



*41st Annual SNF Cost Comparison
and Industry Trends Report:*

The Economics of Skilled Nursing

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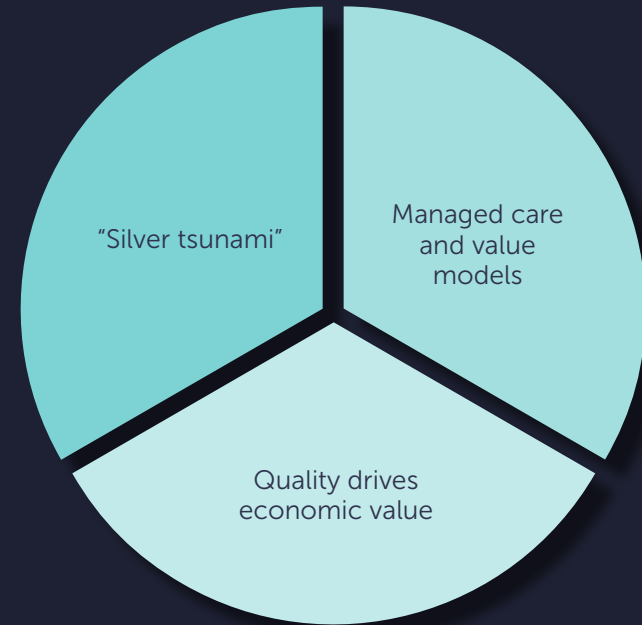
Executive Summary

The 41st SNF Cost Comparison and Industry Trends Report introduces managed care data for the first time while examining the structural forces reshaping skilled nursing. The findings reveal an industry facing strategic choices.

In 2025, occupancy improved, contract labor declined, and margins strengthened, but performance remains uneven by market and operator. The industry's challenge is shifting from recovery to strategic positioning as an aging population, constrained labor, managed care, and tightening capacity increasingly intersect.

The data points to a broader conclusion: Quality is becoming an economic asset. Higher-quality providers show stronger occupancy, lower labor instability, and materially greater admission activity, particularly under Medicare Advantage, where plans can actively manage networks and utilization.

There is no single winning SNF model. The strongest operators understand where they create differentiated value, which residents and payers fit their capabilities, and how to convert scarce staffed capacity into sustainable economics. There may be multiple ways to succeed, but increasingly fewer ways to continue business as usual.



Data sources and methodology

CMS cost report data

This publication provides benchmarks and ratios calculated using annual SNF cost report data released by the Centers for Medicare & Medicaid Services (CMS) as of July 2026. That release included approximately 11,800 cost reports for fiscal years ended 2025, representing more than two-thirds of Medicare-certified nursing facilities. For purposes of comparability, amounts presented for 2021 through 2024 only include the performance of facilities with a 2025 cost report.

Managed care data limitations

The 2025 cost report data includes newly reported managed care information associated with CMS Form 2540-24. Because these fields are available only for qualifying cost reports with fiscal year ends on or after September 30, 2025, the managed care findings reflect a partial reporting population and should be interpreted as directional. Results may change as additional cost reports become available and providers gain experience with the new reporting requirements.



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Summary statistics

Each SNF's data was ranked numerically and stratified into percentiles. These summary statistics and our perspectives are intended to provide a general understanding of financial and operational trends. The benchmarks and perspectives in this report are descriptive. Relationships observed among quality ratings, occupancy, labor, admissions, payer mix, and financial performance should not be interpreted as evidence that one measure causes another.

Other sources

This publication also uses data sources extending beyond fiscal year 2025, which includes the Payroll Based Journal (PBJ) Nurse Staffing, CMS's MA State/County Penetration reports for Medicare Advantage enrollment, and Claritas for population.

State of industry

Nearly half of SNFs are now at **85%** occupancy or higher, with the national median occupancy at **84.8%**.

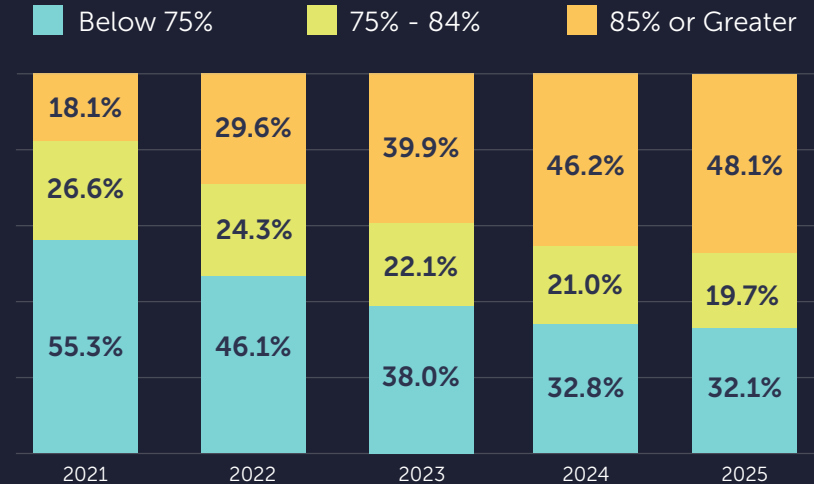
The occupancy recovery cycle appears to be maturing. While the share of providers operating above 85% occupancy continued to increase in 2025, the improvement pace slowed to 1.9 percentage points, compared with gains of 6.3 points in 2024 and 10.3 points in 2023.

As occupancy growth moderates, future gains may depend less on broad industry recovery and increasingly on provider-specific factors such as market position, referral relationships, and operational execution.

An aging population, increasing managed care penetration, staffing constraints, and limited bed capacity are likely to influence future occupancy dynamics. As a result, the industry's focus likely will gradually shift from increasing occupancy toward right-sizing it.

In that environment, competitive advantage may be determined less by the ability to fill beds and more by the ability to align resident needs, reimbursement opportunities, workforce resources, and clinical capabilities.

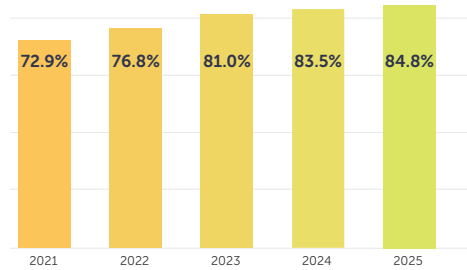
Provider Count by Occupancy Group



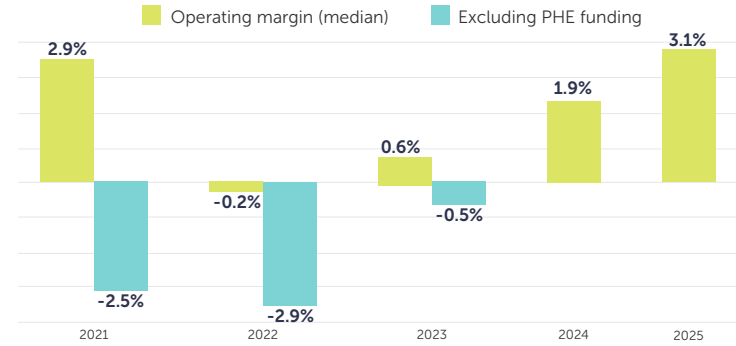
The approach may differ across providers based on market conditions, referral networks, and strategic objectives.

- Occupancy continues to climb, up almost 12 percentage points over the past five years. Approximately 32% of SNFs have occupancy below 75%, demonstrating ongoing variability by market and operator.
- Managed care (both Medicaid and Medicare) continues to shift the payer mix while also providing levers for future economic value.
- Regardless of changes in the SNF landscape, the median paid hours of nursing care remained stable.

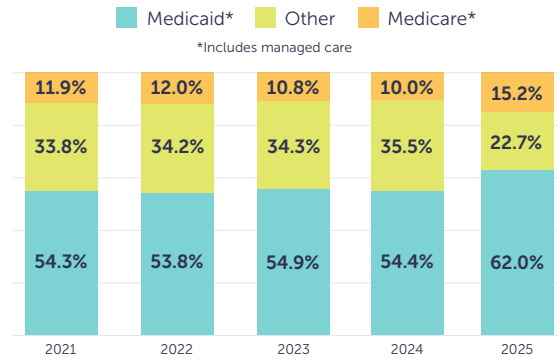
Median Occupancy Rate



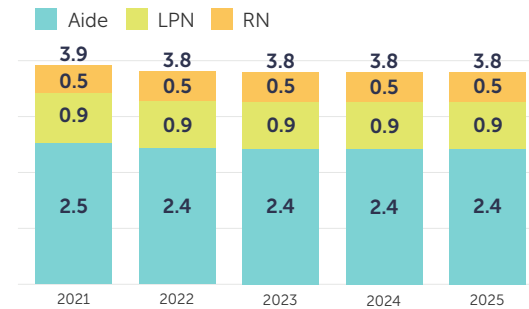
Median Operating Margin



Payor Mix Detail



Median Paid Nursing Hours Per Day



On the horizon: Medicaid's impact on SNFs

Potential disruptions are coming quickly as impending changes from the One Big Beautiful Bill Act to state directed payments, provider taxes, and redeterminations begin to take effect.

States well-positioned for future Medicaid pressure are the ones converting SNF reimbursement from a static per diem into a documented, defensible rate framework: Current cost rebasing, PDPM-aligned acuity, quality and staffing incentives, transparent provider assessment mechanics, and grandfathered state-directed payments where available.

The states most exposed are those with stale base years, heavy Medicaid SNF dependency, reliance on provider taxes or SDPs above future federal caps and limited political appetite to backfill lost federal funding. [Learn more.](#)



Role of managed care

Note: see methodology section for more detail

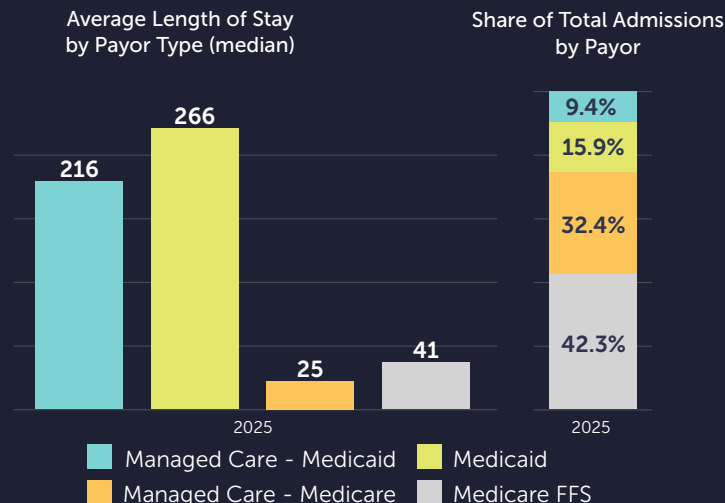
Managed care represents a meaningful share of the SNF resident inflow. There are **35+ million**, or more than 51% of all Medicare eligibles, now covered by a Medicare Advantage plan. Many states also use managed care in their Medicaid programs.

This growth is consequential, especially as plans combine scale with the ability to manage networks and utilization — an ongoing shift with implications beyond payer mix.

Census measures occupancy while admissions measure velocity. As shorter lengths of stay increase, patient throughput requirements — more admissions, transitions, authorizations, and revenue-cycle activity — take on greater importance. Financial sustainability increasingly depends not only on filling beds, but on efficiently moving residents through them.

In other words, managed care is changing not just who occupies SNF beds, but the cadence of the business itself.

- Approximately 42% of admissions in the 2025 data come from managed care plans, including 32.4% from Medicare Advantage and 9.4% from Medicaid managed care.
- Median length of stay is 25 days for Medicare Advantage compared with 41 days for Medicare FFS (39% shorter).
- Median per diem gross charges for Medicare Advantage are approximately 79% of the per diem gross charges for traditional Medicare fee-for-service.
- At those lengths of stay, a Medicare Advantage bed must turn approximately 64% more frequently to generate the same occupied days. Put another way, a SNF would need 1.6 Medicare Advantage admissions for every Medicare admission to generate the same census.

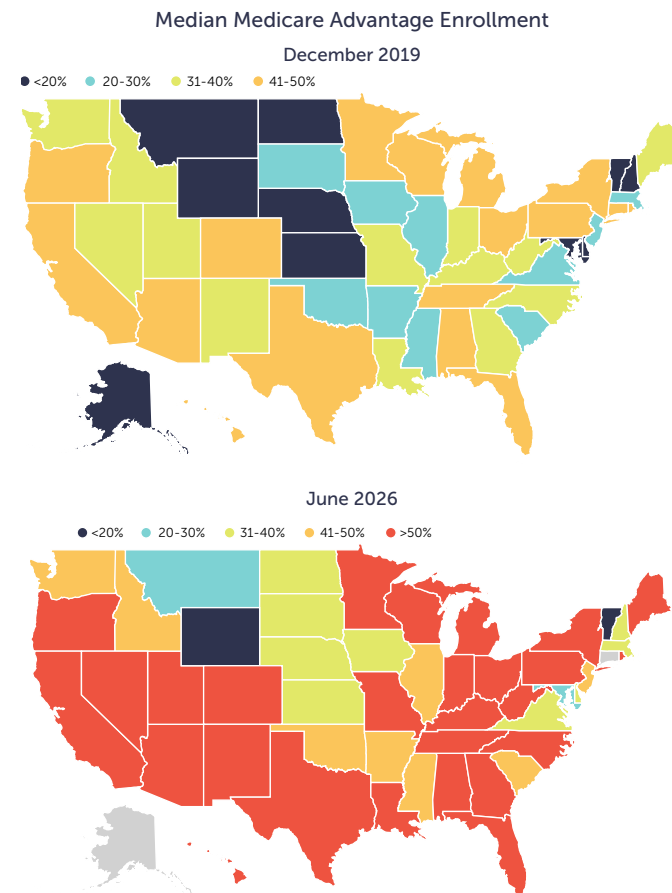


On the horizon: Value models

Success under managed care, whether Medicaid or Medicare, requires operators to focus on quality outcomes, including reduced hospital readmissions or emergency department visits while actively managing care and length of stay. That focus is akin to what success in value-based models require, as well.

Looking forward, multiple Medicare models may offer opportunities for high-quality SNFs (and other post-acute care providers) to leverage enhanced reimbursements and shared economics.

- **TEAM: Transforming Episode Accountability Model** — A mandatory bundled payment model in 188 geographies for certain hospitals for major joint replacements, bowel surgeries, surgical hip and femur fractures, coronary artery bypass grafts, and spinal fusions. TEAM launched Jan. 1, 2026, and moves to two-sided risk (i.e., financial penalties) Jan. 1, 2027. [Learn more.](#)
- **CJR-X: Comprehensive Care for Joint Replacement Expanded** — A mandatory bundled payment model for hospitals nation-wide covering lower extremity joint replacements. Launches Jan. 1, 2028. [Learn more.](#)
- **ACOs: Accountable Care Organizations** — There are multiple ACOs, including the Medicare shared savings program (MSSP) and the Long-Term Enhanced ACO (LEAD) launching Jan. 1, 2027. [Learn more.](#)



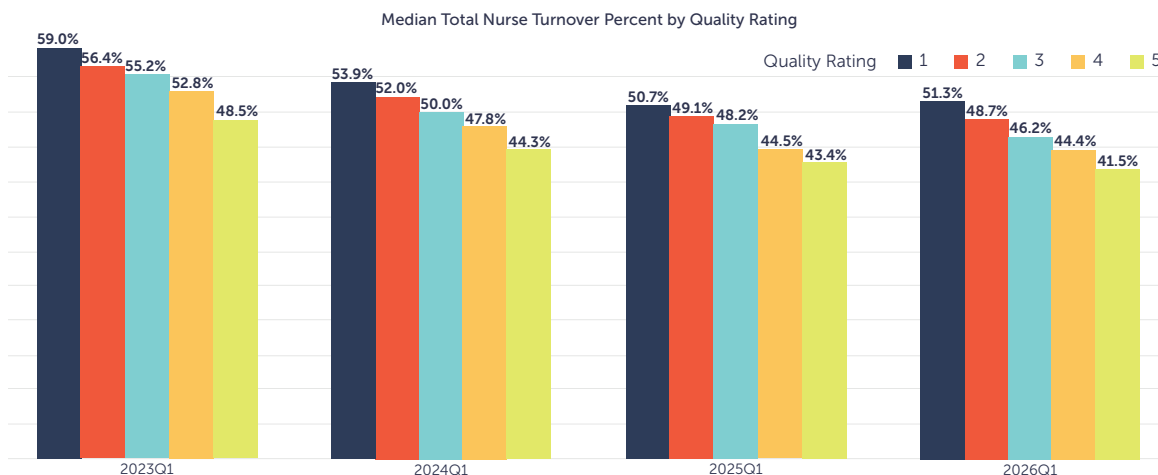
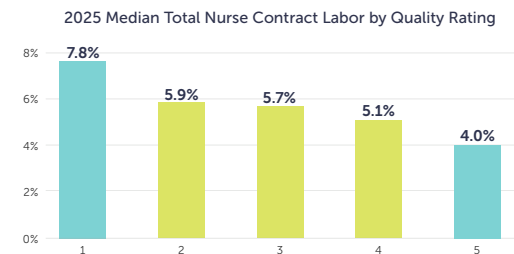
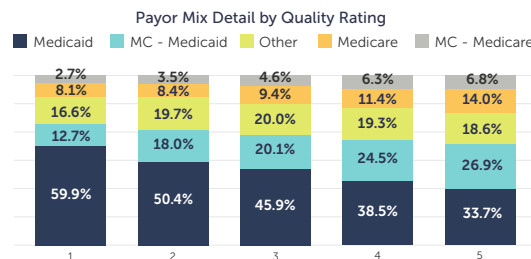
How quality ratings impact financial outcomes

Quality has historically been discussed primarily through resident outcomes, surveys, and regulatory performance. Those remain critically important.

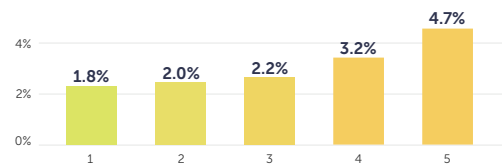
What's changing is quality increasingly creates economic access: Access to preferred referrals, payer networks, potentially value-based economics, and Medicaid incentives. For example, in several states, such as Indiana, Texas, Ohio, and Illinois, Medicaid reimbursement increasingly incorporates quality measures, creating another pathway through which clinical performance can influence economics.

This year's data shows higher 5-star quality ratings are associated with higher occupancy, lower nurse turnover, lower contract labor utilization, and differences in payer mix and operating performance. This suggests quality can serve as an economic flywheel.

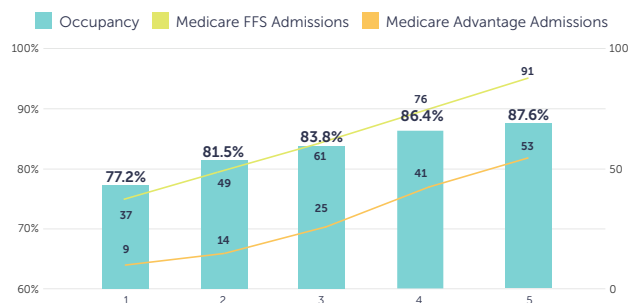
Some of the most revealing insights relate to how quality influences occupancy and margin differently.



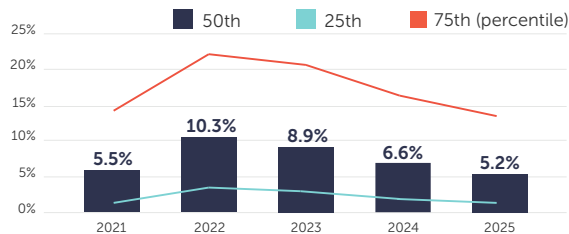
2025 Median Operating Margin by Quality Rating



2025 Median Occupancy by Quality Rating



Nursing Contract Labor Hours as Percentage of Total Nursing



It's not just that occupancy improves as quality improves; it's how admission behavior changes as quality improves, and how much more pronounced that relationship is under Medicare Advantage.

Occupancy and margin don't appear to improve at the same rate across quality levels. Occupancy gains are realized earlier in the quality continuum, with the largest margin improvements occurring among higher-rated providers.

This may suggest early improvements in quality help strengthen demand and occupancy, whereas higher quality rating improvements may influence a provider's economics, competitive position, and ability to attract desirable referral sources. This data also points to a potential "4-star threshold," with the most notable improvement occurring between 3- and 4-star providers.

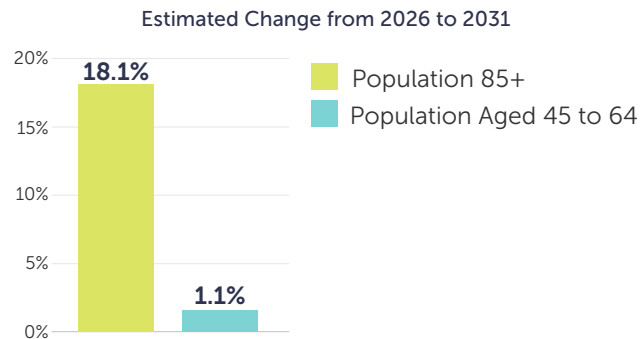
- Median occupancy increases from 77.2% for 1-star facilities to 87.6% for 5-star facilities, a 10.4 percentage-point difference. Over that same quality spectrum, median Medicare FFS admissions increase from 37 to 91 (146% increase). Medicare Advantage admissions increased from 9 to 53 (an increase of 489%).
- Contract labor use follows its years-long downward trend — from a high of 10.3% in 2022 to 5.2% in 2025. Median contract labor utilization among 5-star quality providers in 2025 is 4%, approximately half that of 1-star rated facilities.
- Operating margins rise with quality ratings, from 1.8% for 1-star quality SNFs to 4.7% for 5-star quality SNFs. However, operating margin improves by just 40 basis points between 1-star and 3-star facilities, compared with 250 basis points between 3-star and 5-star facilities. Approximately 86% of the total margin improvement observed occurs above the 3-star level.



Demographic growth: How might it impact SNF capacity?

The “silver tsunami” continues to create structural shifts across the country. All Baby Boomers will have aged into Medicare eligibility by 2030.

The convergence of a rapidly growing 85+ population and a moderating SNF bed supply could reshape the competitive landscape, making referral patterns, occupancy dynamics, labor requirements, payer relationships, overall strategy and market positioning more important than ever.



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Demographic shifts: Health care in 2035

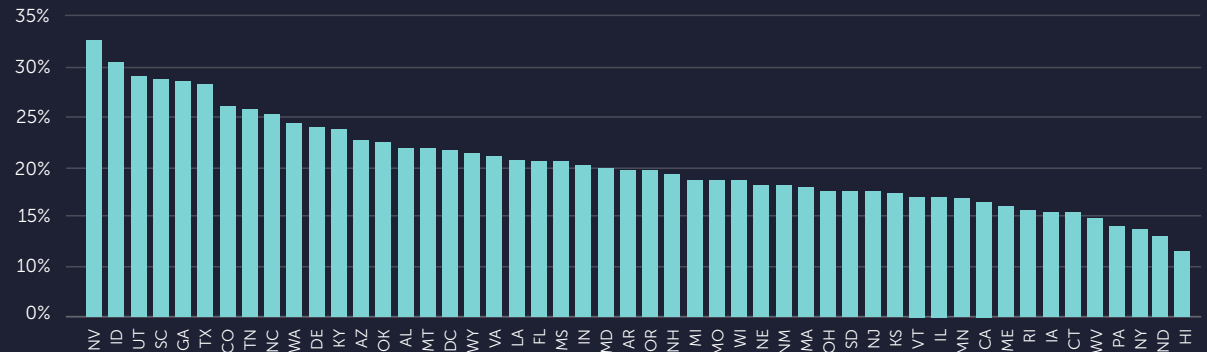
The “silver tsunami” is one of the macro forces hitting the U.S. in the coming decade. The others are impending Medicaid shifts, the economics of health care, and the promise of AI/technology. [Learn more.](#)



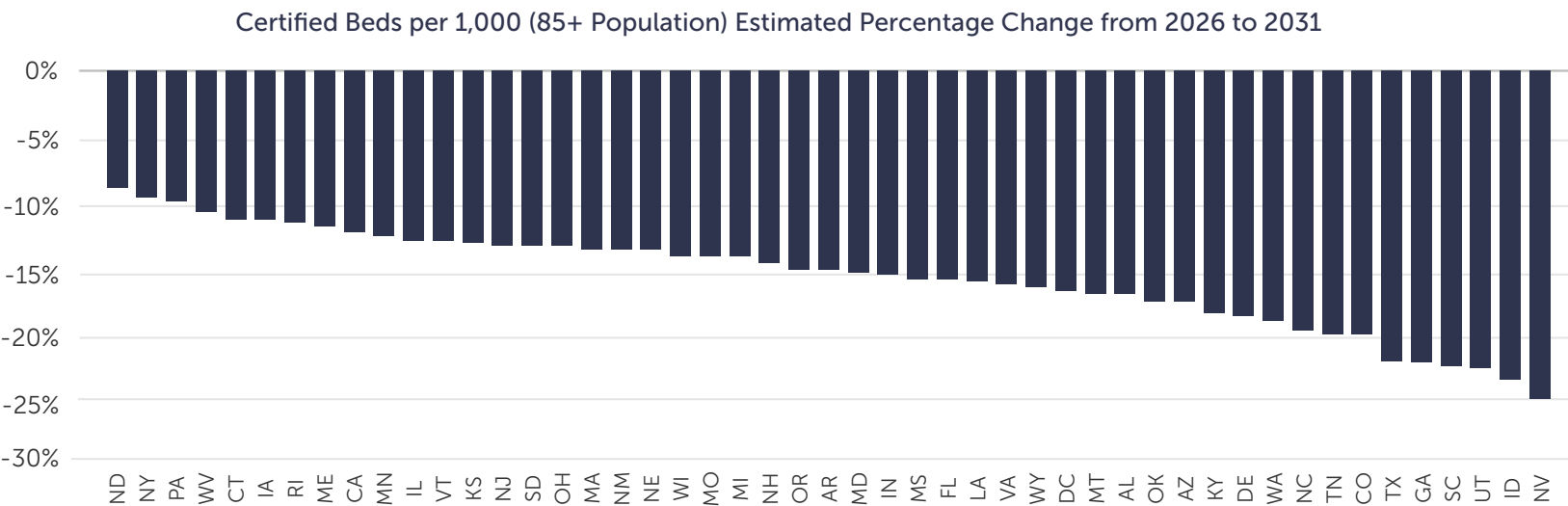
Capacity will be critical. The nation's oldest population is growing at an unprecedented pace, while the bed base is shrinking amid potential workforce shortages. If acuity outpaces RN staffing growth, facilities may face heightened clinical, operational, and financial pressure, making nursing retention a critical driver of future success. Will the industry have sufficient skilled nursing capacity to meet future demand?

- There will be an 18% growth, or 1.22 million additional seniors over the next five years in the population of 85+.
- Population increases vary by state, with an 8% increase in Hawaii to 33.5% in Nevada over the next five years.

Estimated 85+ Population Percentage Change from 2026 to 2031



- At the same time, there are fewer SNF beds nationwide — a decline of 5,800 beds between 2023 and 2025. While the capacity challenge may be national, the severity will be localized. Certified SNF beds relative to the 85+ population are projected to decline across every state analyzed, ranging from approximately 9% to 25%.



Note: Projected change assumes each state’s certified SNF bed count remains constant while the 85+ population changes based on demographic estimates.



Future positioning: Strategies for creating distinctive value

The SNF market may have recovered from the pandemic, but its challenges have shifted. With occupancy generally up and an aging population theoretically creating future demand, *countervailing forces* are also at work:

Shorter stays

Managed care utilization management

Home and community-based alternatives

Geographic differences

Changing clinical acuity

Workforce constraints and Medicaid cuts

The central challenge is no longer recovery alone. Future success depends on a provider's adaptability to strategies contending with these competing realities.



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The next era of skilled nursing may be less about filling beds and more about aligning competencies with local senior needs and referral networks. Those with higher quality are positioned well, as the quality flywheel creates more avenues for success.

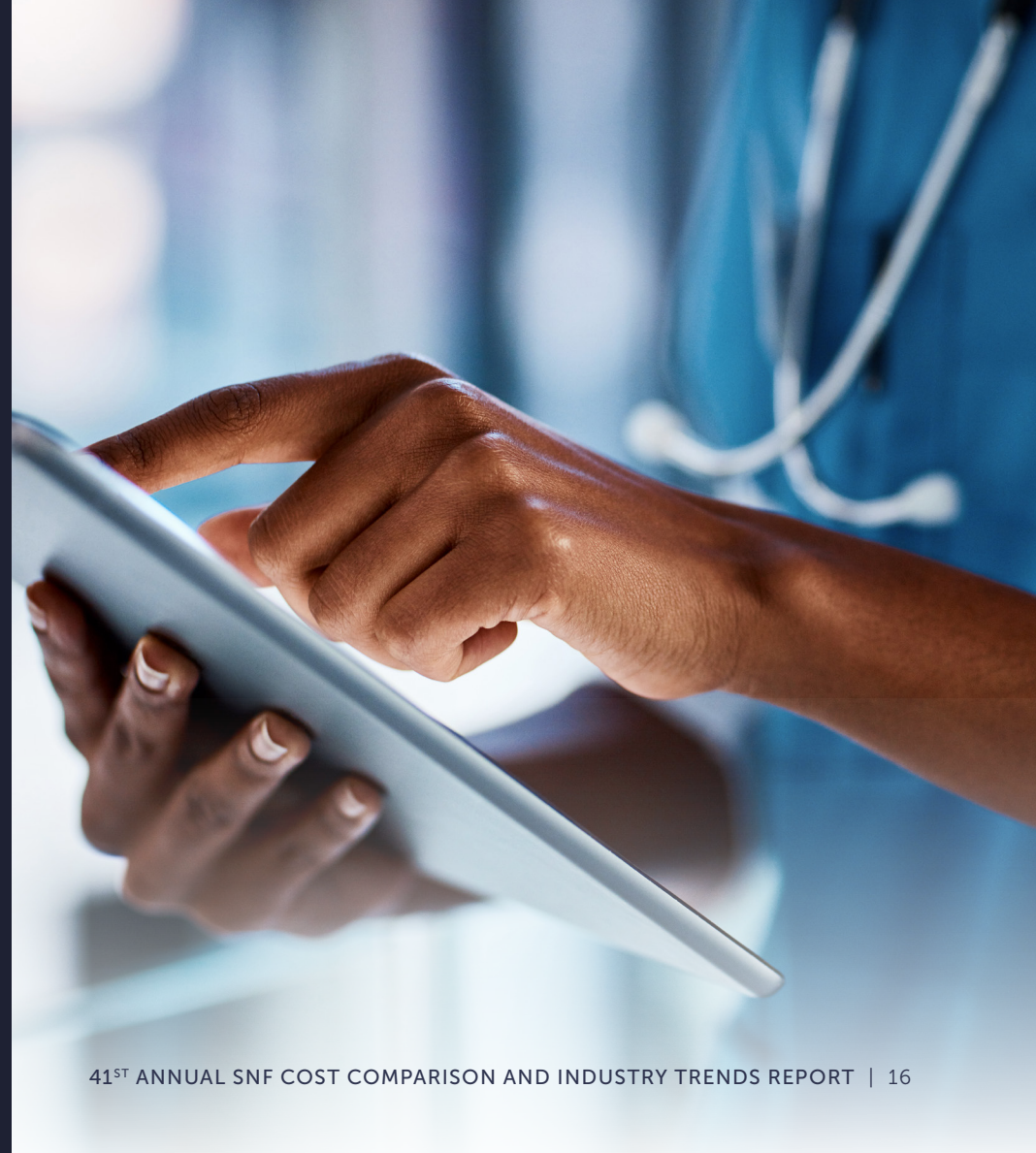
There may be multiple ways to succeed, but there will likely be fewer ways to continue with business as usual. How will your organization answer these questions:

- What's our lane?
- Which residents and clinical needs are we well positioned to serve?
- Which payer and referral relationships are strategically essential?
- Which clinical outcomes give us leverage?
- Are we increasing census or economic occupancy?
- Where might capacity constraints become the most acute?
- What capabilities make us more relevant to payers and health systems five years from now?

Looking to find your path forward? CLA can help.



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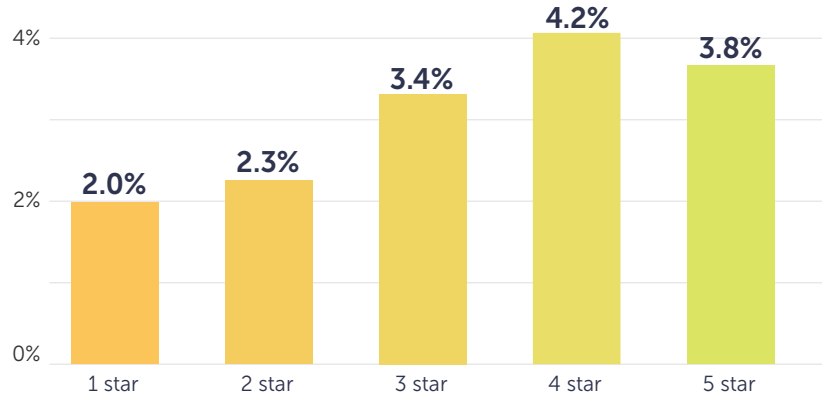
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Appendix

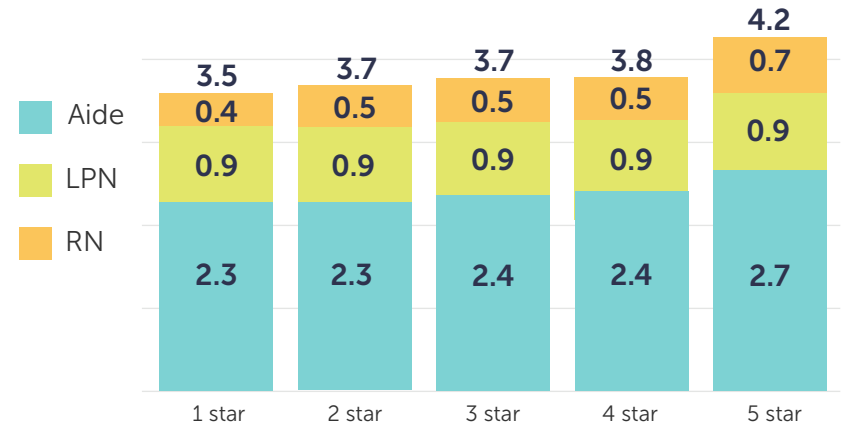
The following graphics display key performance metrics of SNFs grouped by overall star rating. Across these performance indicators, higher overall star-rated facilities generally demonstrated stronger performance.

Skilled nursing facility snapshot by overall star rating

2025 Median Operating Margin by Overall Rating

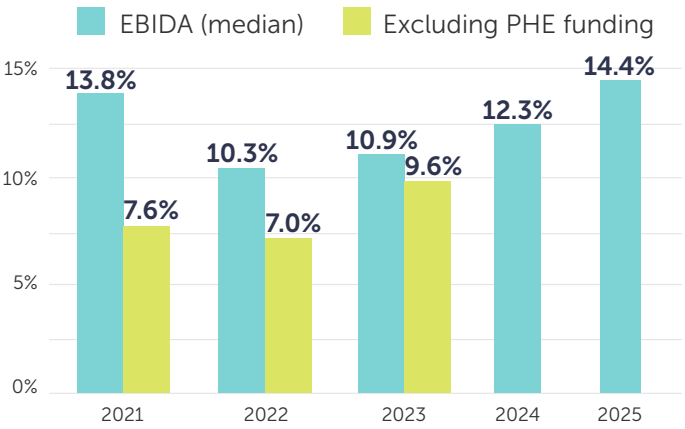


2025 Median Paid Nursing Hours by Overall Rating



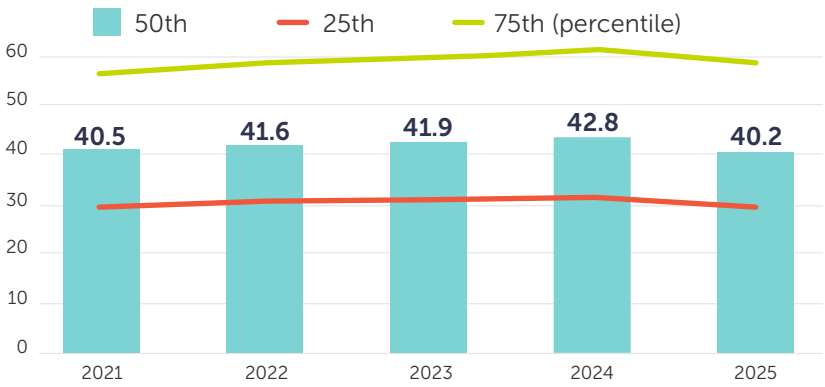
Earnings before interest, depreciation, and amortization (EBIDA)

EBIDA is a commonly used profitability measure because it eliminates capital-related costs. It's a rough measurement of cash flow for skilled nursing operators, so changes measured in this ratio provide a sense for how providers generate cash. The 2021 through 2023 numbers present the EBIDA margin both including and excluding the impact of PHE funding recognized by SNFs.



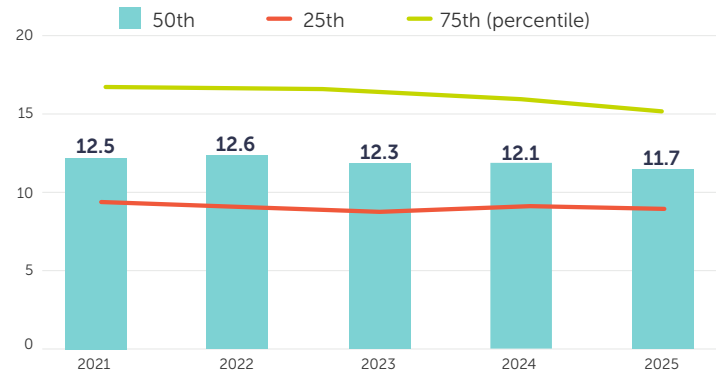
Days revenue in accounts receivable

This ratio calculates the average number of days receivables are outstanding, or how quickly a facility converts receivables to cash. A lower value of days revenue in accounts receivable is desirable, as it indicates a facility takes less time to convert receivables to cash.



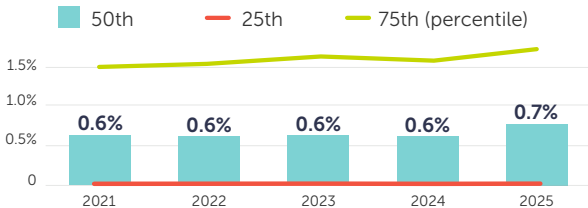
Average age of plant

This ratio measures the average age of a facility by estimating the number of years depreciation has been realized for a facility by dividing accumulated depreciation by depreciation expense.



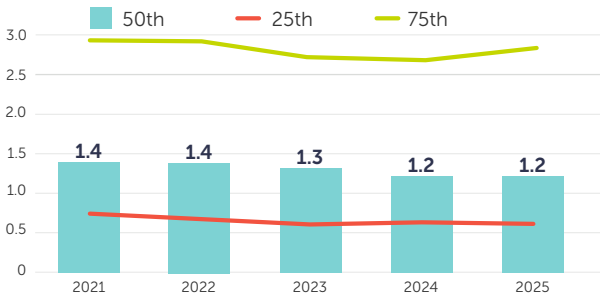
Capital spending ratio

This ratio measures the capital spending of a facility as a percentage of annual operating revenues and indicates how aggressively a facility reinvests its revenue back into its facility.



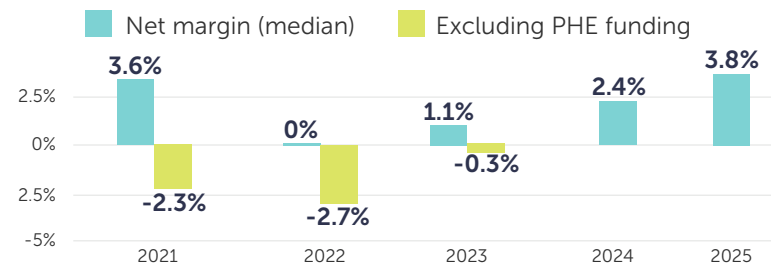
Current ratio

The current ratio measures a facility's liquidity. It demonstrates the degree to which current liabilities are covered by current assets or the ability to pay short-term obligations when due.



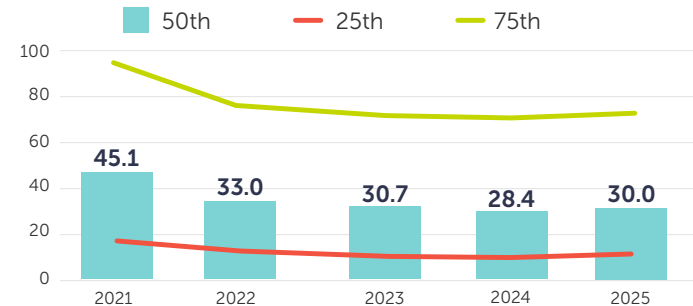
Net margin ratio

This ratio measures a facility's efficiency in controlling costs, calculated by comparing a facility's net income or loss to its total revenue. An organization's ability to maintain its net margin ratio is vital for long-term sustainability. The 2021 through 2023 numbers present the net margin ratio both including and excluding the impact of PHE funding recognized by SNFs.



Days cash on hand

This ratio measures how long an organization's cash on hand covers average expenses. Like the current ratio (defined below), a high number of days cash on hand is considered favorable. However, an extremely high ratio may indicate a facility could earn a higher rate of return through longer-term investments.



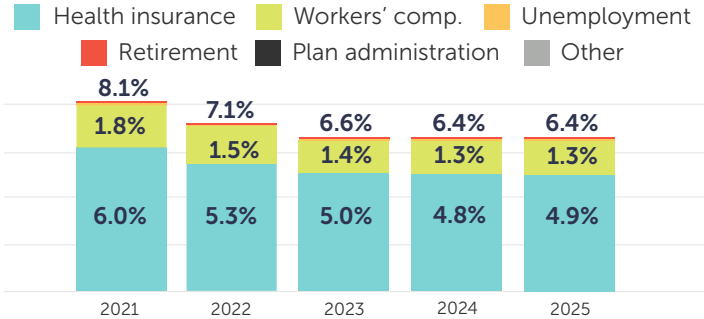
APPENDIX

Fringe benefits

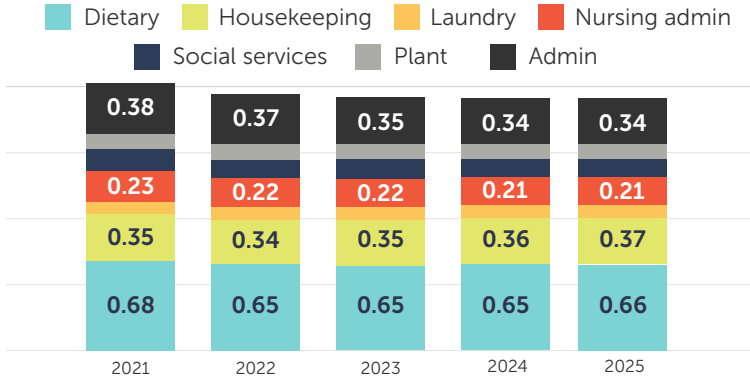
This ratio measures the relative percentage of fringe benefits. In addition to direct payroll costs, fringe benefits are additional labor costs. Fringe benefits include:

- Medical, life, and other group insurance
- Workers' compensation insurance
- Pension or retirement contribution
- Uniform allowance
- Miscellaneous employee benefits

Benefits as percentage of salary



Median paid hours per resident day (excluding nursing)



APPENDIX

Total costs per resident day

Percentile	Nursing	Social services	Ancillary	Plant	Housekeeping	Laundry	Dietary	Admin	Benefits
25th	\$107.70	\$2.30	\$15.28	\$11.64	\$6.29	\$2.02	\$21.19	\$50.71	\$12.90
50th	\$134.67	\$3.64	\$21.50	\$14.53	\$8.16	\$3.32	\$25.02	\$66.72	\$21.69
75th	\$168.81	\$5.74	\$31.12	\$18.51	\$10.66	\$4.79	\$31.09	\$84.81	\$33.81

Salaries per resident day

Percentile	Nursing	Social services	Plant	Housekeeping	Laundry	Dietary	Admin	Total
25th	\$90.47	\$2.06	\$2.40	\$3.60	\$0.00	\$9.04	\$10.08	\$117.65
50th	\$111.57	\$3.40	\$3.29	\$6.54	\$1.53	\$12.68	\$13.61	\$152.63
75th	\$140.98	\$5.43	\$4.83	\$9.09	\$2.85	\$17.22	\$19.70	\$200.11

Salaries per compensated hour

Percentile	Nursing admin	RN	LPN	Aide	Total nursing	Social services	Plant	Housekeeping	Laundry	Dietary	Admin
25th	\$39.24	\$44.10	\$35.34	\$21.33	\$24.27	\$24.32	\$22.65	\$12.51	\$0.00	\$15.50	\$31.62
50th	\$46.77	\$49.97	\$40.32	\$25.00	\$27.41	\$29.28	\$25.97	\$16.17	\$14.52	\$18.60	\$36.75
75th	\$55.65	\$57.35	\$45.74	\$28.70	\$30.71	\$34.56	\$29.77	\$18.79	\$17.95	\$21.45	\$44.13



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