Centers for Medicare & Medicaid Services (CMS) Administrator. The bill outlines criteria for the Administrator to considering in making CMS funding determinations, as well as permitted uses of the funds.	Senate funding could benefit rural SNFs through improved infrastructure, workforce support, and care coordination, depending on state implementation plans.

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Rescind Nursing Home Staffing Rule	The House bill rescinds the nursing home staffing requirements regulation. CBO score: $23 billion	Same as House bill.	Positive

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House-Senate Reconciliation Side by Side

Proposal	House-Passed Bill (5/22/25)	Senate-Passed Bill (7/1/25)/Sent to POTUS As Final (7/3/25)	Impact on SNFs
Other Provisions	The House bill **includes a permanent Medicare Physician Fee Schedule Fix** that ties the update to an inflation measure and removes the differential update for participating in an alternative payment model. The House bill **delays for two years scheduled Medicaid Disproportionate Share Hospital (DSH) cuts** until 2029.	The Senate bill would provide a set update to the Medicare Physician Fee Schedule of 2.5% for calendar year (CY) 2026 only. There is no adjustment for CY 2025.	Changes to the Medicare Physician Fee Schedule may affect SNFs' access to physician services. Delay in DSH cuts could help hospitals that support SNFs, especially in underserved areas.

State-by-State OBBBA Impact Analysis
High Impact States

- Louisiana
- Illinois
- Nevada
- Oregon
- These expansion states will see federal Medicaid spending reduced by 19% or more
- Combined impact includes loss of expansion funding, provider tax revenue, and increased uncompensated care costs
- Rural hospital systems particularly vulnerable to closure

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State-by-State OBBBA Impact Analysis
Impacts on Large States

- California
  - Faces an estimated $14.5 billion annual budget impact:
  - $120 billion in Medicaid cuts over 10 years
  - $25 billion in SNAP reductions
  - Significant impact on safety-net hospitals and community health centers
- Texas
  - Confronts approximately $10.3 billion annually
  - $85 billion Medicaid reduction despite non-expansion status
  - Large rural populations - high risk for rural hospital closures

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- New York
  - Faces roughly $11 billion annual impact.
  - Loss of health insurance for 1.5 million residents
  - $13 billion additional healthcare system funding reductions
  - Projected loss of 200,000 jobs statewide

State-by-State OBBBA Impact Analysis
High Federal Dependency State

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- Mississippi and Alabama
- Face disproportionate impacts despite being non-expansion states.
- Large rural populations served by at-risk hospitals
- Limited state revenue capacity to replace federal cuts

Current Trends
Stabilization of Costs

Cost Center	01/01/2019 - 12/31/2019		01/01/2020 - 12/31/2020		01/01/2021 - 12/31/2021		01/01/2022 - 12/31/2022		01/01/2023 - 12/31/2023	
	TOTAL	PPD	TOTAL	PPD	TOTAL	PPD	TOTAL	PPD	TOTAL	PPD
Employee Benefits	$795,503	$18.13	$789,608	$18.40	$847,090	$19.67	$749,267	$17.85	$811,714	$20.23
Administrative & General	$2,837,795	$64.67	$2,746,837	$64.00	$2,811,106	$65.26	$2,729,479	$65.03	$2,913,311	$72.61
Plant Operation, Maintenance And Repairs	$446,366	$10.17	$457,728	$10.66	$431,628	$10.02	$398,455	$9.49	$412,169	$10.27
Laundry And Linen Services	$123,530	$2.82	$135,147	$3.15	$137,654	$3.20	$140,376	$3.34	$149,085	$3.72
Housekeeping	$185,438	$4.23	$189,864	$4.42	$191,702	$4.45	$197,848	$4.71	$207,479	$5.17
Dietary	$624,404	$14.23	$641,316	$14.94	$642,633	$14.92	$647,126	$15.42	$652,748	$16.27
Nursing Administration	$820,645	$18.70	$874,030	$20.36	$948,628	$22.02	$856,393	$20.40	$847,022	$21.11
Central Services And Supply	$162,292	$3.70	$192,622	$4.49	$144,216	$3.35	$121,570	$2.90	$120,861	$3.01
Medical Records And Library	$38,625	$0.88	$31,832	$0.74	$26,695	$0.62	$46,177	$1.10	$43,773	$1.09
Social Service	$119,282	$2.72	$143,212	$3.34	$180,299	$4.19	$177,422	$4.23	$141,670	$3.53
Other General Service Cost	$92,669	$2.11	$58,560	$1.36	$41,588	$0.97	$72,479	$1.73	$78,377	$1.95
Skilled Nursing Facility	$3,642,147	$83.00	$3,946,464	$91.95	$4,529,309	$105.15	$4,193,379	$99.91	$4,029,664	$100.44
Total Routine Cost	**$9,888,696**	**$225.36**	**$10,207,220**	**$237.81**	**$10,932,548**	**$253.82**	**$10,329,971**	**$246.11**	**$10,407,873**	**$259.40**

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Current Trends– Stabilization of Costs

	Facility				County				State			
	Hours PPD	$ PPD	Agency Hours %	Agency $ %	Hours PPD	$ PPD	Agency Hours %	Agency $ %	Hours PPD	$ PPD	Agency Hours %	Agency $ %
RN	0.60	$33.87	0.0%	0.0%	0.44	$22.12	10.3%	12.2%	0.54	$24.39	6.3%	7.8%
LPN	0.54	$23.23	0.0%	0.0%	0.86	$35.29	14.7%	18.5%	0.84	$32.05	9.5%	12.4%
CNA	2.22	$57.83	0.0%	0.0%	2.43	$57.88	4.5%	6.1%	2.52	$55.26	3.4%	4.6%
Blended Total	**3.36**	**$114.93**	**0.0%**	**0.0%**	**3.74**	**$115.29**	**7.5%**	**11.3%**	**3.91**	**$111.71**	**5.2%**	**8.0%**

	Facility	County	State
Average Revenue $PPD	$325.75	$339.99	$347.15
Spent on Direct Care	35.3%	34.4%	32.8%
Average Non-Medicare Revenue $PPD	$294.50	$307.09	$310.23
Non-Medicare $ Spent on Direct Care	39.0%	38.2%	36.8%

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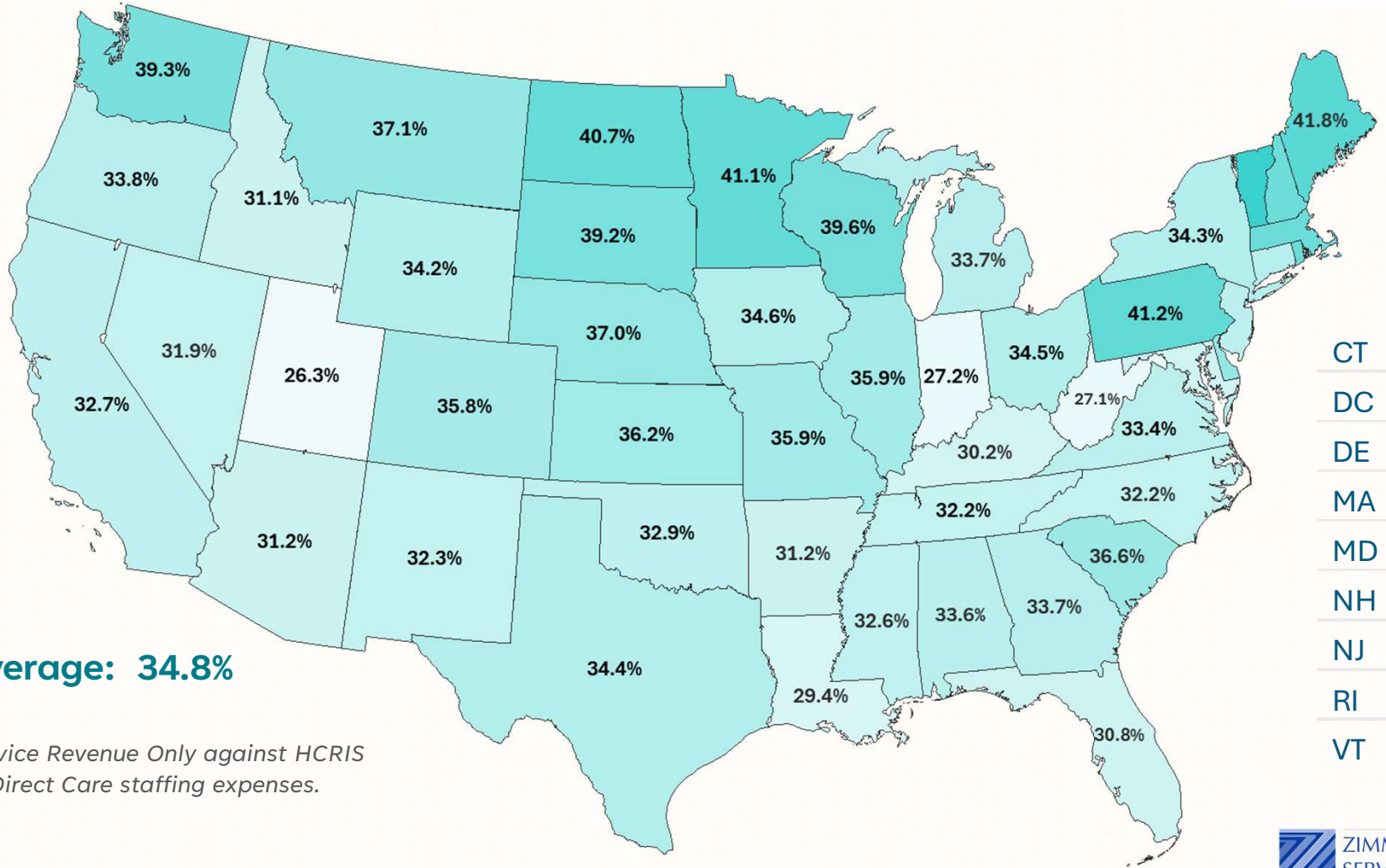
% Patient Care Revenue to Direct Care

Commentary



CT	34.1%
DC	34.4%
DE	37.1%
MA	40.3%
MD	30.4%
NH	40.2%
NJ	33.3%
RI	40.5%
VT	44.2%

Start Average: 34.8%

Patient Service Revenue Only against HCRIS allowable Direct Care staffing expenses.

Source: CMS PBJ ; Contextualized by ZHSG

ZIMMET HEALTHCARE SERVICES GROUP, LLC

Nursing CMI

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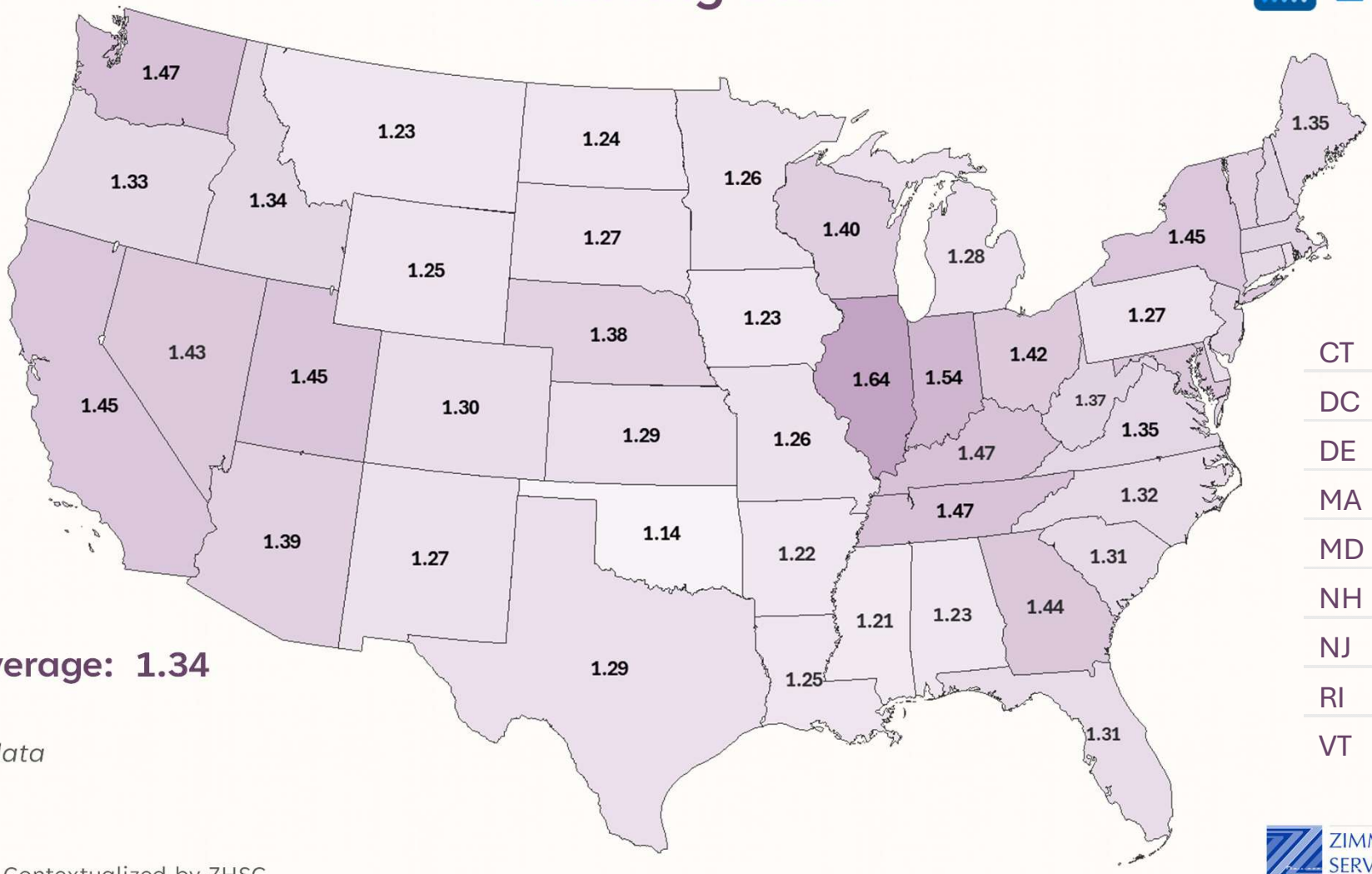


CT	1.33
DC	1.26
DE	1.31
MA	1.38
MD	1.45
NH	1.37
NJ	1.36
RI	1.30
VT	1.39

Start Average: 1.34

Q4 2024 data

Source: CMS; Contextualized by ZHSG

ZIMMET HEALTHCARE SERVICES GROUP, LLC

“Good States”

- High Medicaid Rate Elasticity
  - RUGs
  - PDPM
- High Relative Reimbursement
- Low Medicare Advantage Penetration
- High Average Occupancy
- Low Utilization of ACOs/Closed networks
- Low Average Agency Utilization
- Low Operational Regulatory Burden
- CON/Bed Need Methodology

The most profitable SNFs:

Size is most significant variable at high occupancy (but large, low occupancy SNFs also lost the most money)

Large enough for partial participation in CMMI, ISNP, etc.

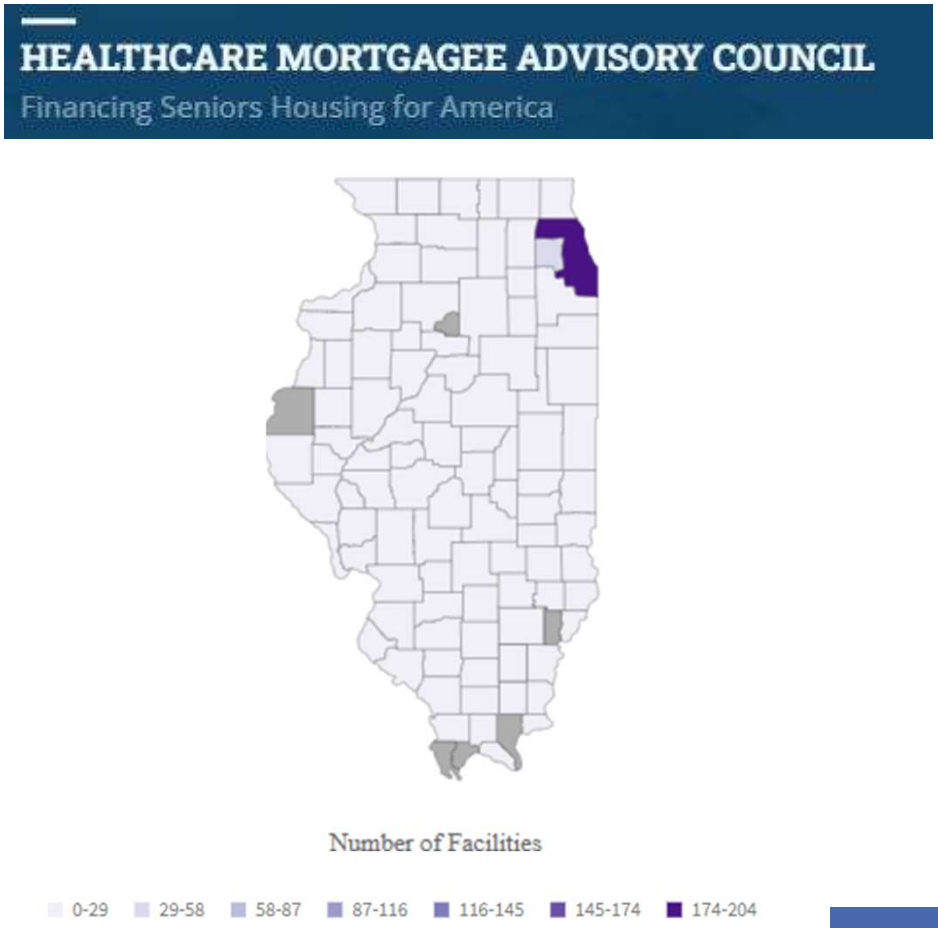
Mispriced Medicare AWIs

Favorable state Medicaid policies (e.g., Cost Sharing)

Aggressive Medicare Part B therapy

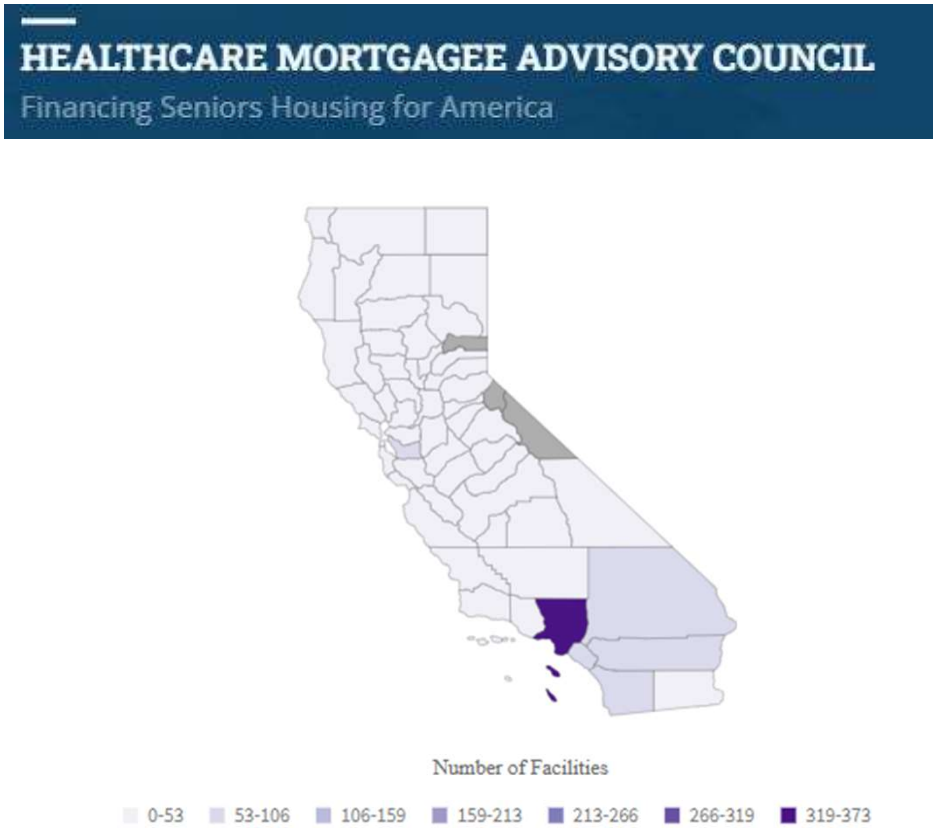
Market Notes: Illinois

- Major Changes to Medicaid a few years ago
  - Quality
  - Disproportionate Share
  - First to PDPM
- State Budgetary Issues
- Two distinct Marketplaces
  - Chicagoland
  - The Hinterlands
- “Halo” effects here



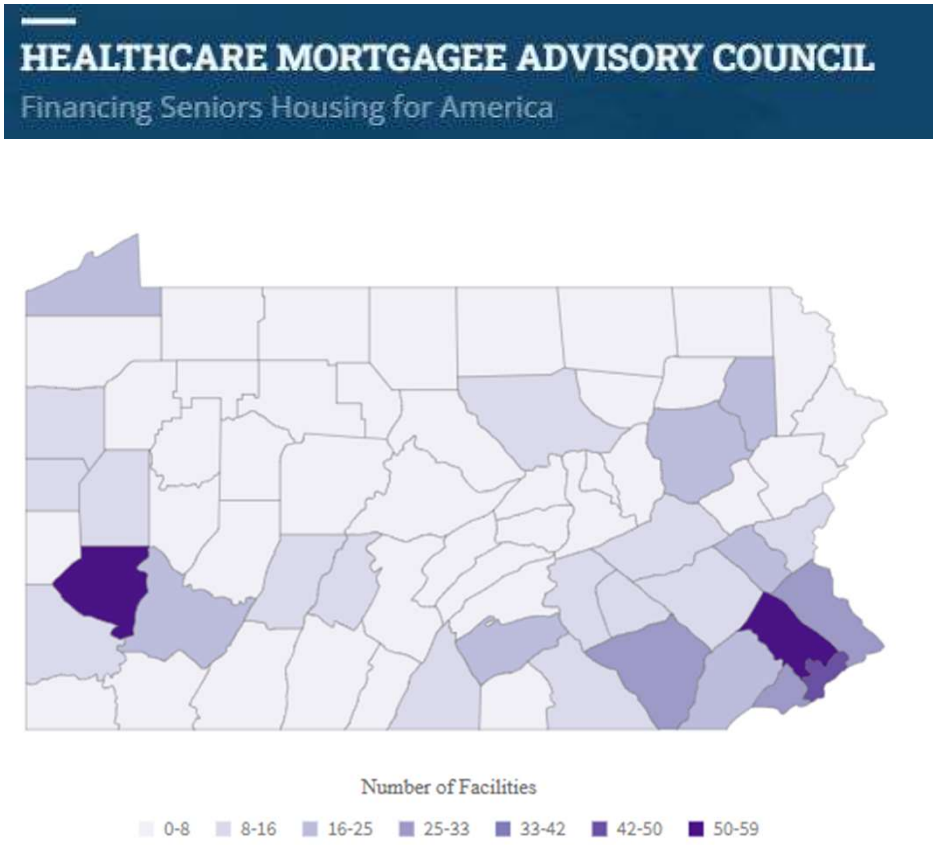
Market Notes: California

- Medicaid (a.k.a MediCal)
  - Not acuity adjusted
  - Legacy Cost Based system vs current system
- Robust Workforce & Quality program that's under the gun
  - Ending early
  - Workforce phase out
- Medicare mis-pricing (to their favor)
- Large integrated health systems (Kaiser, etc.)
- MCO tax exposure plus large state budget issues



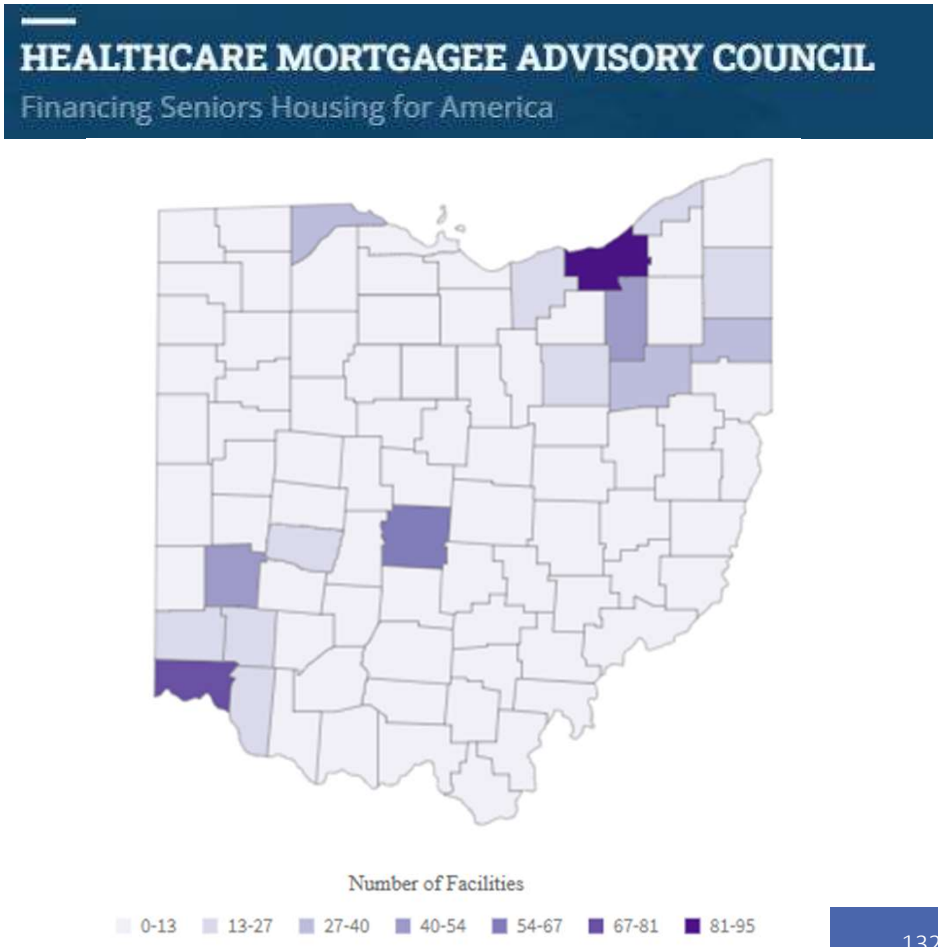
Market Notes: Pennsylvania

- Medicaid
  - Tough system
    - BAF
    - Rebasing
    - CMI “I’ll drink your milkshake”
- Medicare mis-pricing (to their detriment)
- Large integrated health systems, but very active in ACO/Alternative Payments
- Large regional Variation



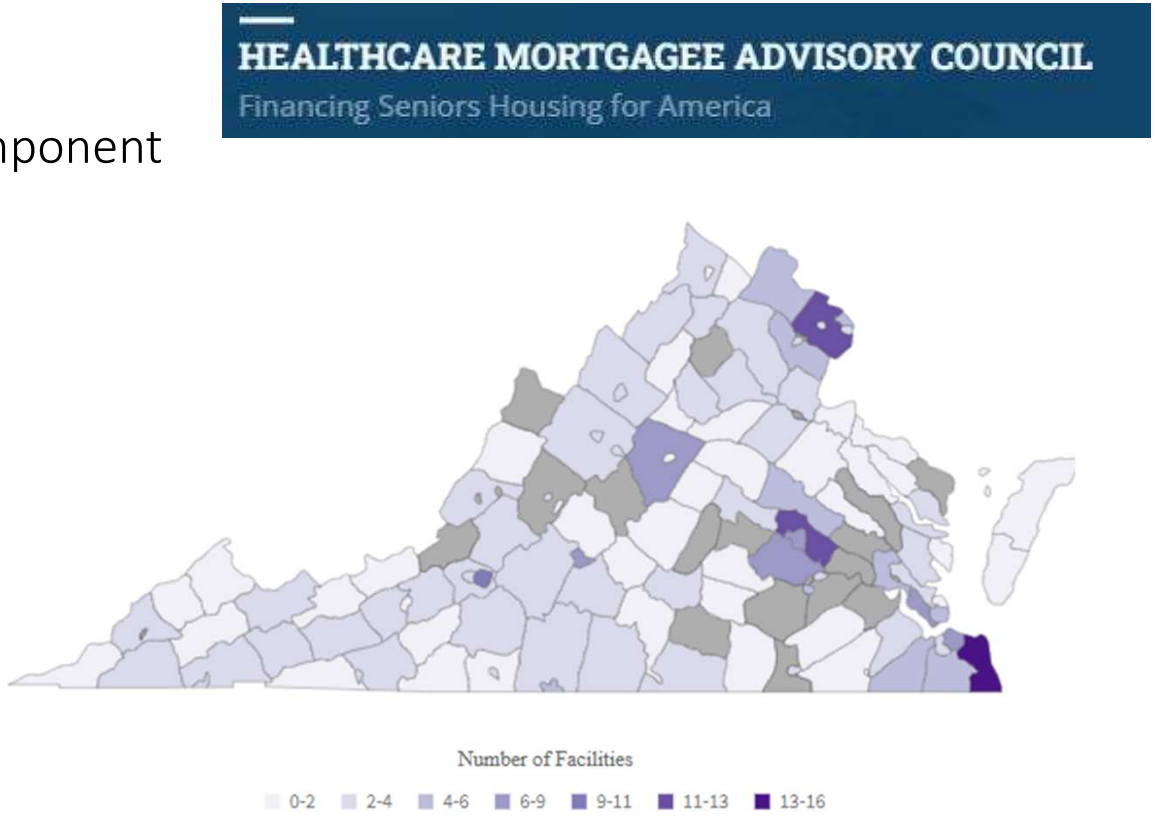
Market Notes: Ohio

- Medicaid
  - Significant quality component
  - Historic Frozen CMI→ PDPM
  - Robust Incentives
    - Private Room
    - Dementia
  - Quality $s
    - Lawsuit and Settlement
- CHOWs
- High number of homes
- Active Market



Market Notes: Virgina

- Medicaid
  - Embedded sustainable quality component
  - Strong base rate
  - PDPM just published
    - Base Rate drop
    - Actual Rate Increase
    - Why? MATH!!!!!
- Active Transactions
- Relatively easy CHOW
- Growing Market



Market Notes: North Carolina

- Medicaid
  - Large recent rate increases driven by “add on” & cost-based inflation

Effective Date	Avg. SNF Medicaid Rate	% Increase
7/1/2025	$329.54	1.1%
10/1/2024	$325.94	2.9%
10/1/2023	$316.90	31.3%
7/1/2022	$241.41	3.9%
7/1/2021	$232.24	3.6%
7/1/2020	$224.14	N/A

  - 10% Cut?!?!?!?!

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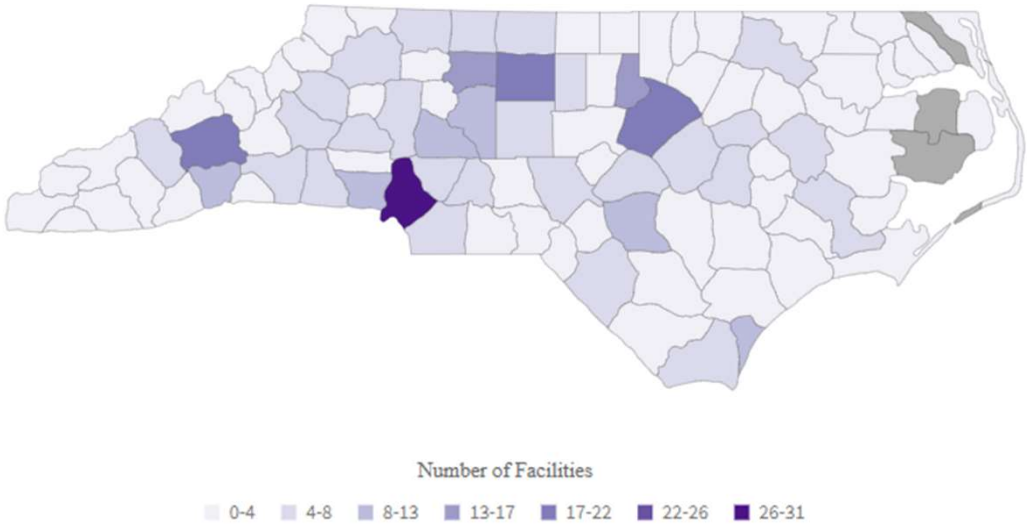
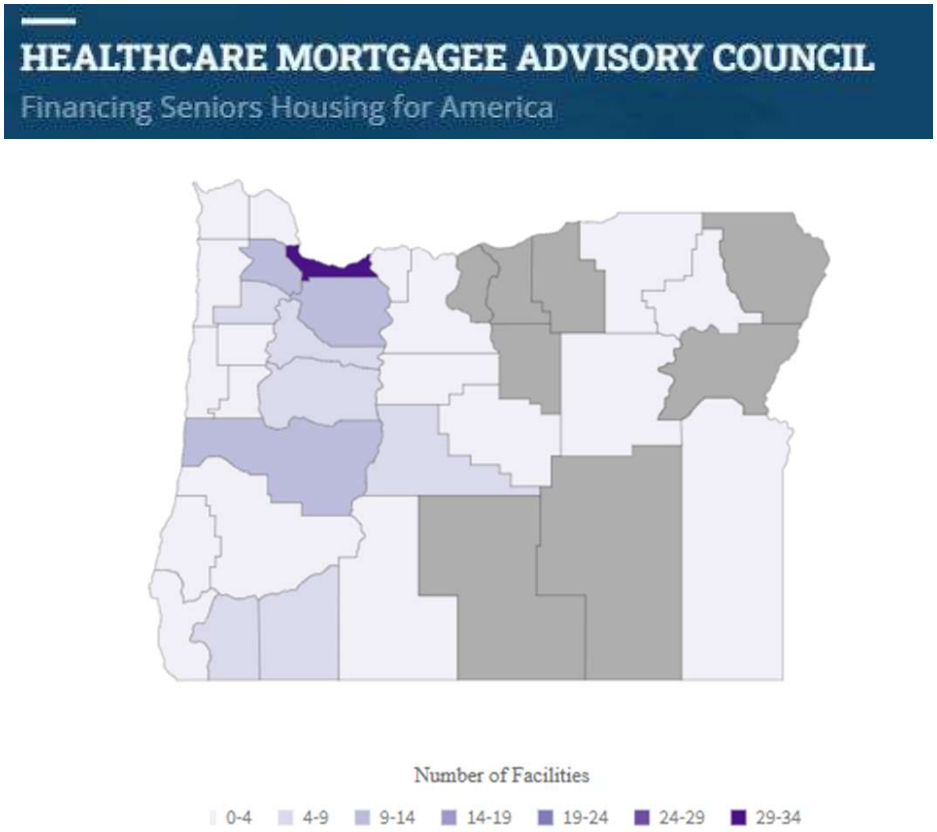


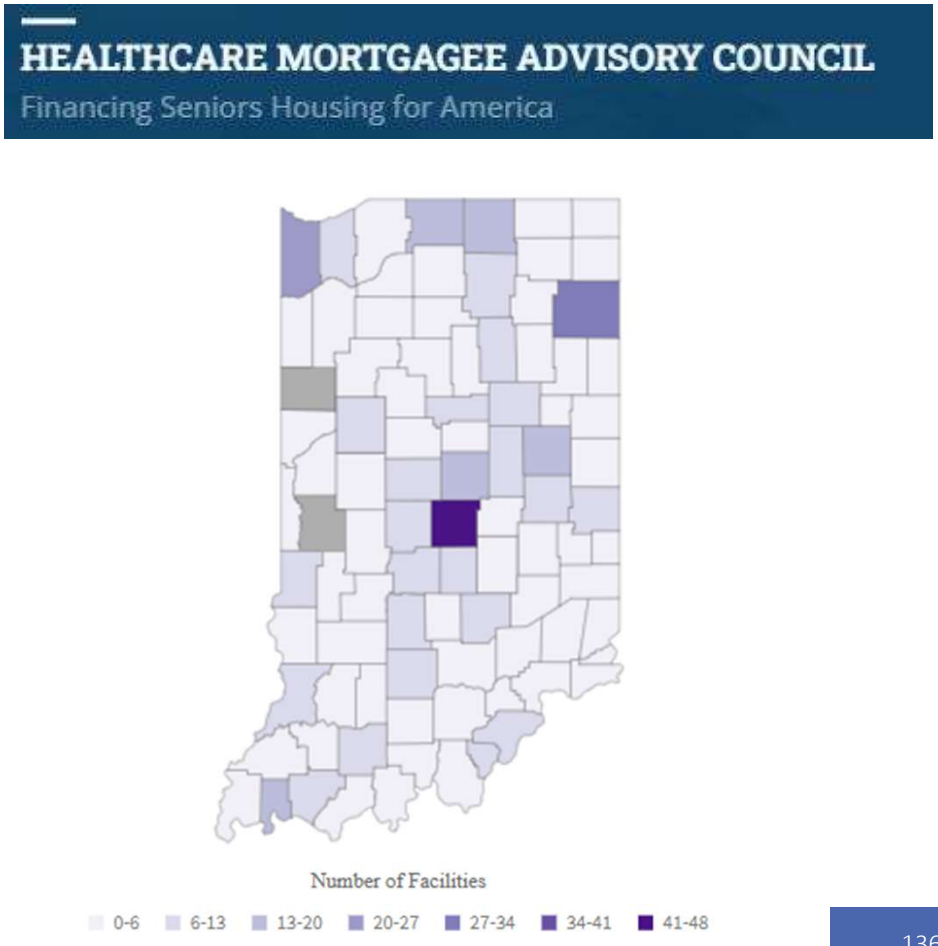
Market Notes: Oregon

- Medicaid
  - Highest average rates in the country
  - Typical rates are over $500 per day
  - Why? Because costs are high and utilization is very acute
- Largest per capita Medicaid Waiver Assisted Living program in the country
- Large integrated health systems pushing on LOS
- Rising urban MA population



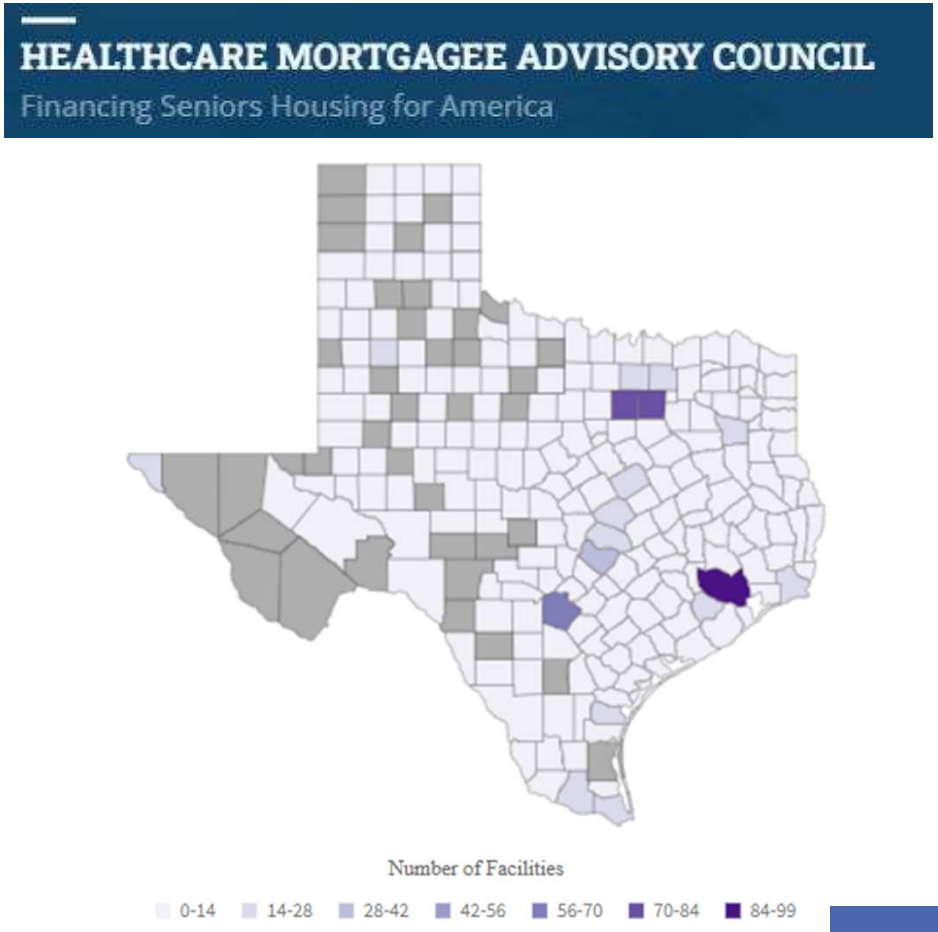
Market Notes: Indiana

- Medicaid
- The story here is UPL & State Directed Payments
- Transitioning to Managed Care/Quality Driven via MCO Pathways
- Big Beautiful Bill on State Directed Payments
- HUD & LTV implications



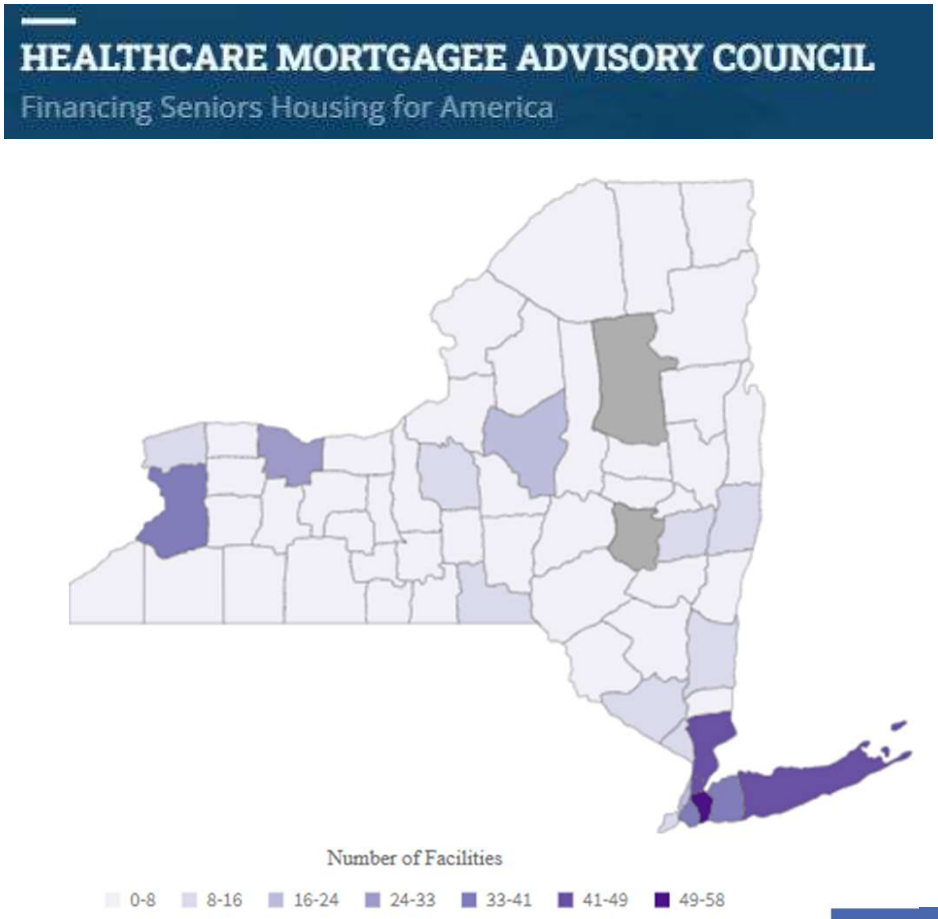
Market Notes: Texas

- Medicaid
  - The story here is IGT quality programs- QIPP
    - Worth about $31 a day
  - TX also converted to PDPM as of 9/1
    - Unique system
    - Nursing "Groups"
      - Collapsed rates in Clinically Complex, Behavioral & Physical Functioning
    - NTA points
    - BIMS
  - Pre 9/1 Rate = $185
  - 9/1 Ave Rate= $203.50
  - Stabilized Rate – $220ish
- Low Medicare FFS volume
- Lower valuations till recently
- No CON or licensure barriers to entry



Market Notes: New York

- Medicaid
  - Strong Rates downstate, weak upstate
  - Why?
    - Base rate frozen since 2012
    - Growth due to increased acuity capture
    - Base costs in upstate grew more rapidly than downstate
- Very low MA rates as a %
- Some of the highest budget neutral Medicare rates, but mis priced AWIs (not at bad as PA
- MCO tax exposure
- NYS Essential Plan

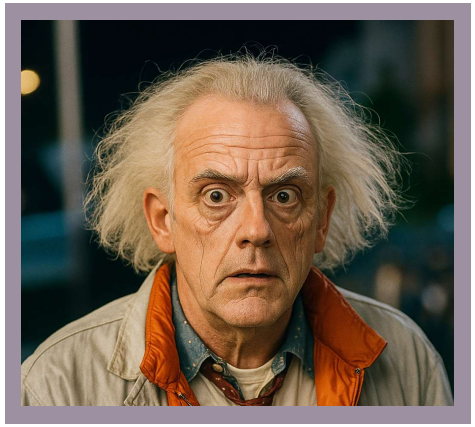


THANK YOU!!!!

Ritchie

Dan

Marty



Jay

HEALTHCARE MORTGAGEE ADVISORY COUNCIL

Financing Seniors Housing for America