NORC at the University of Chicago

Value of Senior Housing 2025 Research Portfolio

Care for Older Adults with Neurodegenerative Disease
Value of Longer Stays in Senior Housing

September 2025

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Introduction

Since 2023, the National Investment Center for Seniors Housing & Care (NIC) and NORC at the University of Chicago have collaborated to explore the value of senior housing in supporting the health and well-being of older adults. Many older adults transition into senior housing due to increasing medical needs, the loss of a spouse, or other shifts in personal circumstances that make independent living difficult. This transition often occurs during a particularly vulnerable stage of life—marked by rising frailty, a higher risk of adverse health events, and growing prevalence of neurodegenerative disease. As the aging population expands and their health needs become more complex, a new generation of consumers is shaping the expectations and future of senior housing.

Our research focuses not only on the initial health outcomes for older adults who move into senior housing, but also on the sustained impact it has on their health, quality of life, and medical costs. By tracking outcomes and healthcare costs for several years post move-in, our research shows that long-term residents experience continued and, in some cases, improved quality of life, and findings among the top quartile (25%) of senior housing communities demonstrate what is possible with effective management and coordination of care. These insights highlight the vital role senior housing communities—along with their partners—can play in improving the lives of older adults well beyond the initial transition period.

This research builds on years of evidence demonstrating that senior housing is well-positioned to meet the evolving needs of older adults. This report includes three sections: an **executive summary** outlining opportunities for the industry, **detailed research findings** on the value of senior housing—particularly for those with neurodegenerative disease and over time—and **state-level summaries of key results**.

Executive Summary

Highlighting the opportunity for Senior Housing to meet the evolving needs of older adults

NORC at the University of Chicago

Changing demographics, housing and health care needs, and preference are informing the future of senior housing

By 2030:

- 73 million adults over 65[1]
- 1 in 5 Americans over 65[1]

Population

- 97.5% live in private homes, not necessarily built for aging care needs[2]
- Shrinking number in nursing homes

Housing

- More than 90% with 1 chronic condition[3]
- 40% struggle with mobility[4]
- More than 20% experience early signs of cognitive decline[5]

Health

- Independence
- Choice
- Social connection
- Wellness

Priorities

Adult children are:

- Key influencers and decision-makers
- Future consumers

Influences

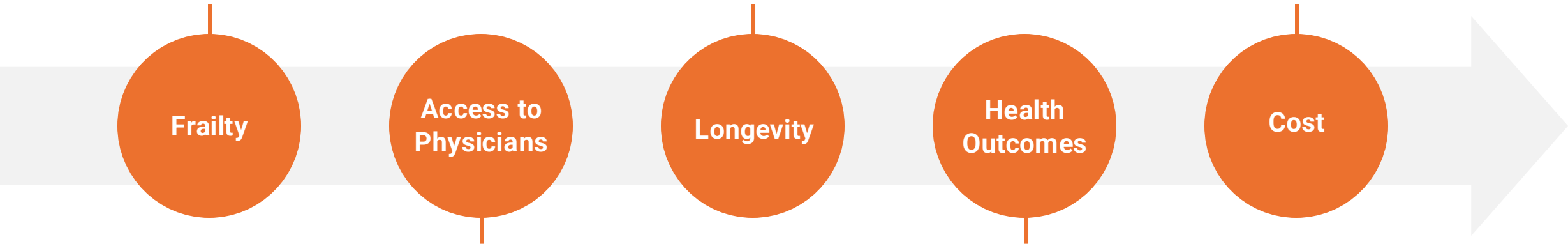
Sources: (1) Census Bureau Report: By 2030, All Baby Boomers Will Be Age 65 or Older; (2) Harvard Joint Center for Housing Studies' Housing America's Older Adults 2023; (3) DOI:http://dx.doi.org/10.5888/pcd22.240539; (4) Census Bureau Report: Mobility is Most Common Disability Among Older Americans; (5) DOI:10.1001/jamaneurol.2022.3543

NIC and NORC's five-part study in 2023 and 2024 demonstrated the value of senior housing for older adults

Frailty and vulnerability to poor outcomes peaks and then declines within 6 months of move-in to senior housing

Seniors live longer and receive more rehabilitative and preventive care

Medicare costs are lower for residents in over 50% of AL and 30% of IL communities



Access to health care services improves following move-in to senior housing

Health outcomes improve when older adults move into senior housing facilities

Sources: NIC x NORC Value of Senior Housing Research Portfolio

NIC commissioned NORC to research health outcomes and costs for older adults with neurodegenerative disease (NDD)

42%

Research found that 42% of residents in residential care communities were diagnosed with Alzheimer's disease or other dementias.[1]

70%+

It is estimated that more than 70% of older adults with dementia have at least one comorbidity, underscoring the importance of coordinated care.[2]

46%

Among older adults with cognitive impairment that live alone, an estimated 46% struggle with ADLs and IADLs.[3]

Care for Older Adults with NDD Study

To understand health outcomes for older adults with NDD and the role of senior housing, NORC conducted a comprehensive data analysis with measures of primary and preventative care, health outcomes, and costs of care.

The study highlights the differences across three mutually-exclusive populations:

- Older adults with NDD living in senior housing communities (i.e., assisted living, memory care)
- Older adults with NDD living in non-congregate settings
- Older adults with NDD living in nursing homes

Sources: (1) Variation in Residential Care Community Resident Characteristics, by Size of Community: United States, 2020. National Center for Health Statistics. (2) How to manage comorbidities in people with dementia. Aging Research Reviews. (3) Difficulty and help with activities of daily living among older adults living alone with cognitive impairment, Alzheimer's Association.

Senior housing promotes health and wellness for older adults with neurodegenerative disease (NDD)

- **Primary Care**

  98% of older adults with NDD had one or more primary care visits, per year.

- **Neurology**

  >20% of older adults with NDD had one or more neurologist visits, per year.

- **Physical Therapy**

  >20% of older adults with NDD had one or more physical therapy visits, per year.

- **Home Health Services**

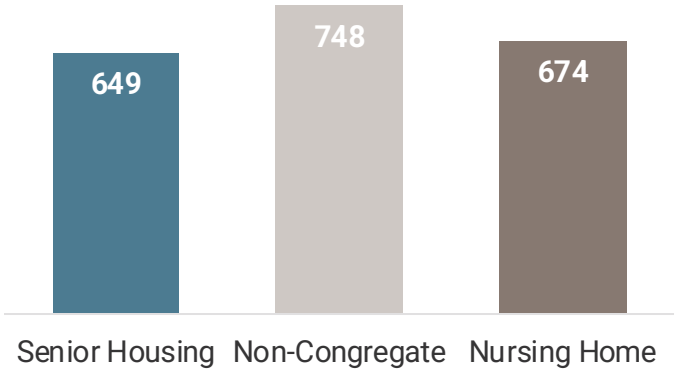
  >45% of older adults with NDD received home health services, per year.

Data represent select results for Traditional Medicare beneficiaries with NDD residing in Assisted Living and Memory Care communities in calendar year 2022.

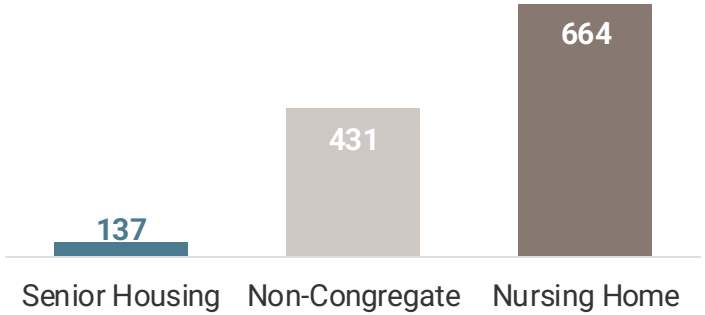
Top 25% of senior housing communities create stability and safety for residents with NDD, preventing crises

The top 25% of senior housing communities had fewer hospital visits and stays:

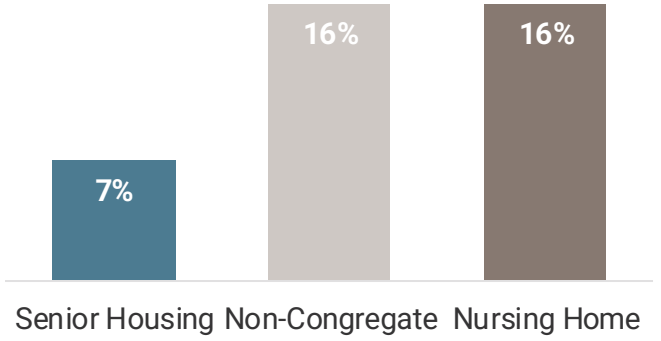
Outpatient ED Visits (per 1,000)



Hospital Stays (per 1,000)



Hospital Readmission Rate

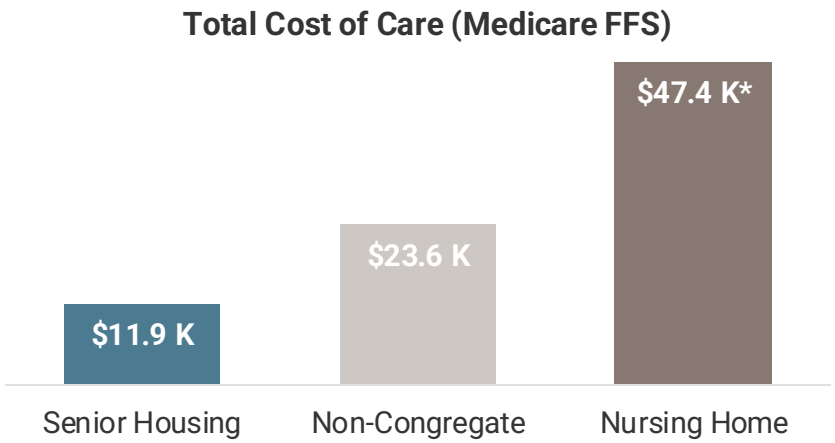


Data represent select results for Traditional Medicare beneficiaries age 65+ with NDD residing in Assisted Living and Memory Care communities in calendar year 2022.

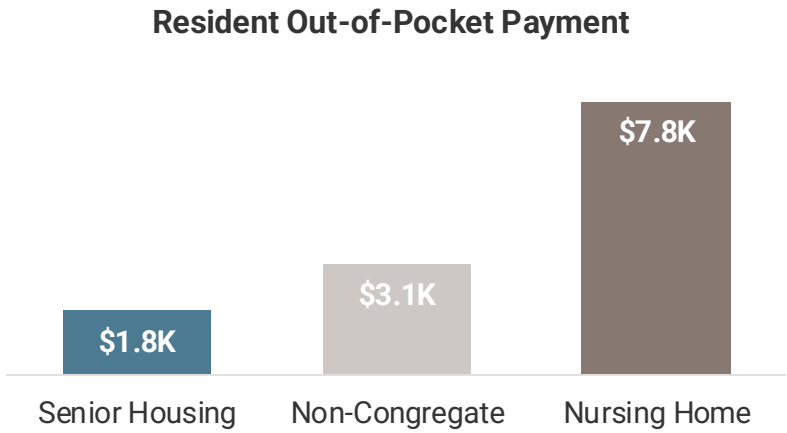
The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential.

Top 25% of senior housing communities associated with lower Medicare and out-of-pocket costs for residents with NDD

Residents in the top quartile of senior housing communities had **average total Medicare costs of $11.9K per year** – approximately half the non-congregate average



Residents in the top quartile of senior housing communities spend **approximately 40% less** out-of-pocket than non-congregate beneficiaries

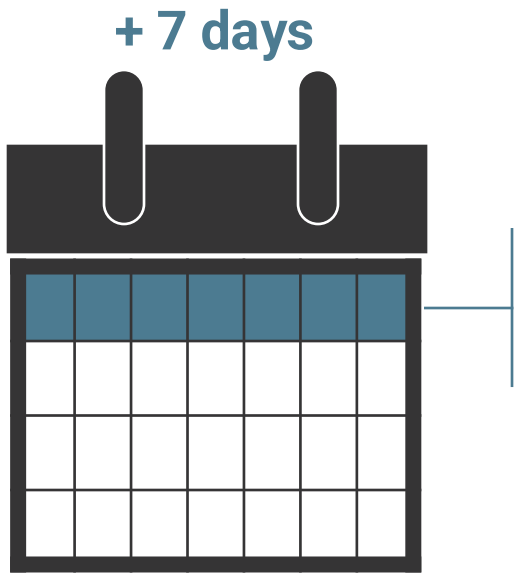


*Our research assessed applicable SNF Part A claims, which includes a fixed room and board component of the per member per diem rate. This component, alongside the nursing and therapy components is the "non-case-mix (room & board)" which is part of normal SNF PPS Market Basket.

Data represent select results for Traditional Medicare beneficiaries age 65+ with NDD residing in Assisted Living and Memory Care communities in calendar year 2022.

The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential.

Top 25% of senior housing communities keep residents with NDD healthy at home



Residents in the top quarter of senior housing communities spend about **a week more at home, compared with people living in non-congregate settings.**

Alternatively, a 7-day hospital stay translates to **$24.9K.**[1]

1. Based on a KFF study that found the average per-day hospital cost was $2,883 in 2021; adjusted for inflation to 2025 dollars.

Data represent select results for Traditional Medicare beneficiaries age 65+ with NDD residing in Assisted Living and Memory Care communities in calendar year 2022.

The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential.

Senior housing is a vital partner in supporting caregivers of older adults with NDD

Caregivers of people with dementia experience **higher rates of emotional, financial, and physical stress**

A dementia diagnosis requires high daily care needs of caregivers

Unpaid caregiving hours in the US are valued at $413.5 billion

Caregivers provide 90+ hours of care per month, on average

About 25% of dementia caregivers also care for at least one child

12M **Nearly 12 million Americans provide unpaid care for a family member or friend with dementia**

Senior Housing Offers a Supportive Environment

- Coordinated health services
- 24/7 staff & support
- Reclaimed relationships between caregiver and resident
- Emotional relief
- More time and support for working caregivers

Source: Alzheimer's & Dementia: Facts and Figures—Caregivers. Alzheimer's Association

NIC commissioned NORC to research health outcomes and costs for older adults over time to measure stability and improvement

Frailty & Vulnerability

Previous NIC-NORC research used the frailty index[1] to understand vulnerability to adverse health outcomes among senior housing residents.

- This research found that vulnerability increases for a short period as residents settle into their new community before leveling off and showing improvement.
- Vulnerability to adverse health outcomes was found to level off or decrease approximately 3 months after move-in.[2]

Value of Longer Stays in Senior Housing

Building from previous findings, NORC conducted the longer stays study to further understand how health outcomes and costs of care change over time, from move-in through several years post move-in to senior housing.

The analysis includes measures of primary and preventative care, health outcomes, and costs of care; highlighting the differences across three mutually-exclusive populations:

- Older adults in senior housing communities (i.e., assisted living, memory care)
- Older adults living in non-congregate settings

Sources: (1) Claims-Based Frailty Index; (2) Vulnerability To Adverse Health Outcomes Amongst Senior Housing Residents, NORC.

The year before move-in is commonly a period of increasing health and care challenges

Gradual Decline Over 12 Months

- Frequent ER visits, hospital stays, infections
- Falls, mobility loss, and increased ADL needs
- Cognitive decline, behavioral symptoms
- Home care stretched beyond capacity

Triggering Event

- Major fall or hospitalization
- Unsafe behaviors or wandering
- Caregiver burnout or health emergency

Why the Decision is Made

- Care exceeds home safety limits
- Professionals recommend higher-level care
- Family prioritizes safety and stability

The first year in senior housing is a challenging transition period to meet the high-risk needs of new residents

1 in 3 residents were hospitalized

Proportion of FFS Residents (65+) with an Inpatient Hospital Admission

Average SNF Days Among FFS Residents (65+) Who Had a SNF Stay

Residents who had a SNF stay spent over a month in SNF—away from home

More than 4 in 10 residents had an ED visit

Proportion of FFS Residents (65+) with an ED Visit

Average Medicare Total Cost of Care for FFS Residents (65+)

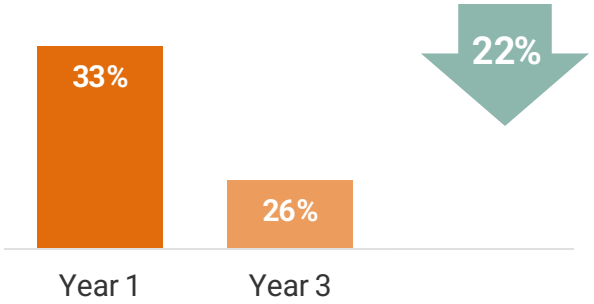
Residents had Medicare costs of approximately $30K

Data represent select results for Traditional Medicare beneficiaries age 65+ who resided in Independent Living, Assisted Living, and/or Memory Care communities between calendar years 2016 and 2022.
Fee-for-Service (FFS) Medicare: The Traditional Medicare program in which the federal government pays providers directly for each covered health care service a beneficiary receives.
Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

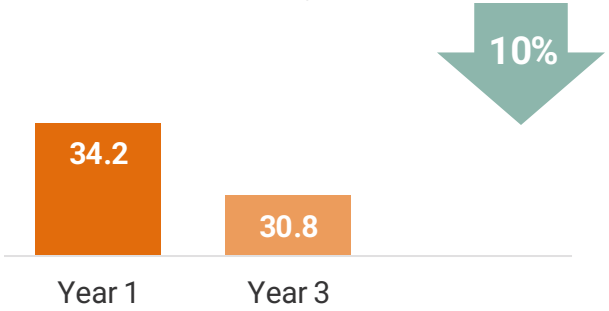
By the third year, senior housing communities have stabilized the frailty of their residents

By year 3, approximately 1 in 4 residents had a hospital admission

Proportion of FFS Residents (65+) with an Inpatient Hospital Admission



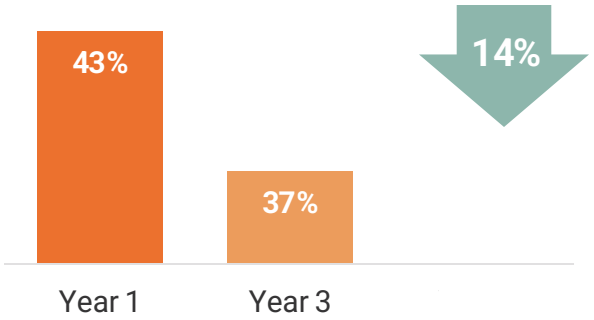
Average SNF Days Among FFS Residents (65+) Who Had a SNF Stay



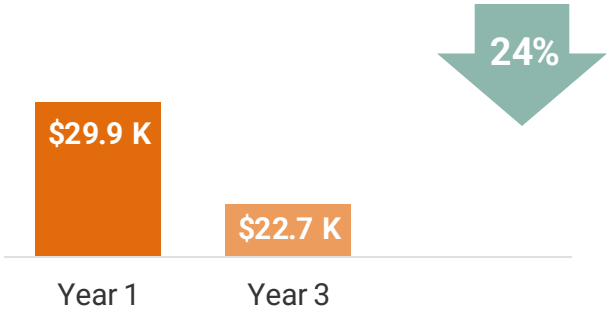
By year 3, residents who had a SNF stay, spent 3.5 more days at home, on average

By year 3, the proportion of residents with an ED visit declined by 14%

Proportion of FFS Residents (65+) with an ED Visit



Average Medicare Total Cost of Care for FFS Residents (65+)



By year 3, average total Medicare costs were $7.2K lower than year 1

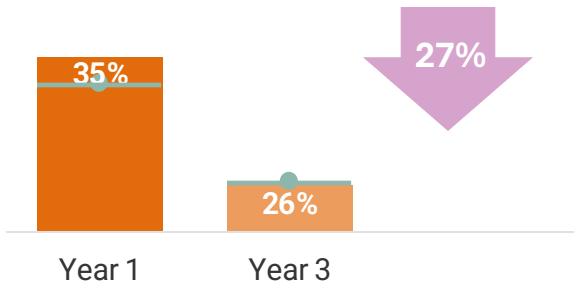
Data represent select results for Traditional Medicare beneficiaries age 65+ who resided in Independent Living, Assisted Living, and/or Memory Care communities between calendar years 2016 and 2022.
Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Younger senior housing residents—1 in 8—experience even greater reductions in costly care after the first year

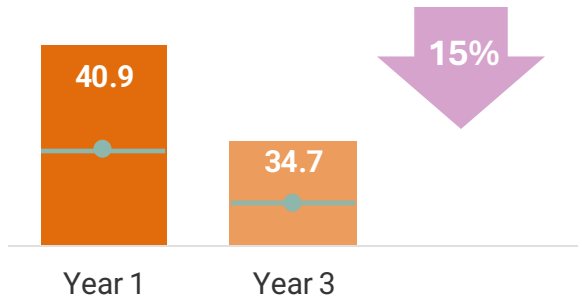
Average among all residents (65+)

By year 3, approximately 1 in 4 residents age 65-74 had a hospital admission

Proportion of FFS Residents (Age 65-74) with an Inpatient Hospital Admission



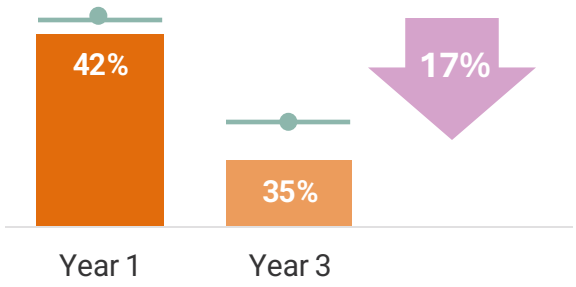
Average SNF Days Among FFS Residents Age 65-74 Who Had a SNF Stay



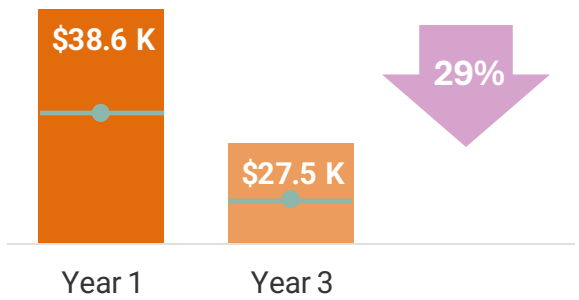
By year 3, 65-74 year old residents who had a SNF stay, spent 6 more days at home, on average

By year 3, the proportion of 65-74 year old residents with an ED visit declined by 17%

Proportion of FFS Residents (Age 65-74) with an ED Visit



Average Medicare Total Cost of Care for FFS Residents Age 65-74

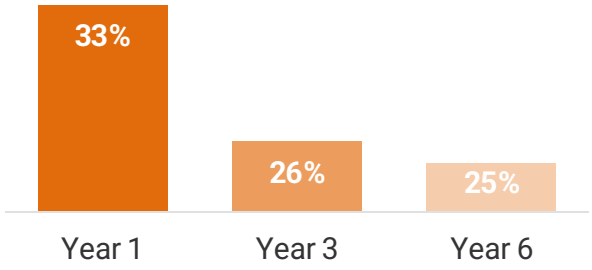


By year 3, average total Medicare costs were more than $11K less than year 1 for residents 65-74 years old

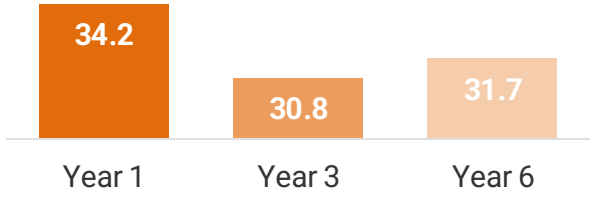
Data represent select results for Traditional Medicare beneficiaries age 65+ who resided in Independent Living, Assisted Living, and/or Memory Care communities between calendar years 2016 and 2022.
Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Residents who remain in senior housing see continued improvement and stabilization for several years post move-in

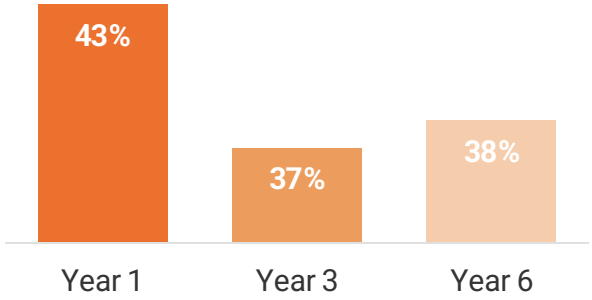
Proportion of FFS Residents (65+) with an Inpatient Hospital Admission



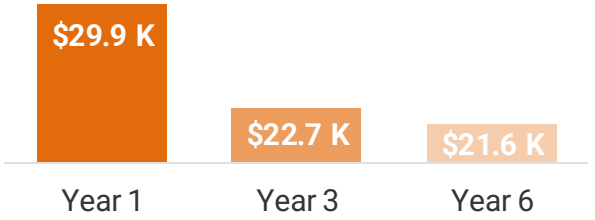
Average SNF Days Among FFS Residents (65+) Who Had a SNF Stay



Proportion of FFS Residents (65+) with an ED Visit



Average Medicare Total Cost of Care for FFS Residents (65+)



By Year 6:

- ✓ Health scores continue to improve
- ✓ More healthy days at home
- ✓ Sustained fewer hospitalizations
- ✓ Sustained fewer ED visits
- ✓ Sustained lower costs of care

Data represent select results for Traditional Medicare beneficiaries age 65+ who resided in Independent Living, Assisted Living, and/or Memory Care communities between calendar years 2016 and 2022. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

In summary, senior housing is uniquely positioned to meet the needs of older adults with NDD and promotes stability for years following move-in to a residential community

Care for Older Adults with NDD

For older adults diagnosed with neurodegenerative disease, senior housing can:

- **Promote Health and Wellness**
- **Create Stability and Safety That Prevents Crises**
- **Demonstrate Lower Medicare Spending and Out-of-Pocket Costs**
- **Enable Healthy Days at Home**
- **Reduce Caregiver Stress**

Value of Longer Stays

The year before move-in to senior housing is commonly a period of increasing health and care challenges:

- **Residents typically experience higher health care utilization and costs during Year 1**
- **Health care utilization and costs decrease, and frailty is stabilized by Year 3**
- **Younger residents (65-74) experience greater reductions in high-cost care after Year 1**
- **Residents who remain in senior housing see continued improvement and stabilization for several years post move-in**

Full methodology and findings can be found in the final report (chartpack) on the NORC website.

Care for Older Adults with Neurodegenerative Disease

National Results

NORC at the University of Chicago

The Care for Older Adults with NDD research explores the differences in health outcomes and costs among senior housing residents with NDD

Overall Study Population Criteria

- Traditional Medicare (TM) Fee-for-Service (FFS) and Medicare Advantage (MA) beneficiaries
- Must reside in an Assisted Living or Memory Care community included in the NIC MAP data as of January 1, 2022[1]
- 65+ years old as of January 1, 2022
- Alive as of January 1, 2023

Analytic Approach

NORC analyzed Medicare claims and encounter data to compare outcomes and costs among assisted living and memory care residents with neurodegenerative diseases (NDD)—including Alzheimer's and other dementias—compared to two separate mutually-exclusive, risk-adjusted comparison groups:

1. Individuals with an NDD diagnosis living in non-congregate settings
2. Individuals with an NDD diagnosis living in nursing homes

NORC produced outputs at both the national and state levels

(1) **NIC MAP® Data:** Senior housing data from the National Investment Center for Senior Housing & Care (NIC) was used to identify communities at the 9-digit ZIP level.

See slide 72 for a description of the research study limitations.

NORC segmented senior housing communities into quartiles by assessing costs of care among Traditional Medicare beneficiaries

Quartiles were determined based on the average difference between actual and expected total costs of care

- Expected costs were projected among Traditional Medicare beneficiaries using person-level demographic and diagnostic information, including Hierarchical Condition Category (HCC) scores, aggregated to the senior housing community level.
- Senior housing communities were ranked based on the difference between their actual and expected costs among their Traditional Medicare population; cost data is not available for Medicare Advantage (MA) beneficiaries.
- The top quartile (Q1) includes communities with the lowest actual Medicare costs relative to expected costs.
- This approach ensures the top quartile reflects communities that are effective at managing costs, not just those with the healthiest or lowest-cost residents.
- NORC analysis showed that HCC and frailty scores were similar across quartiles, confirming differences were not solely due to underlying health differences.

The Care for Older Adults with NDD research explores the differences in health outcomes and costs across four measure domains

NORC evaluated health care utilization, outcomes, and cost among senior housing residents with NDD compared to their demographically and clinically similar counterparts in non-congregate settings and nursing homes

Primary and Supportive Care

Proportion of residents with at least one:

- Primary care visit
- Neurologist visit
- Mental health visit
- Physical therapy visit
- Clinical social worker visit
- Home health care visit
- Antipsychotic mediations

Acute Care

- Proportion of residents with at least one emergency department (ED) visit
- Rate of ED visits per 1,000 residents
- Proportion of residents with at least one inpatient hospital admission
- Rate of acute care stays per 1,000 residents
- Readmission rate following an inpatient stay
- Proportion of residents with Skilled Nursing Facility (SNF) stay (limited to those covered by Medicare) [1]
- Rate of SNF stays per 1,000 residents[1]

Cost of Care*

- Average total Medicare FFS costs
- Resident out-of-pocket (OOP) costs

Outcomes

- Healthy days at home**

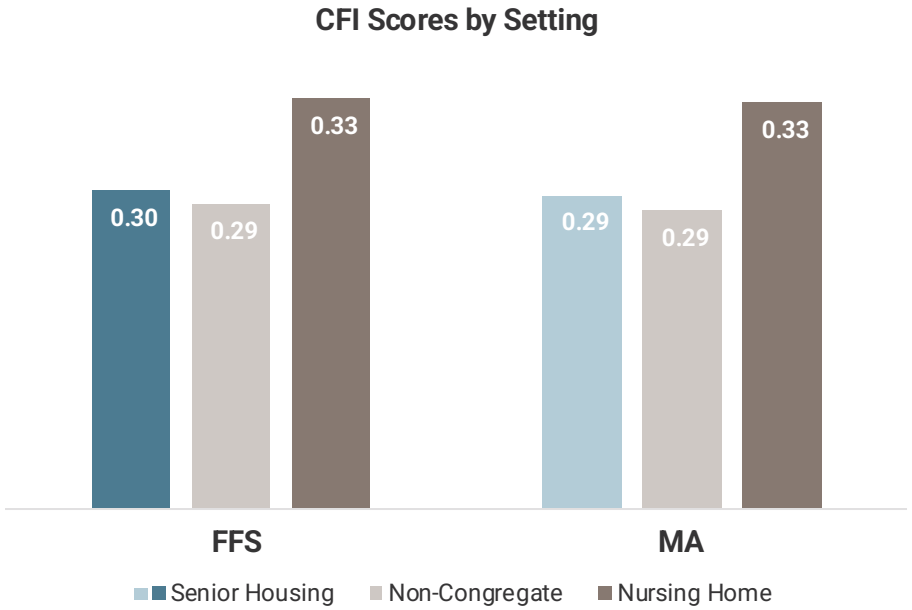
[1] Our research assessed applicable SNF Part A claims, which includes a fixed room and board component of the per member per diem rate. This component, alongside the nursing and therapy components is the "non-case-mix (room & board)" which is part of normal SNF PPS Market Basket.

* Cost analysis is limited to senior housing residents enrolled in FFS

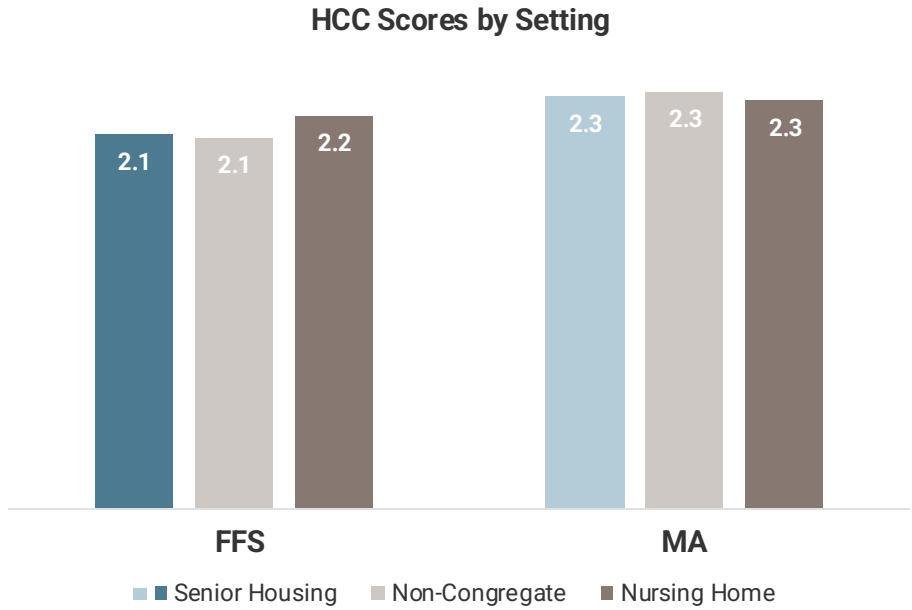
** "Healthy days at home" is defined as the total number of days in the measurement year minus days spent in inpatient hosptal stays, emergency department visits, skilled nursing facilities.

Groups were balanced using key factors including CFI and HCC to ensure fair comparison across health care utilization, outcomes, and cost measures

Claims-Based Frailty Index (CFI) measures cumulative health deficits—including chronic conditions and functional limitations—to quantify frailty and characterize vulnerability to poor health outcomes[1]



Hierarchical Condition Categories (HCCs) are a risk-adjustment model that assigns patients a score based on their documented health conditions—commonly used to evaluate clinical complexity and predict future utilization and cost[2]



[1] Kim DH, Glynn RJ, Avorn J, et al. Validation of a Claims-Based Frailty Index Against Physical Performance and Adverse Health Outcomes in the Health and Retirement Study. *J Gerontol A Biol Sci Med Sci*. 2019;74(8):1271–1276. doi:10.1093/gerona/gly197. [2] CMS | Medicare Risk Adjustment Information

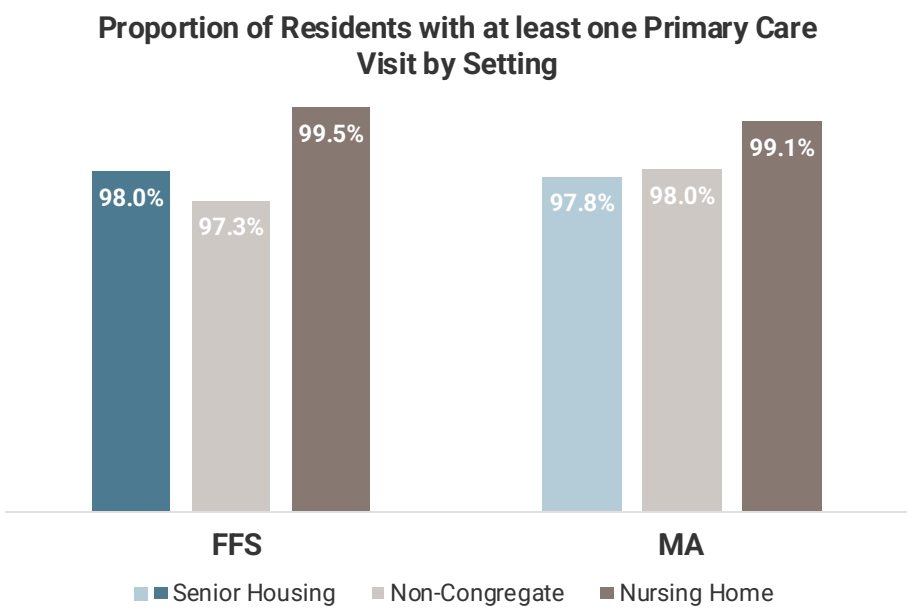
Values shown are rounded; exact figures differ slightly.

Primary and Supportive Care

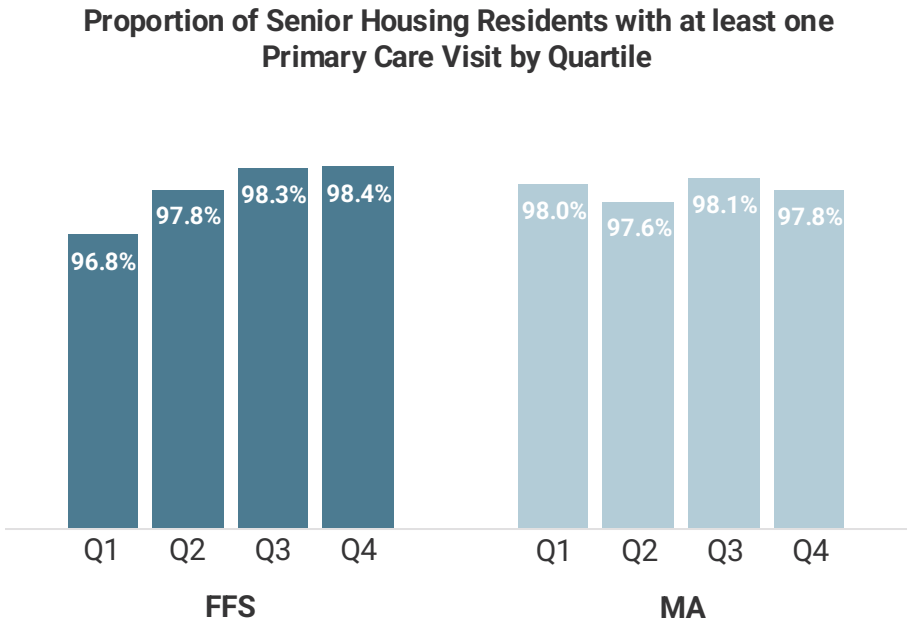
NORC at the University of Chicago

The proportion of senior housing residents that had at least one primary care visit is similar across FFS (98.0%) and MA (97.8%)

Nearly all senior housing residents (98.0% FFS, 97.8% MA) had at least one primary care visit in 2022, similar to both non-congregate and nursing home comparison groups



Senior housing residents have high primary care use across quartiles and coverage types (96.8-98.4% FFS, 97.6-98.1% MA)

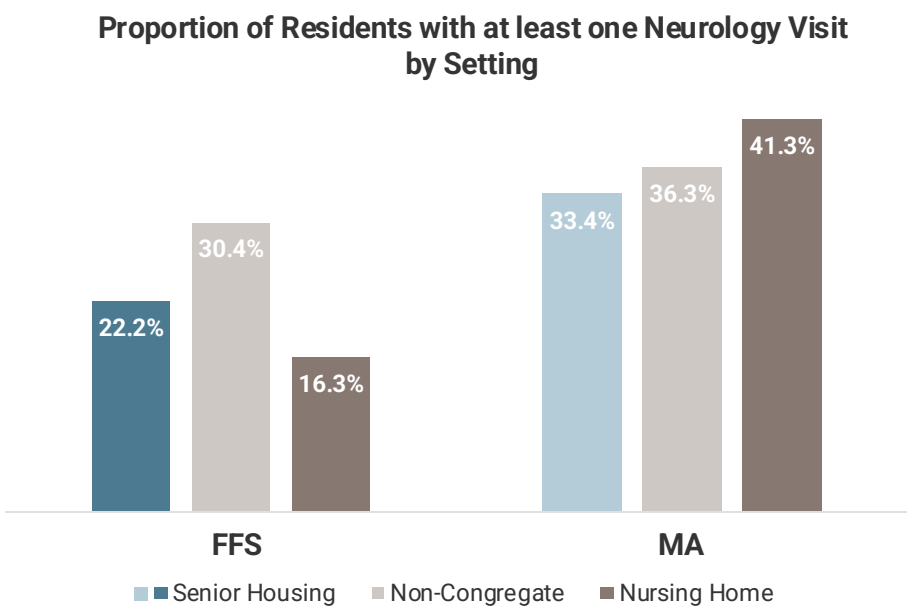


The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

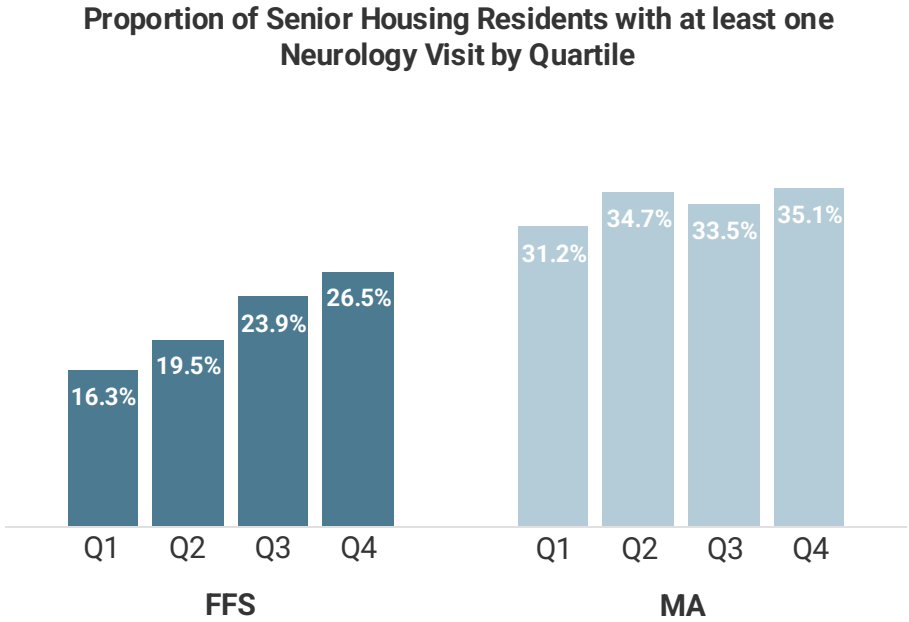
Values shown are rounded; exact figures differ slightly.

A greater proportion of MA senior housing residents (33.4%) received at least one visit with a neurologist than FFS senior housing residents (22.2%)

More senior housing residents with FFS (22.2%) received at least one visit with a neurologist compared to their counterparts in nursing homes (16.3%)



Neurology visits varied by quartile; in the bottom quartile (Q4) of senior housing communities, more than 1 in 4 FFS residents and more than 1 in 3 MA residents received at least one visit with a neurologist

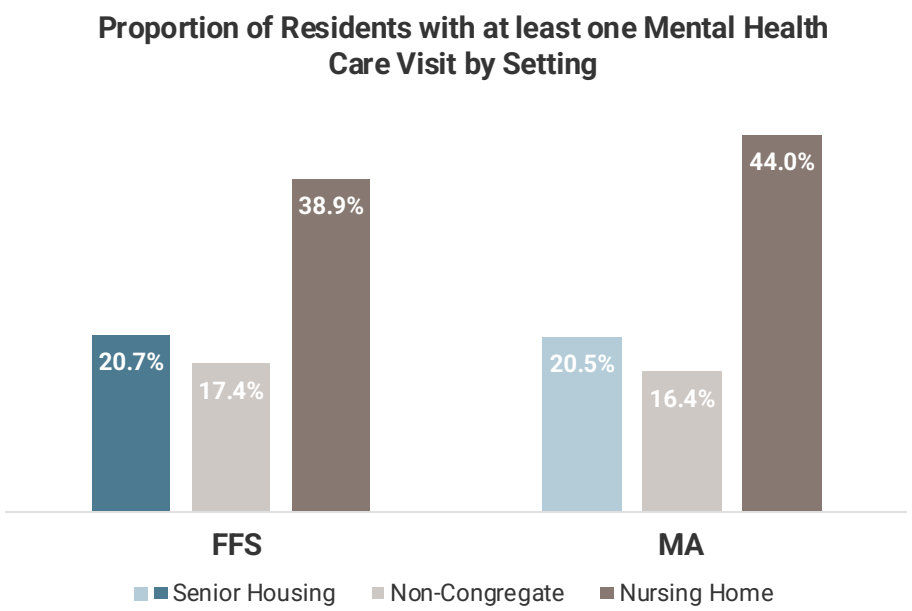


The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

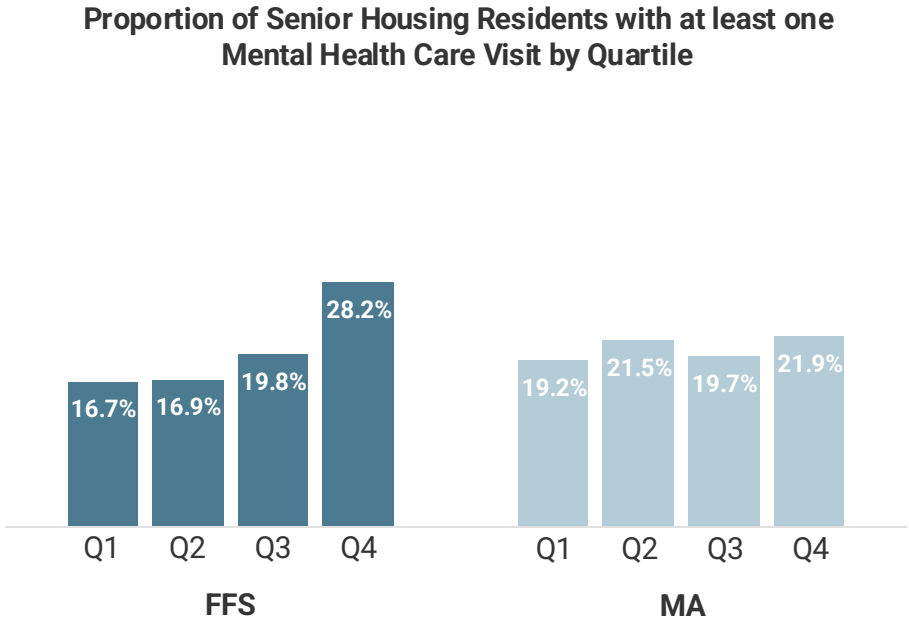
Values shown are rounded; exact figures differ slightly.

The proportion of senior housing residents that had at least one mental health care visit is similar across FFS (20.7%) and MA (20.5%)

On average, a greater proportion of FFS and MA senior housing residents received at least one mental health care visit compared to their non-congregate peers



A greater proportion of MA senior housing residents received at least one mental health care visit than non-congregate peers across all quartiles; FFS residents in Q3–Q4 also exceeded non-congregate rates



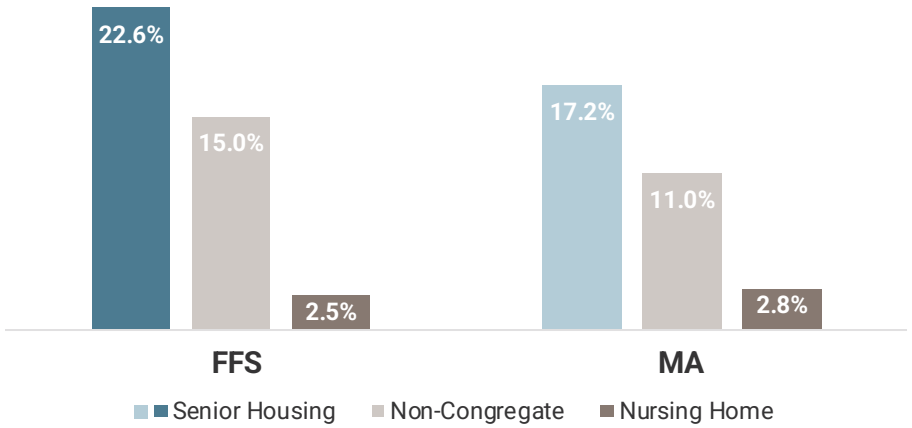
The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

Values shown are rounded; exact figures differ slightly.

A greater proportion of FFS senior housing residents (22.6%) received at least one physical therapist visit than MA senior housing residents (17.2%)

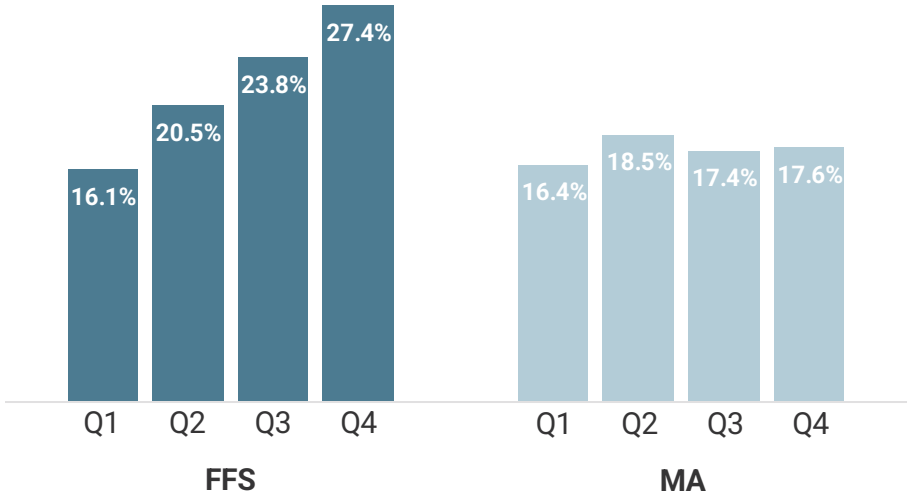
A higher proportion of both FFS and MA residents received at least one physical therapist visit compared to the non-congregate and nursing home averages

Proportion of Residents with at least one Physical Therapist Visit by Setting



Across all quartiles, a greater proportion of senior housing residents received at least one physical therapy visit than the non-congregate or nursing home averages

Proportion of Senior Housing Residents with at least one Physical Therapist Visit by Quartile

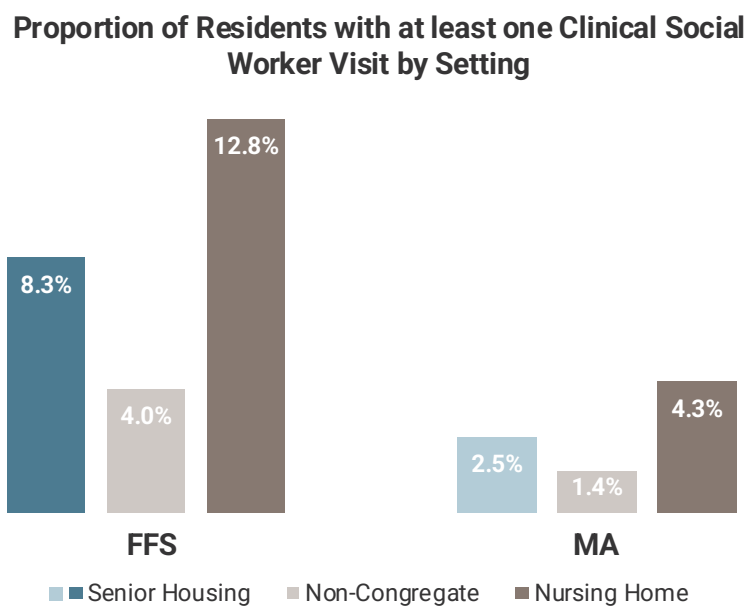


The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

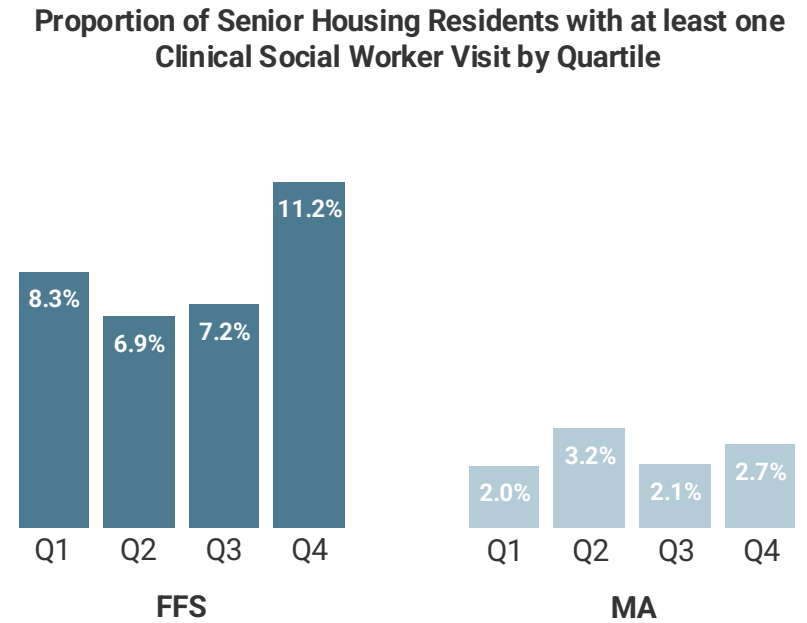
Values shown are rounded; exact figures differ slightly.

A greater proportion of FFS senior housing residents (8.3%) received at least one clinical social worker visit than MA senior housing residents (2.5%)

A greater proportion of FFS and MA senior housing residents received at least one clinical social worker visit than their non-congregate peers; rates were lower than the nursing home average for both FFS and MA



A greater proportion of FFS and MA senior housing residents across all quartiles received at least one clinical social worker visit than the non-congregate average



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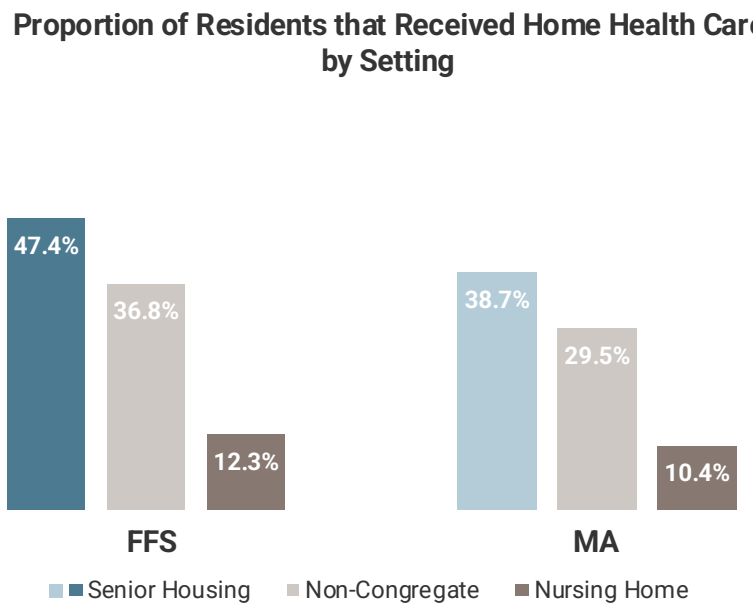
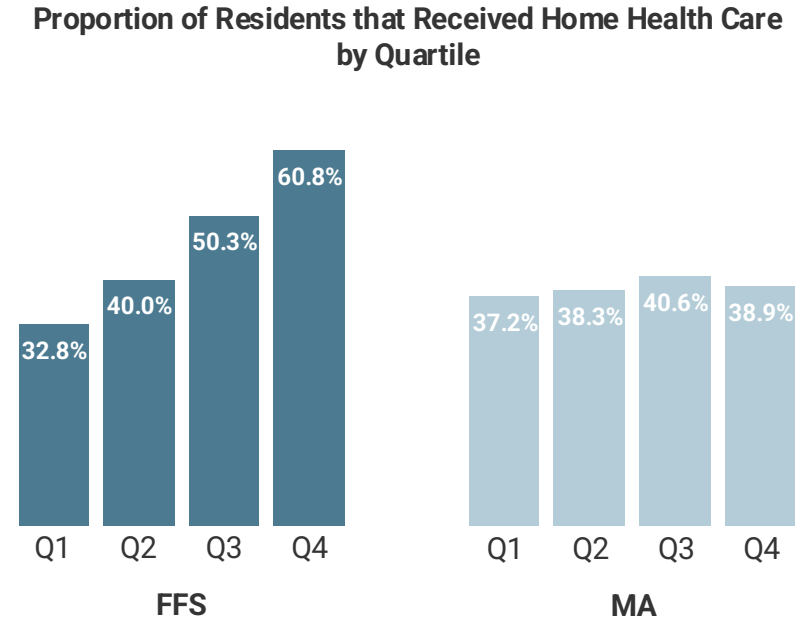
Values shown are rounded; exact figures differ slightly.

A greater proportion of FFS senior housing residents (47.4%) received a home health care visit compared to MA senior housing residents (38.7%)

On average, a greater proportion of FFS and MA senior housing residents received at least one home health care visit compared to the non-congregate and nursing home average



A greater proportion of FFS residents in three quartiles (Q2-Q4) and MA residents of all quartiles of senior housing communities received at least one home health care visit compared to the non-congregate and nursing home averages

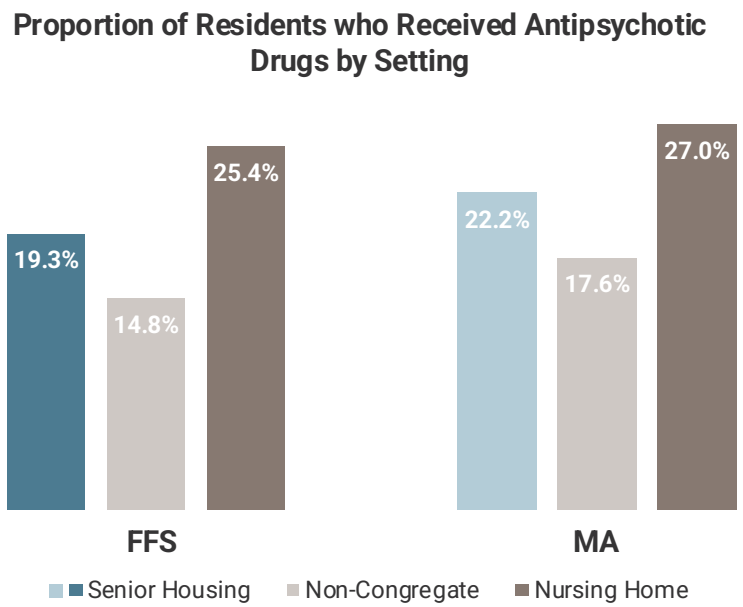


The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

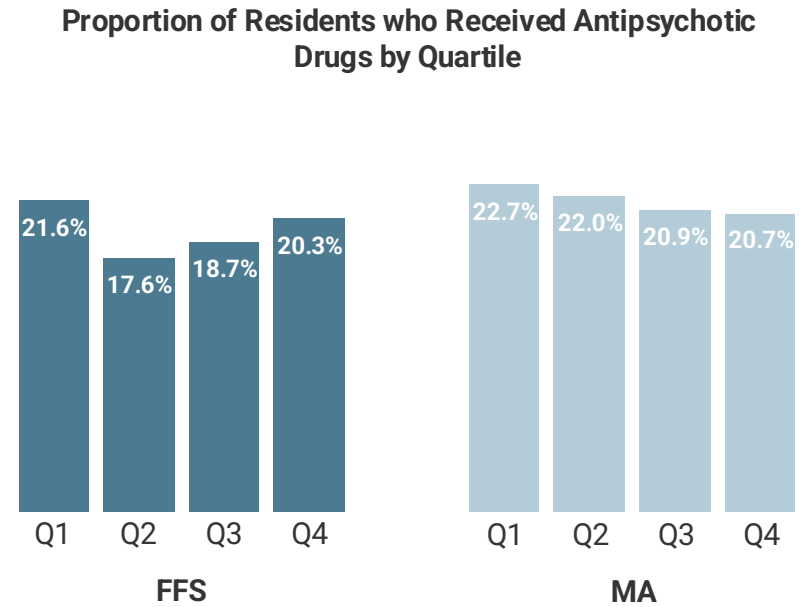
Values shown are rounded; exact figures differ slightly.

A greater proportion of MA senior housing residents (22.2%) received antipsychotic drugs compared to FFS senior housing residents (19.3%)

A higher proportion of senior housing residents received antipsychotic medications than the non-congregate average; a lower proportion of senior housing residents were prescribed antipsychotics than the nursing home average



Across all quartiles, a higher proportion of senior housing residents received antipsychotic medications than the non-congregate average and a lower proportion received antipsychotic drugs than the nursing home average



The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

Values shown are rounded; exact figures differ slightly.

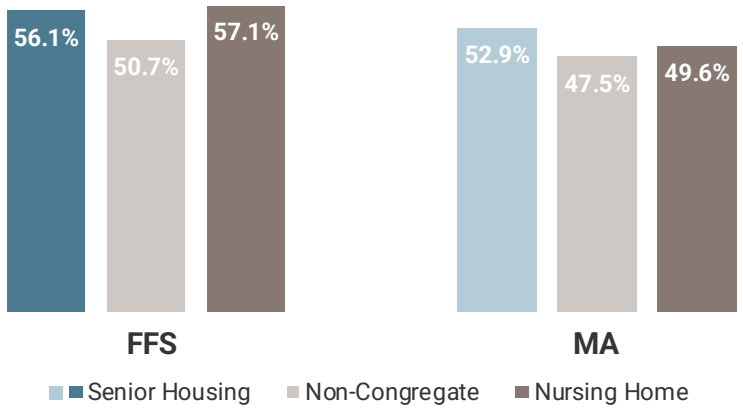
Acute Care

NORC at the University of Chicago

A greater proportion of FFS senior housing residents (56.1%) had at least one emergency department (ED) visit than MA senior housing residents (52.9%)

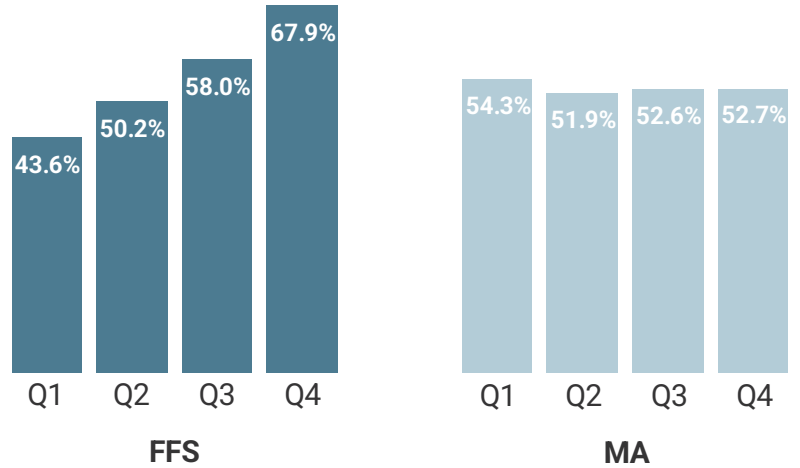
On average, a greater proportion of FFS and MA senior housing residents had at least one ED visit compared to their non-congregate counterparts

Proportion of Residents with at least one Emergency Department Visit by Setting



The top two quartiles (Q1-Q2) of senior housing communities had a lower proportion of FFS residents with an ED visit than both the non-congregate and nursing home average

Proportion of Senior Housing Residents with at least one Emergency Department Visit by Quartile



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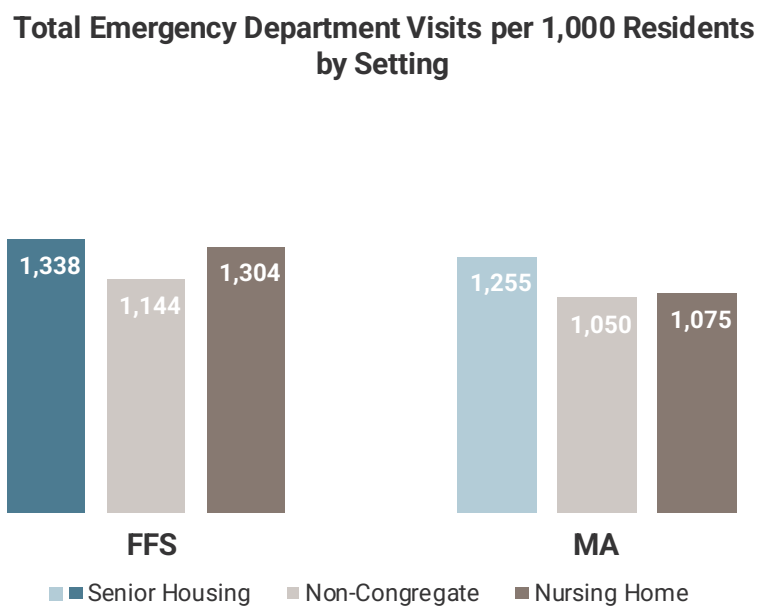
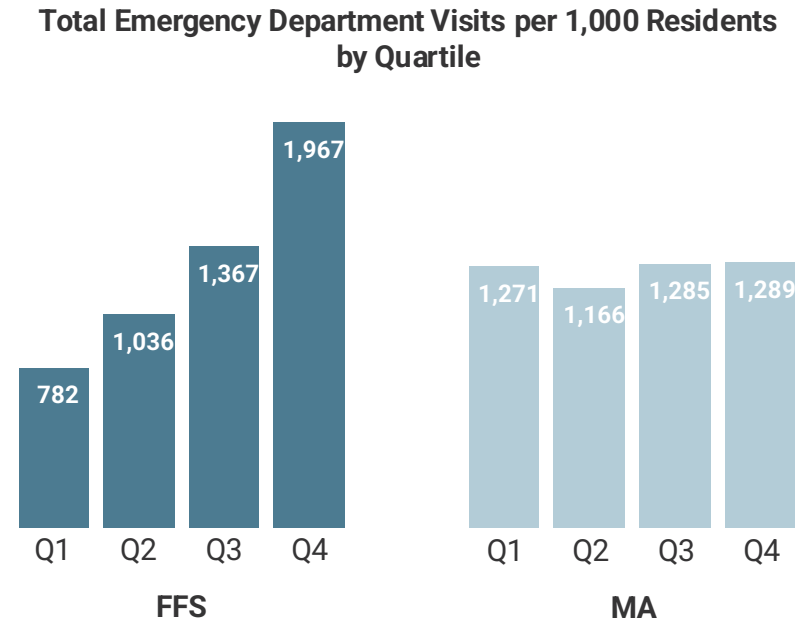
Values shown are rounded; exact figures differ slightly.

The rate of emergency department (ED) visits per 1,000 senior housing residents is greater among FFS residents (1,338) than MA residents (1,255)

On average, FFS and MA senior housing residents had higher rates of ED visits per 1,000 residents compared to their non-congregate and nursing home peers



The top two quartiles (Q1-Q2) of senior housing communities had lower ED utilization among FFS residents compared to both non-congregate and nursing home settings



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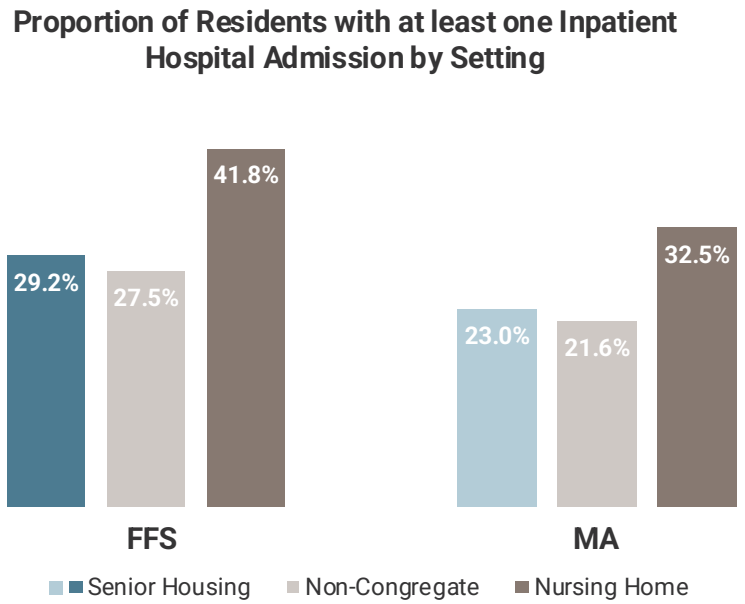
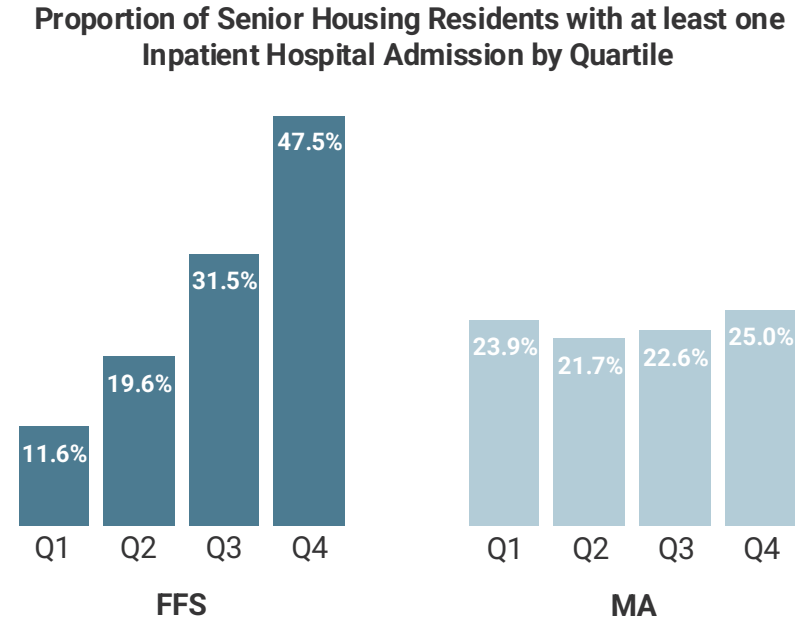
Values shown are rounded; exact figures differ slightly.

A greater proportion of FFS senior housing residents (29.2%) had at least one inpatient admission compared to MA senior housing residents (23.0%)

On average, a higher proportion of FFS and MA senior housing residents had an inpatient admission than the non-congregate average; a lower proportion of FFS and MA residents had an inpatient admission than the nursing home average



The top two quartiles (Q1-Q2) of senior housing communities had a lower proportion of FFS residents with a hospital admission than both the non-congregate and nursing home average



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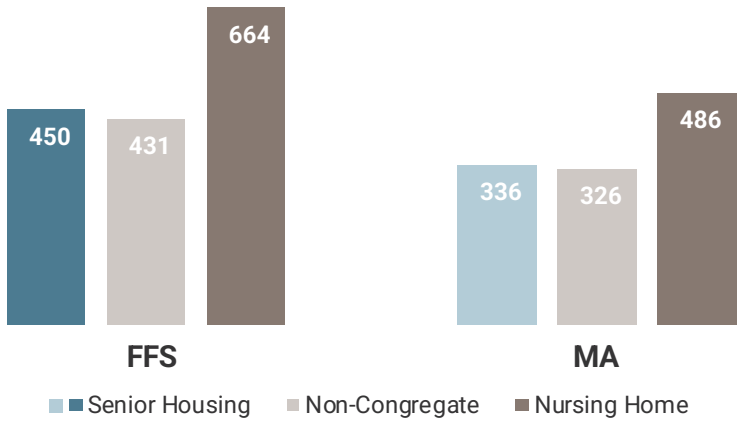
Values shown are rounded; exact figures differ slightly.

The rate of acute care stays per 1,000 senior housing residents is greater among FFS residents (450) than MA residents (336)

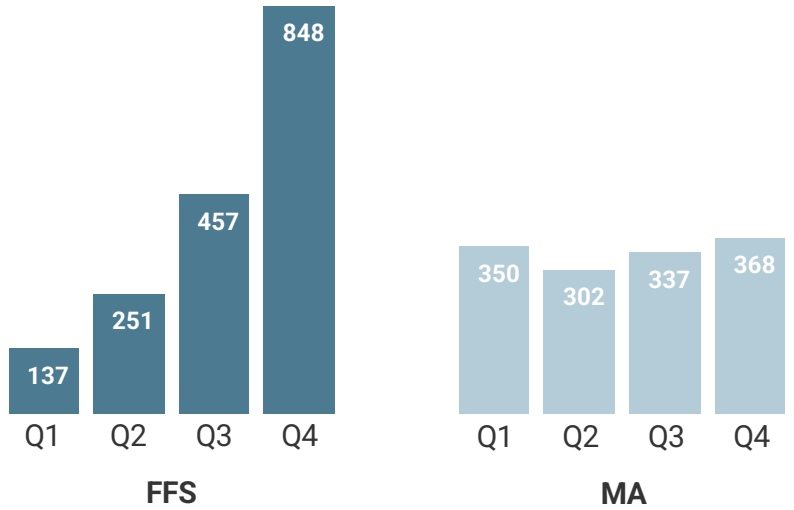
On average, FFS and MA senior housing residents experienced a higher rate of acute care hospital stays than the non-congregate average; FFS and MA residents experienced a lower rate of acute care hospitalizations than the nursing home average

Total Acute Care Stays per 1,000 Residents by Setting



FFS residents of the top two quartiles (Q1-Q2) of senior housing communities had lower rates of acute care hospital stays than both the non-congregate and nursing home average

Total Acute Care Stays per 1,000 Residents by Quartile

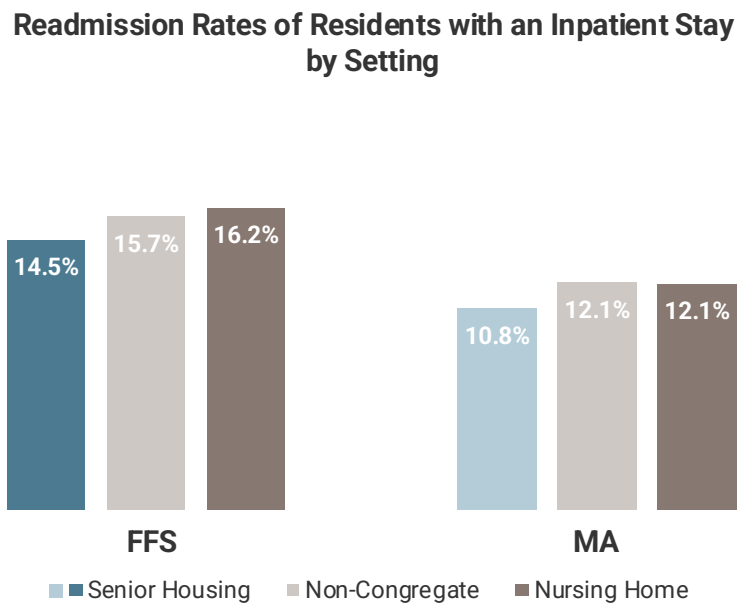


Acute care stays include admissions only to acute care hospitals—such as short-term and critical access hospitals—and exclude specialty hospitals like inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs).
The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

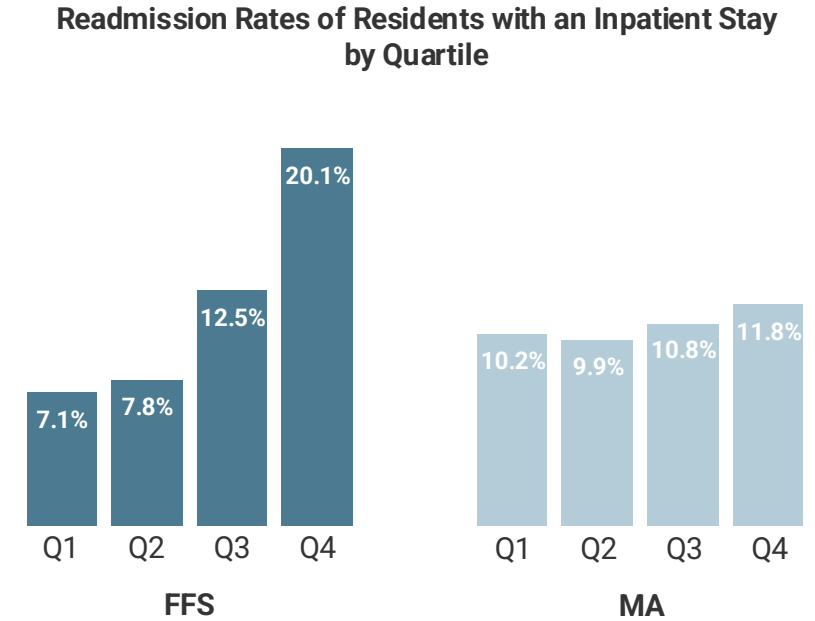
Values shown are rounded; exact figures differ slightly.

Among residents who experienced an inpatient stay, FFS senior housing residents had a higher readmission rate (14.5%) than MA residents (10.8%)

FFS and MA senior housing residents had lower rates of readmission following an inpatient stay compared to both the non-congregate and nursing home averages



FFS residents of the top three quartiles (Q1-Q3) and MA residents of all quartiles of senior housing communities had a lower rate of readmission following inpatient stays than both the non-congregate and nursing home average



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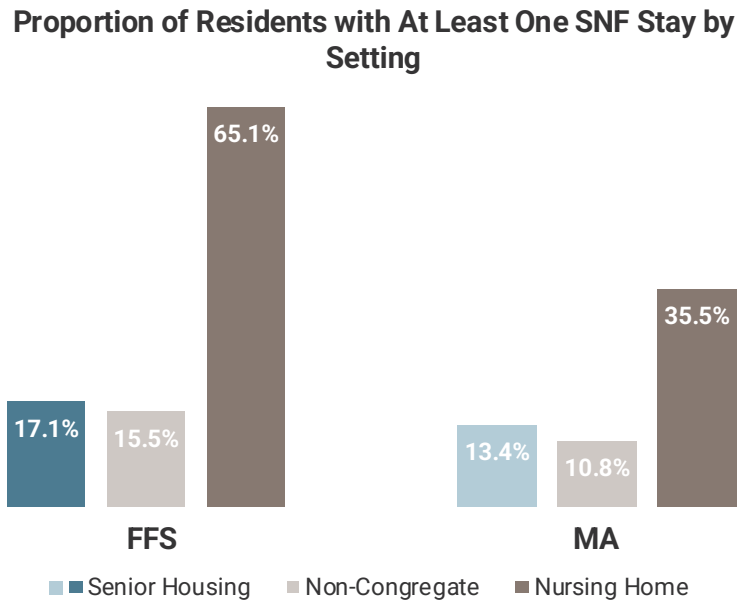
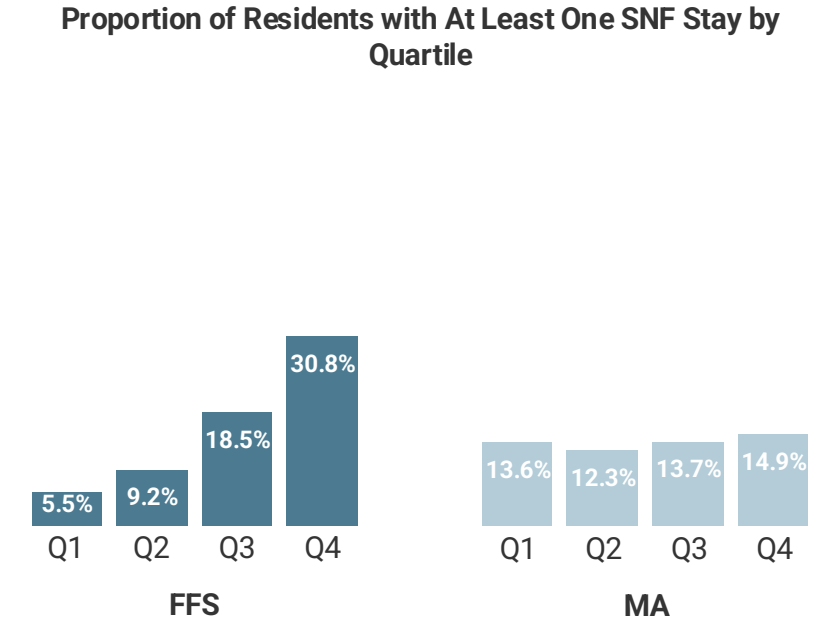
Values shown are rounded; exact figures differ slightly.

A greater proportion of FFS senior housing residents (17.1%) had at least one Skilled Nursing Facility (SNF) stay than MA senior housing residents (13.4%)

On average, a greater proportion of FFS and MA senior housing residents experienced at least one SNF stay than the non-congregate average; FFS and MA residents experienced a lower rate of SNF stays than the nursing home average



A lower proportion of FFS residents of the top two quartiles (Q1-Q2) of senior housing communities experienced at least one SNF stay than both the non-congregate and nursing home average



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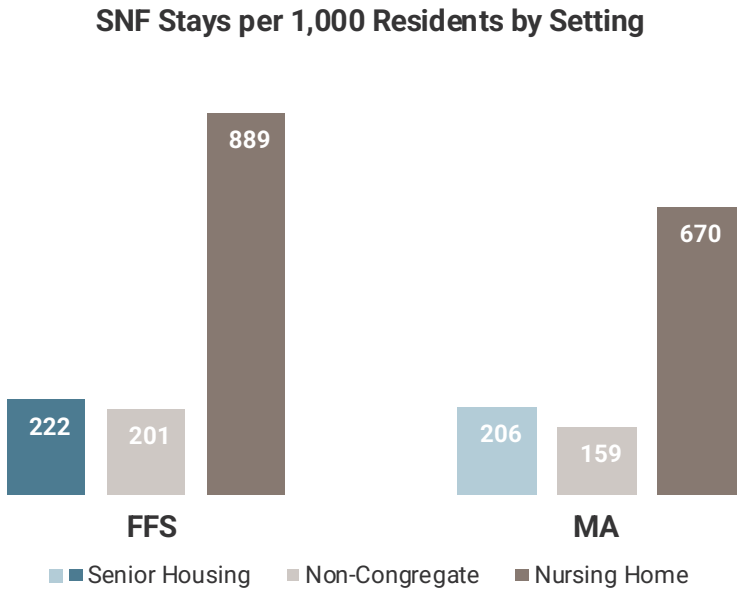
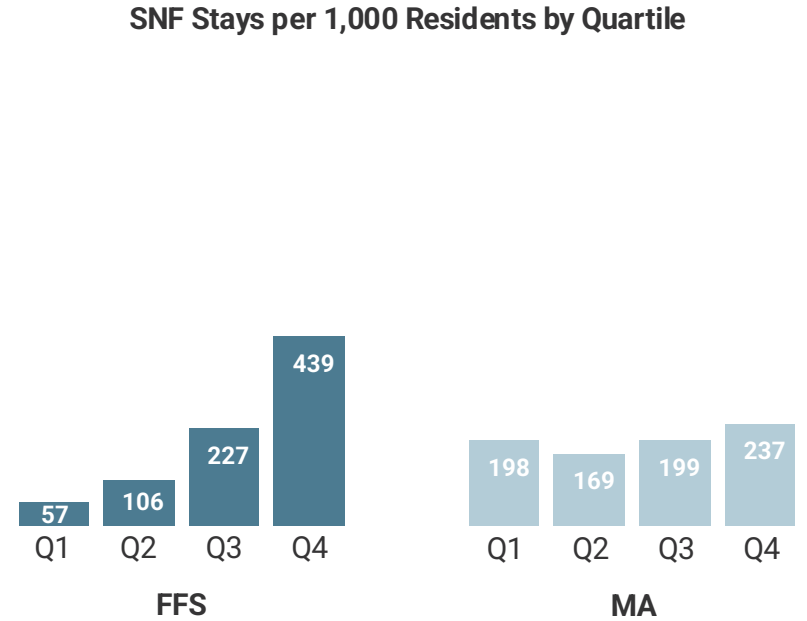
Values shown are rounded; exact figures differ slightly.

The rate of Skilled Nursing Facility (SNF) stays per 1,000 senior housing residents is higher among FFS residents (222) than MA residents (206)

FFS and MA senior housing residents experienced a higher rate of SNF stays than the non-congregate average; FFS and MA senior housing residents had lower rates of SNF stays than the nursing home average



FFS residents of the top two quartiles (Q1-Q2) of senior housing communities had lower rates of SNF stays than both the non-congregate and nursing home averages



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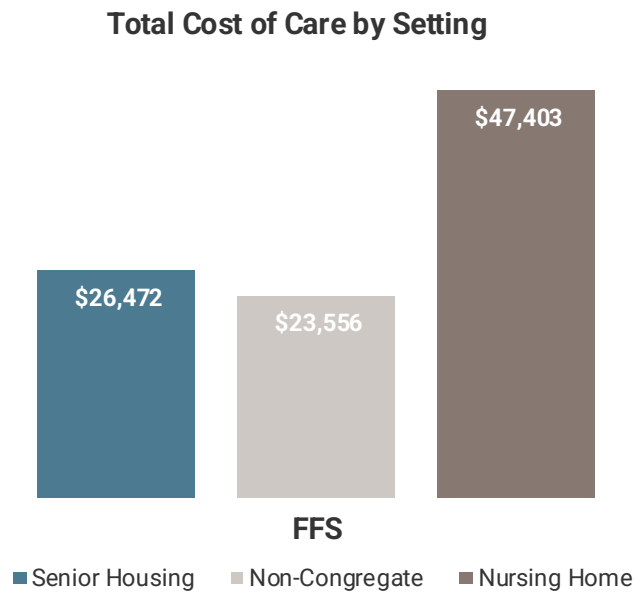
Cost of Care

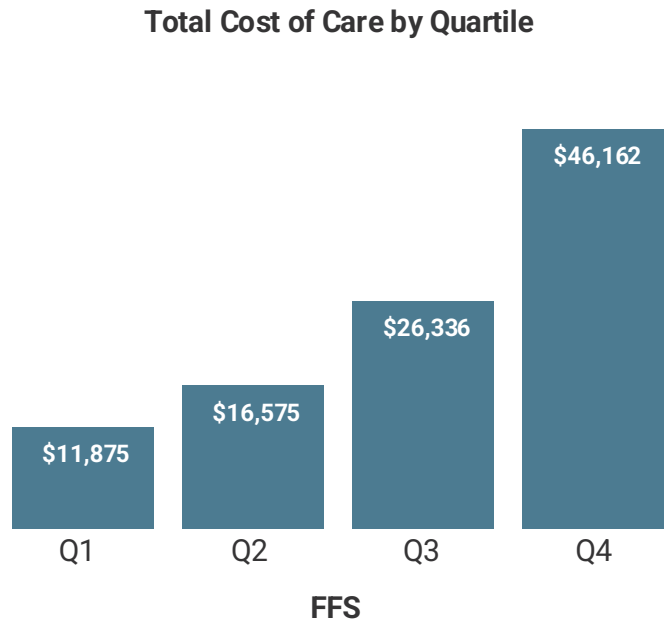
NORC at the University of Chicago

On average, the total Medicare cost of care for senior housing residents (FFS) was $26,472

Medicare total cost of care for senior housing residents was somewhat higher than non-congregate residents, on average; however, the cost of care for senior housing residents was $20.9K—or 44%—lower than the nursing home average



Residents in the top quartile (Q1) of senior housing communities had an average total Medicare cost of care of $11.9K per year – approximately half the non-congregate average



**Our research assessed applicable SNF Part A claims, which includes a fixed room and board component of the per member per diem rate. This component, alongside the nursing and therapy components is the "non-case-mix (room & board)" which is part of normal SNF PPS Market Basket.*

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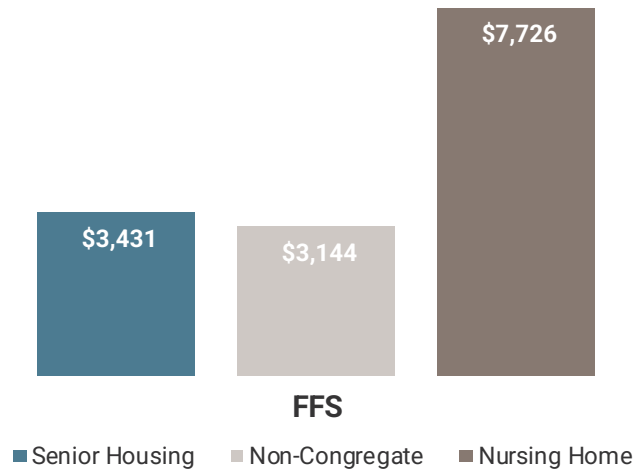
On average, out-of-pocket (OOP) Medicare costs for FFS senior housing residents was $3,431

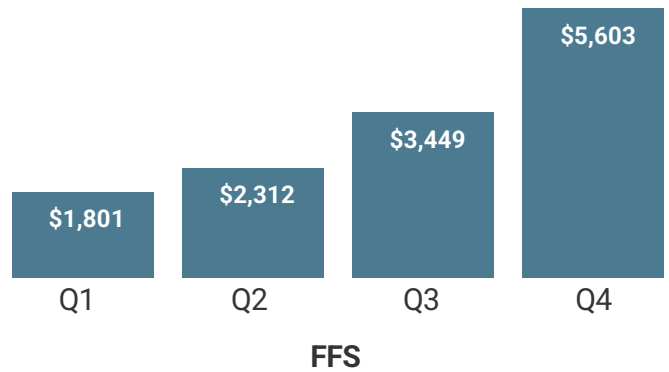
Out-of-pocket Medicare costs for senior housing residents was somewhat higher than non-congregate residents, on average; however, senior housing resident OOP costs were $4.3K—or 55%—lower than the nursing home average

Resident Out-of-Pocket Costs by Setting



Residents in the top quartile (Q1) of senior housing communities spend approximately 40% less in OOP costs than non-congregate beneficiaries

Resident Out-of-Pocket Costs by Quartile



**Our research assessed applicable SNF Part A claims, which includes a fixed room and board component of the per member per diem rate. This component, alongside the nursing and therapy components is the "non-case-mix (room & board)" which is part of normal SNF PPS Market Basket.*

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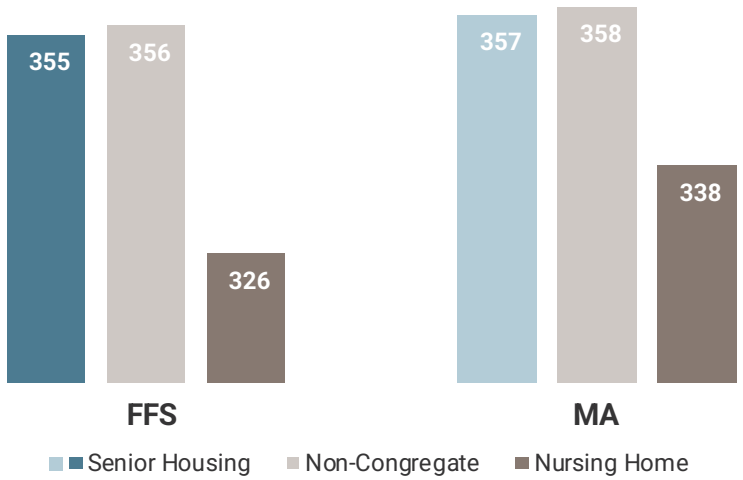
Health Outcomes

NORC at the University of Chicago

Senior housing residents spend most of the year healthy at home—355 and 357 healthy days at home* among FFS and MA residents, respectively

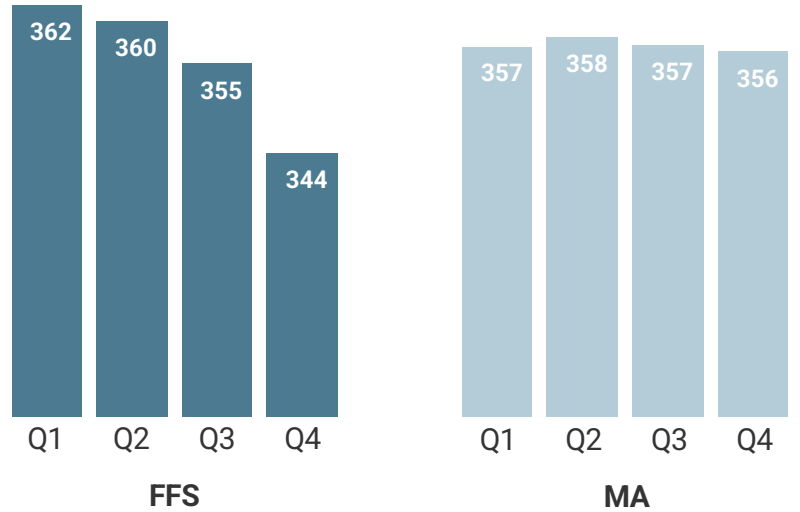
On average, both FFS and MA senior housing residents have more healthy days at home than those in a nursing homes (+29 days FFS, +19 days MA), but one fewer healthy day at home than those in non-congregate settings

Average Healthy Days at Home per Resident by Setting



FFS and MA senior housing residents across all quartiles have more healthy days at home than those in nursing homes, on average; healthy days at home varies more by quartile among FFS senior housing residents than MA senior housing residents

Average Healthy Days at Home per Resident by Setting



* "*Healthy days at home*" is defined as the total number of days in the measurement year minus days spent in inpatient hospital stays, emergency department visits, skilled nursing facilities.

The top 25% (quartile) of communities were identified based on the difference between actual and expected total costs of care. Expected costs were risk-adjusted using each senior housing community's demographic and diagnostic profiles, including Hierarchical Condition Category (HCC) scores. Senior housing communities with the lower costs relative to expected benchmarks were ranked higher, with the top quartile (Q1) representing those with the largest cost differential. Cost data is limited to the FFS population.

Values shown are rounded; exact figures differ slightly.

Caregiver Support

NORC at the University of Chicago

Senior housing is a vital partner in supporting caregivers of older adults with NDD

Caregivers of people with dementia experience **higher rates of emotional, financial, and physical stress**

A dementia diagnosis requires high daily care needs of caregivers

Unpaid caregiving hours in the US are valued at $413.5 billion

Caregivers provide 90+ hours of care per month, on average

About 25% of dementia caregivers also care for at least one child

12M **Nearly 12 million Americans provide unpaid care for a family member or friend with dementia**

Senior Housing Offers a Supportive Environment

- Coordinated health services
- 24/7 staff & support
- Reclaimed relationships between caregiver and resident
- Emotional relief
- More time and support for working caregivers

Source: Alzheimer's & Dementia: Facts and Figures—Caregivers. Alzheimer's Association

Value of Longer Stays in Senior Housing

NORC at the University of Chicago

The Value of Longer Stays research evaluates changes in health care utilization, outcomes, and cost of senior housing residents over time

Overall Study Population Criteria

- Traditional Medicare (TM) Fee-for-Service (FFS) beneficiaries
- Moved into an Independent Living, Assisted Living, or Memory Care community included in the NIC MAP data between 2016-2023[1]
- 65+ years old as of move-in

Analytic Approach

NORC analyzed Traditional Medicare FFS claims data to explore how health outcomes and costs change for residents over time, from move-in (Year 1) through several years post move-in (Years 3 and 6).

Using FFS data from 2016-2023, NORC constructed cohorts of residents based on their move-in date and tracked outcomes and costs over time, by calendar year, among residents who remained in senior housing.

NORC concatenated stays across settings (Independent Living, Assisted Living, Memory Care) to construct an overall "senior housing stay". If a resident moved in during Q1-Q3 of any year 2016-2023, that year is considered their Year 1; if they moved in during Q4, they were included in the following year's cohort.

(1) **NIC MAP® Data**: Senior housing data from the National Investment Center for Senior Housing & Care (NIC) was used to identify communities at the 9-digit ZIP level.

See slide 72 for a description of the research study limitations.

The Value of Longer Stays research explores the differences in health outcomes and costs across four types of key measures

NORC analyzed health care utilization and outcomes among senior housing residents in the years following their move-in to senior housing

Primary and Supportive Care

- Primary care visits
- Mental health visits
- Physical therapy visits
- Clinical social worker visits
- Home health care visit
- Antipsychotic medications
- Days supply of antipsychotic medications

Acute Care

- Proportion of residents with at least one emergency department (ED) visit
- Rate of ED visits per 1,000 residents
- Proportion of residents with at least one inpatient hospital admission
- Number of inpatient days among residents with an inpatient stay
- Proportion of residents with Skilled Nursing Facility (SNF) stay (limited to those covered by Medicare)[1]
- Number of SNF days among residents with a SNF stay[1]

Cost of Care*

- Average total Medicare FFS costs
- Resident out-of-pocket (OOP) costs

Outcomes

- Healthy days at home**

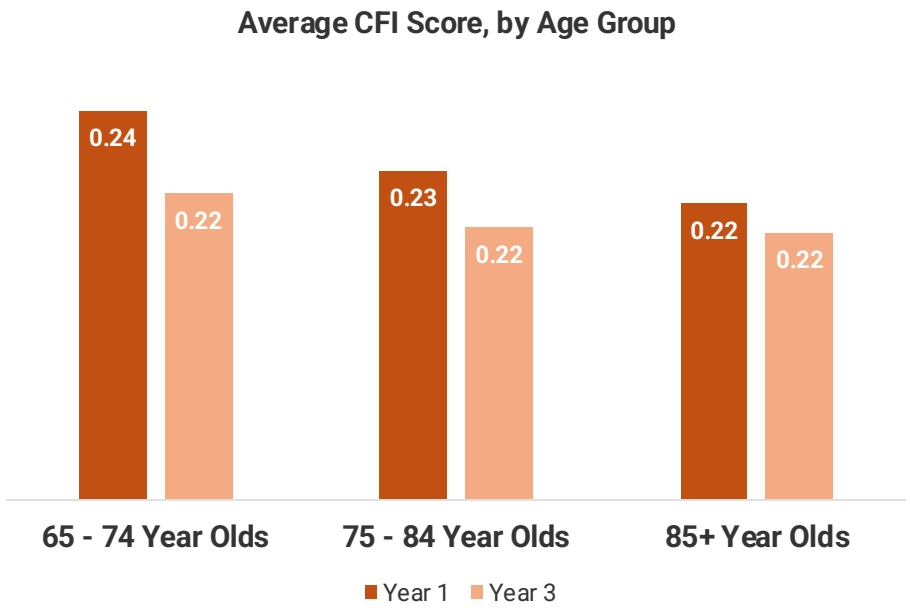
[1] Our research assessed applicable SNF Part A claims, which includes a fixed room and board component of the per member per diem rate. This component, alongside the nursing and therapy components is the "non-case-mix (room & board)" which is part of normal SNF PPS Market Basket.

* Cost analysis is limited to senior housing residents enrolled in FFS

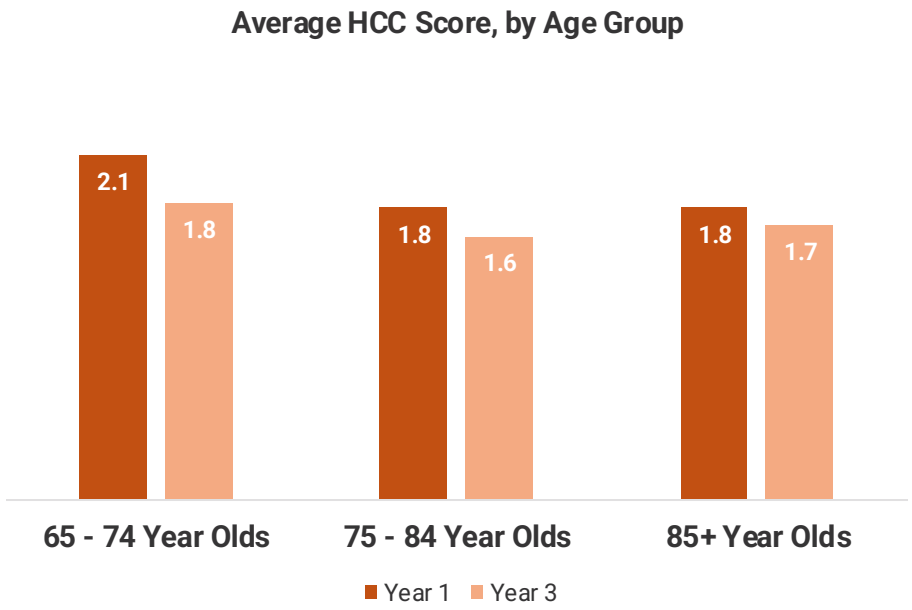
** "Healthy days at home" is defined as the total number of days in the measurement year minus days spent in inpatient hospital stays, emergency department visits, skilled nursing facilities.

Residents' frailty and clinical complexity were assessed in each year

Claims-Based Frailty Index (CFI) measures cumulative health deficits—including chronic conditions and functional limitations—to quantify frailty and characterize vulnerability to poor health outcomes[1]



Hierarchical Condition Categories (HCCs) are a risk-adjustment model that assigns patients a score based on their documented health conditions—commonly used to evaluate clinical complexity and predict future utilization and cost[2]



Sources: (1) Kim DH, Glynn RJ, Avorn J, et al. Validation of a Claims-Based Frailty Index Against Physical Performance and Adverse Health Outcomes in the Health and Retirement Study. *J Gerontol A Biol Sci Med Sci*. 2019;74(8):1271–1276. doi:10.1093/gerona/gly197. (2) CMS | Medicare Risk Adjustment Information

Values shown are rounded; exact figures differ slightly.

The year before move-in is commonly a period of increasing health and care challenges

Gradual Decline Over 12 Months

- Frequent ER visits, hospital stays, infections
- Falls, mobility loss, and increased ADL needs
- Cognitive decline, behavioral symptoms
- Home care stretched beyond capacity

Triggering Event

- Major fall or hospitalization
- Unsafe behaviors or wandering
- Caregiver burnout or health emergency

Why the Decision is Made

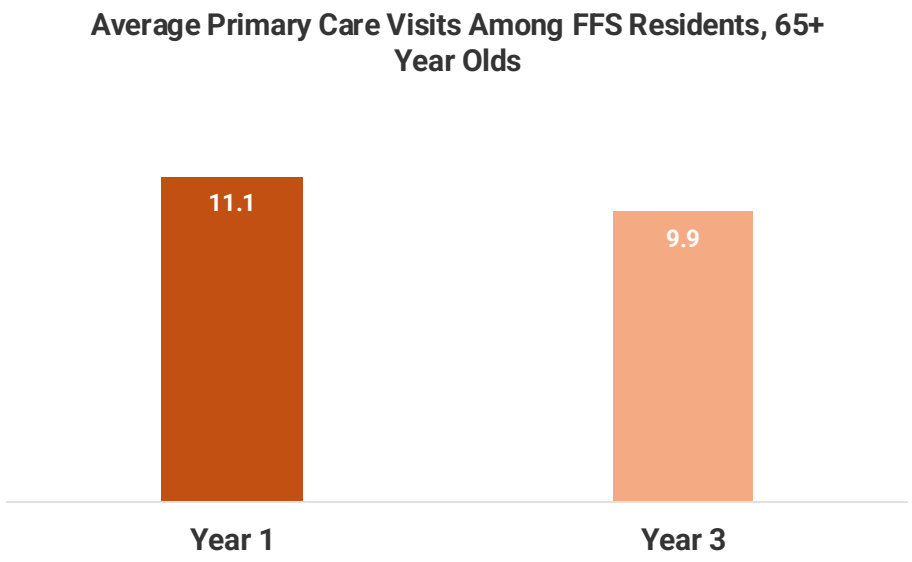
- Care exceeds home safety limits
- Professionals recommend higher-level care
- Family prioritizes safety and stability

Primary and Supportive Care

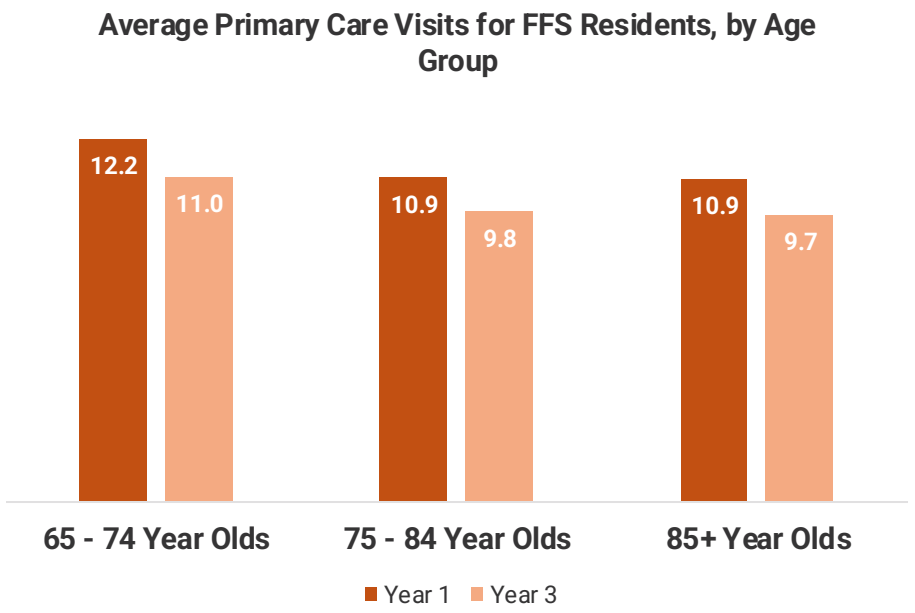
NORC at the University of Chicago

Senior housing residents experience a higher volume of primary care visits in their first year following move-in, compared to subsequent years

On average, senior housing residents received 11.1 primary care visits in Year 1 and 9.9 primary care visits in Year 3—an 11% reduction



This reduction in primary care visit volume was consistent across age groups—in both magnitude and direction—from Year 1 to Year 3



Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

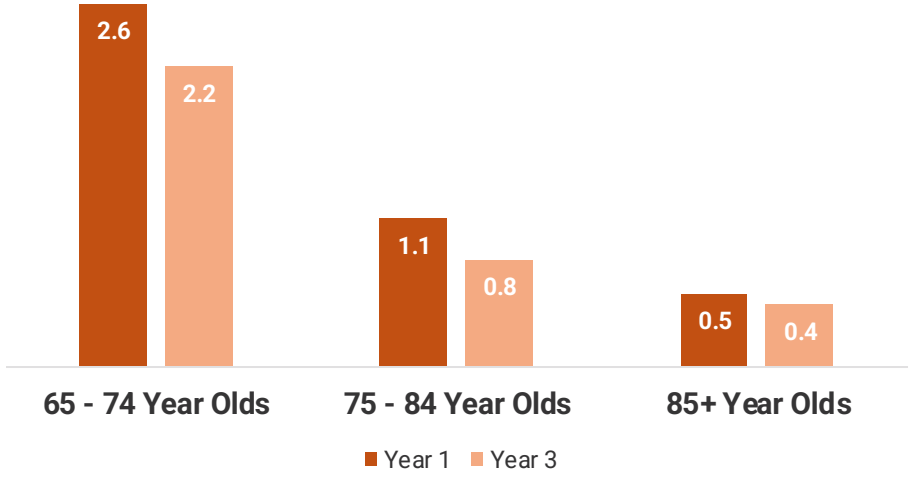
Senior housing residents experience a higher volume of mental health visits in their first year following move-in, compared to subsequent years

On average, senior housing residents experienced 1.0 mental health visit in Year 1 and 0.8 mental health visits in Year 3—a 21% reduction

Average Mental Health Care Visits Among FFS Residents, 65+ Year Olds

Senior housing residents age 65-74 experience the highest volume of mental health care visits, on average—2.6 visits per person in Year 1, declining to 2.2 visits per person in Year 3

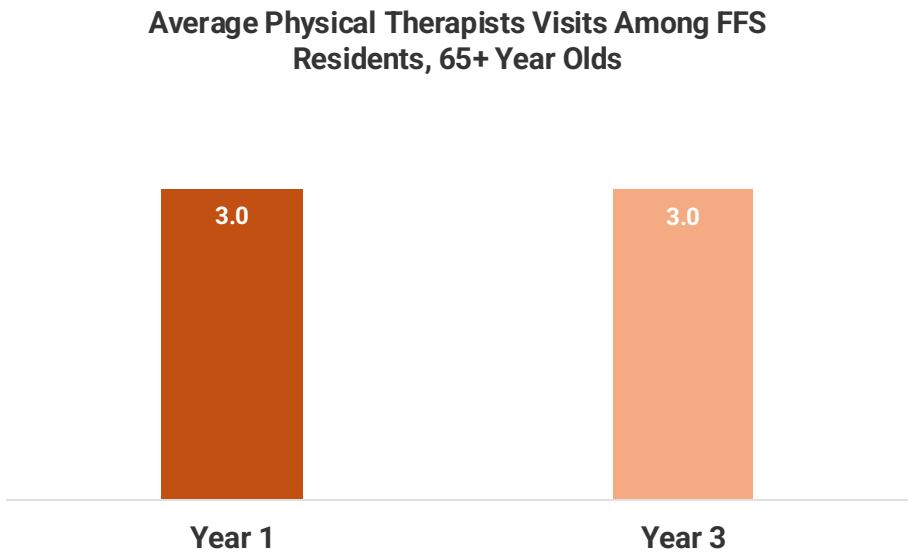
Average Mental Health Care Visits for FFS Residents, by Age Group



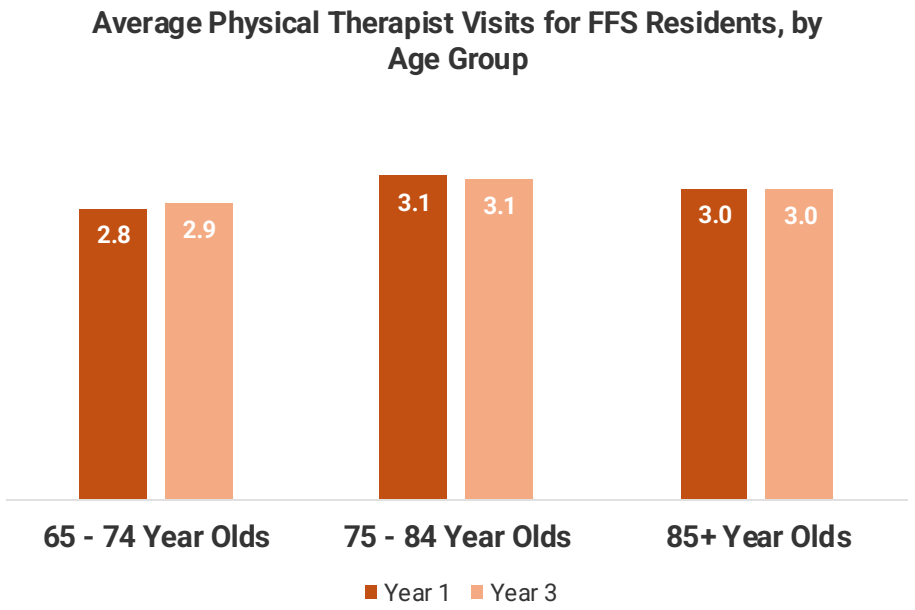
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Senior housing residents experienced a consistent number of physical therapist visits each year, on average

Senior housing residents received a consistent volume of physical therapy services over time, averaging 3.0 visits per person in both Year 1 and Year 3



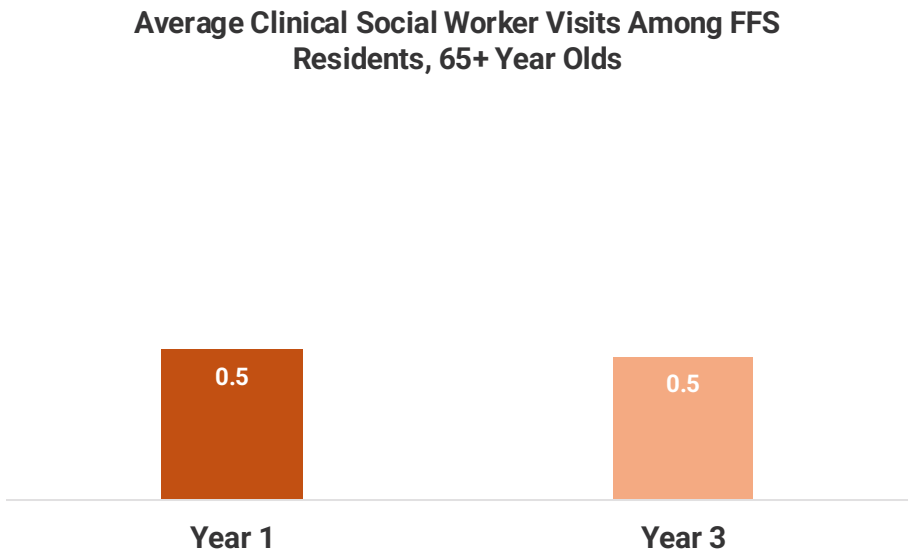
Physical therapy use was consistent across age groups, ranging from 2.8 to 3.1 visits per person in Year 1 and 2.9 to 3.1 visits per person in Year 3



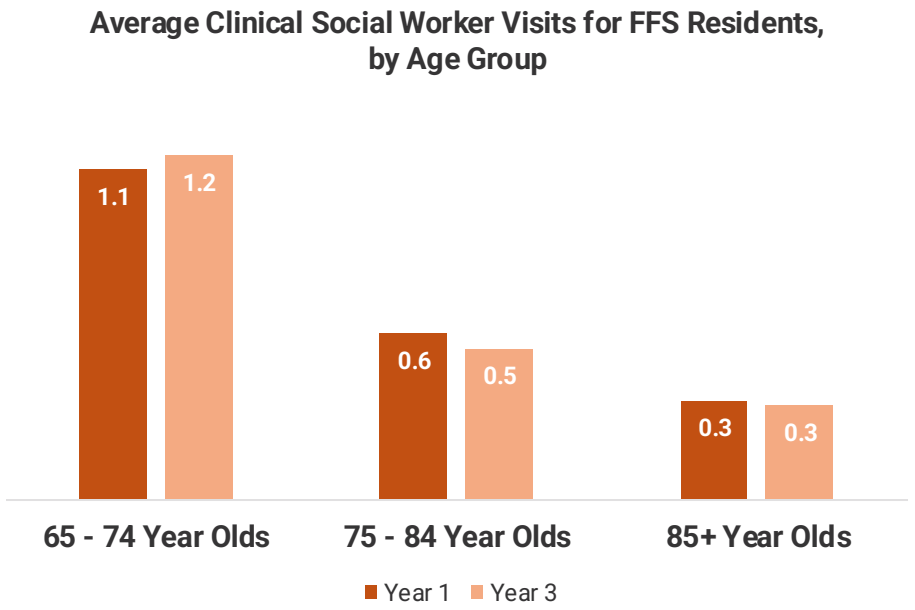
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Senior housing residents experience a consistent number of clinical social worker visits each year, on average

Senior housing residents received a consistent volume of clinical social worker visits over time, averaging 0.5 visits per person in both Year 1 and Year 3



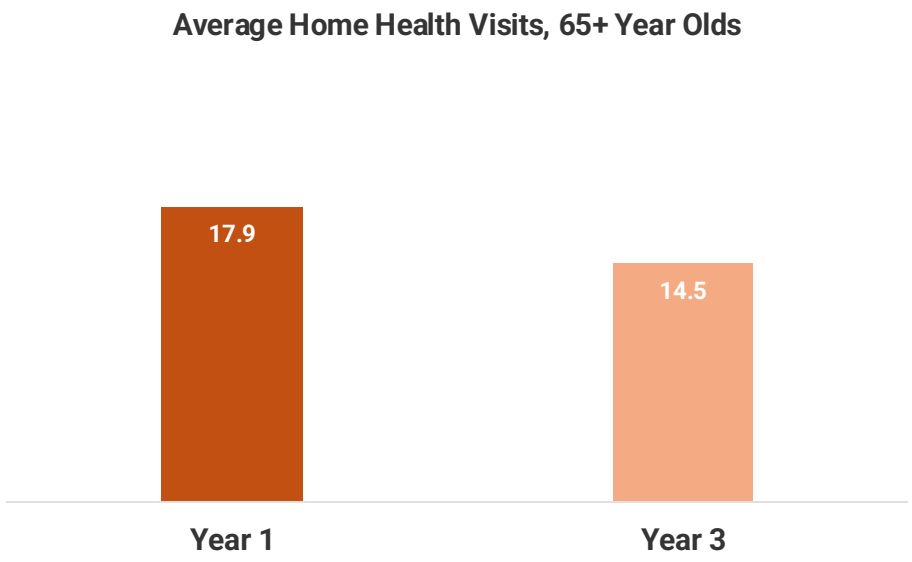
Senior housing residents age 65-74 received the highest volume of clinical social worker visits in both Year 1 and Year 3



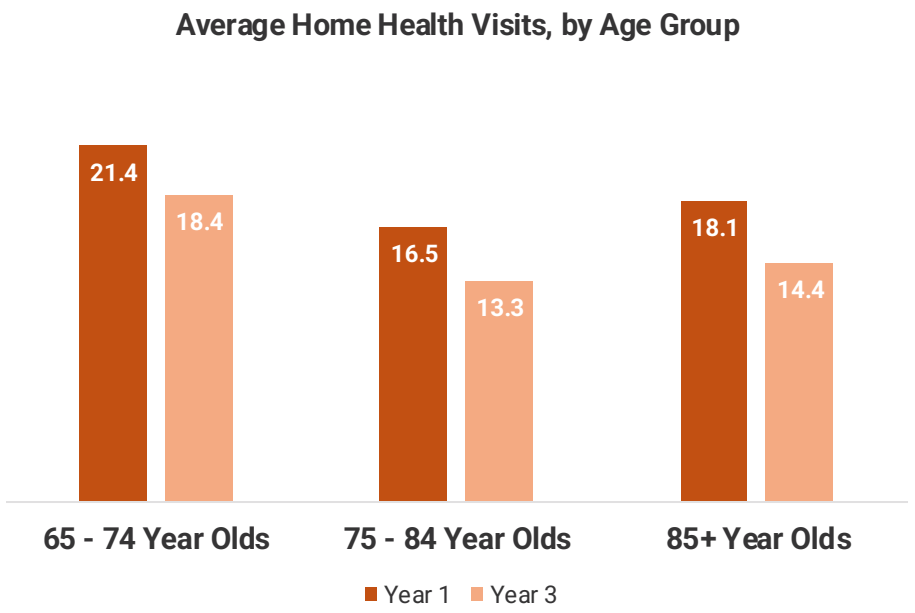
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Senior housing residents experience a higher volume of home health visits in their first year following move-in compared to subsequent years

On average, senior housing residents experienced 17.9 home health visits in Year 1 and 14.5 home health visits in Year 3—a 19.2% reduction



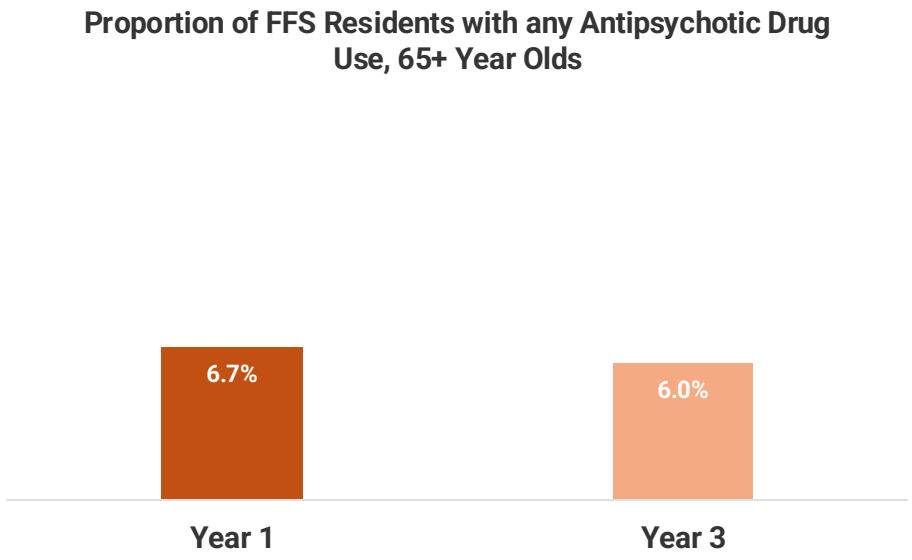
Senior housing residents, across all age groups experienced a 14-21% reduction in the number of home health care visits from Year 1 to Year 3



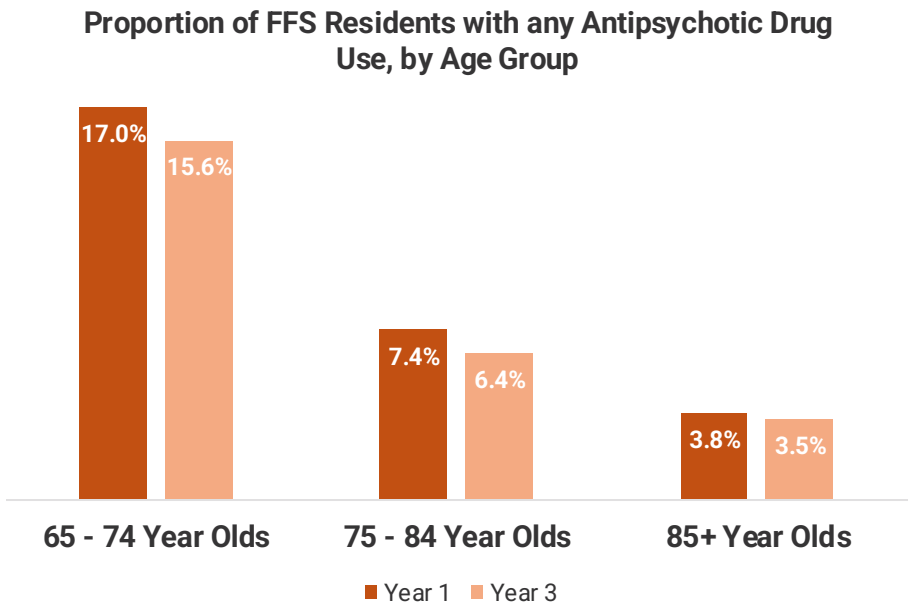
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

The proportion of senior housing residents that were prescribed antipsychotic medication decreased from Year 1 to Year 3

On average, the proportion of senior housing residents that were prescribed antipsychotic medications decreased from 6.7% in Year 1 to 6.0% in Year 3—a 10% reduction



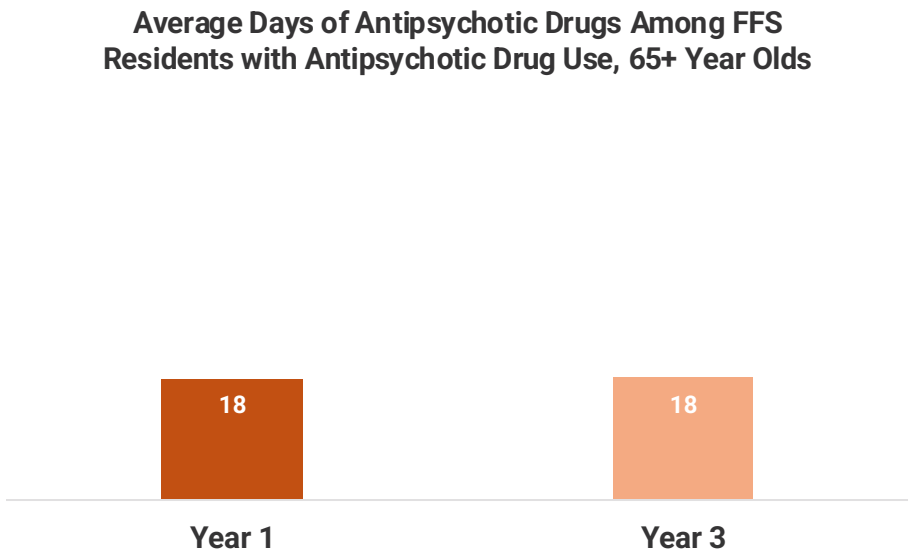
The proportion of senior housing residents prescribed antipsychotic medication was highest among 65-to-74-year-olds; the proportion of residents prescribed antipsychotic medication declined among all age groups from Year 1 to Year 3



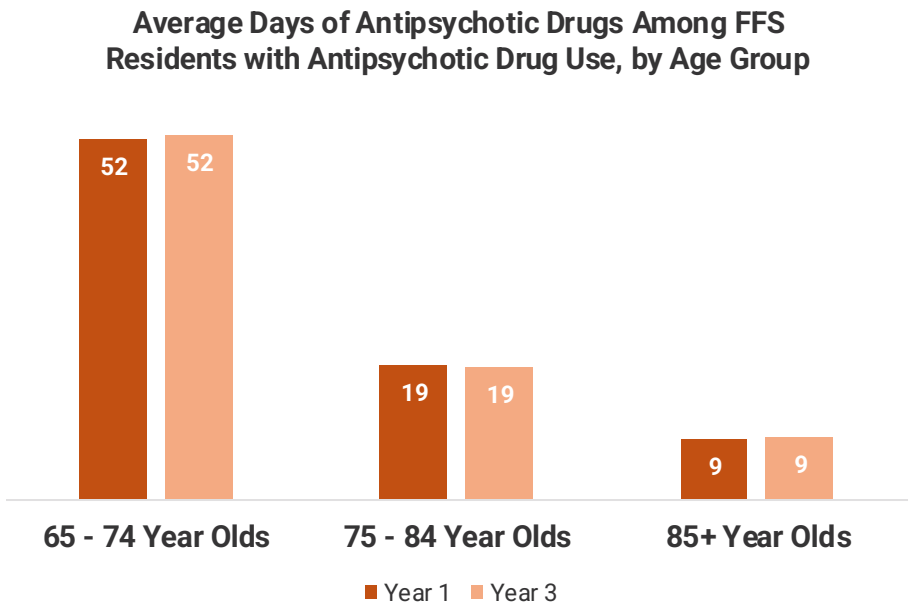
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Average days supply of antipsychotic medications for senior housing residents was consistent from Year 1 to Year 3

Average days supply of antipsychotic medication was 18 days per year in both Year 1 and Year 3



Average days supply of antipsychotic medications was highest among 65-to-74-year-olds in both periods; within each age group, average days supply was consistent between Year 1 and Year 3



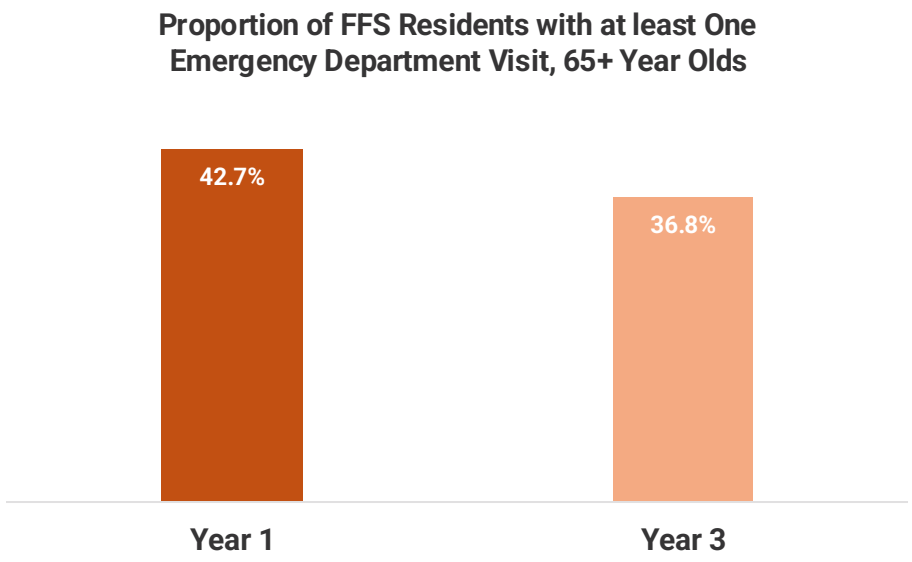
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Acute Care

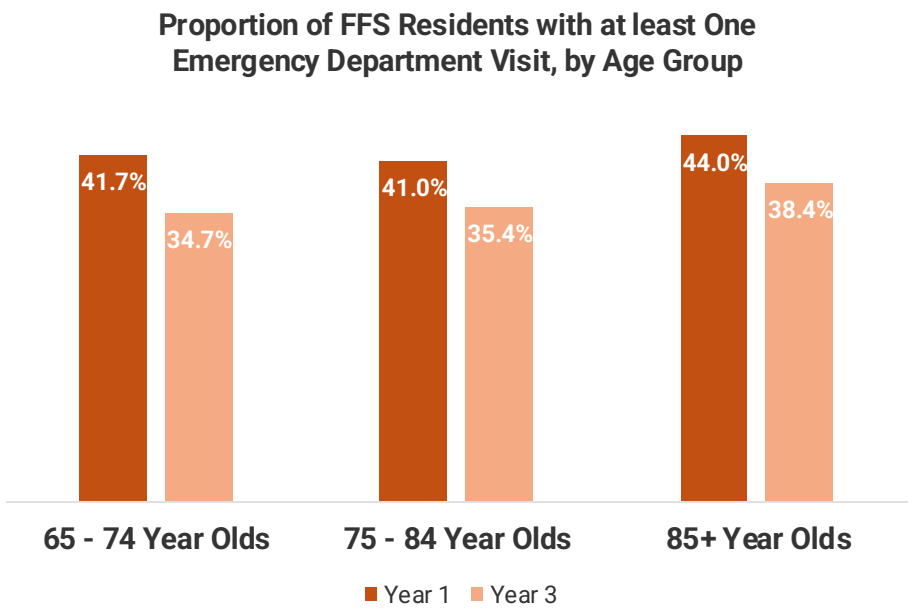
NORC at the University of Chicago

The proportion of senior housing residents with at least one emergency department (ED) visit decreased from Year 1 to Year 3

The average proportion of senior housing residents with at least one ED visit declined from 42.7% to 36.8% of residents from Year 1 to Year 3—a 13.6% reduction



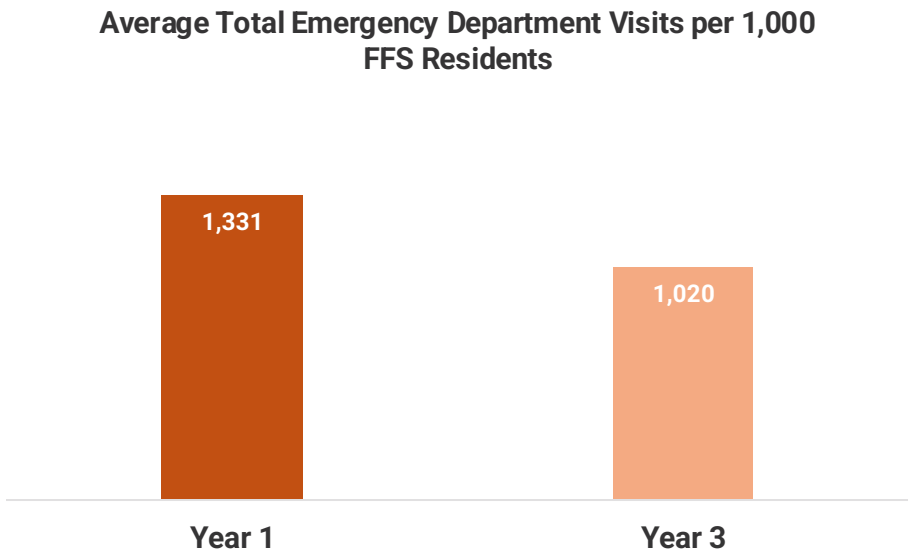
The average proportion of senior housing residents with an emergency department visit declined across all age groups; reductions ranged from 13-17%



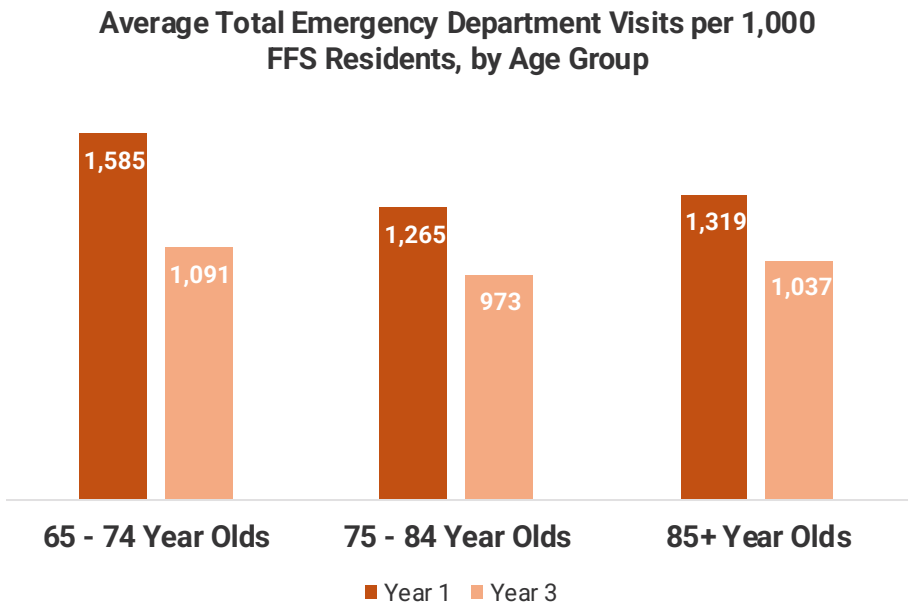
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Senior housing residents experienced lower rates of emergency department (ED) utilization by Year 3

On average, the rate of ED visits per 1,000 residents declined from 1,331 in Year 1 to 1,020 in Year 3—a 23.4% reduction



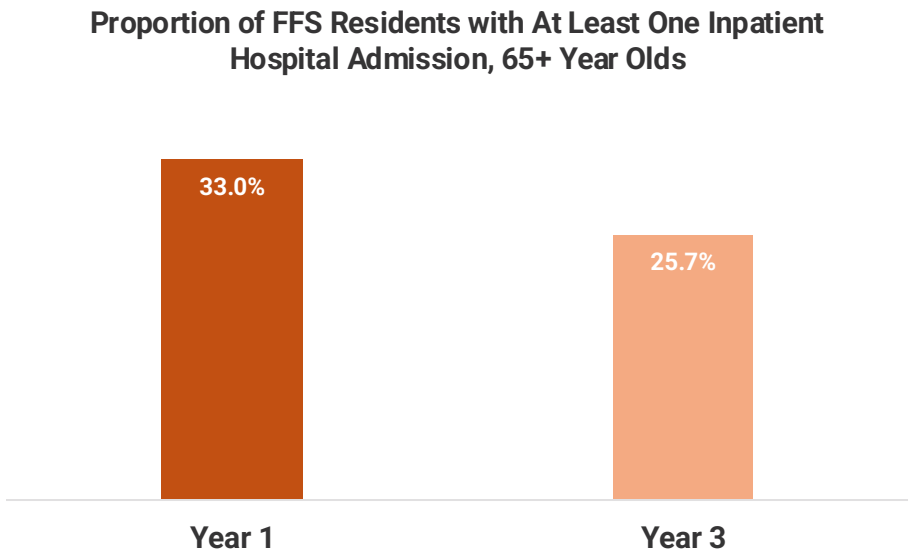
Senior housing residents age 65-74 had the highest ED utilization in both periods, but experienced the largest reduction ED visits per 1,000 residents—from 1,585 in Year 1 to 1,091 in Year 3, a 31% reduction



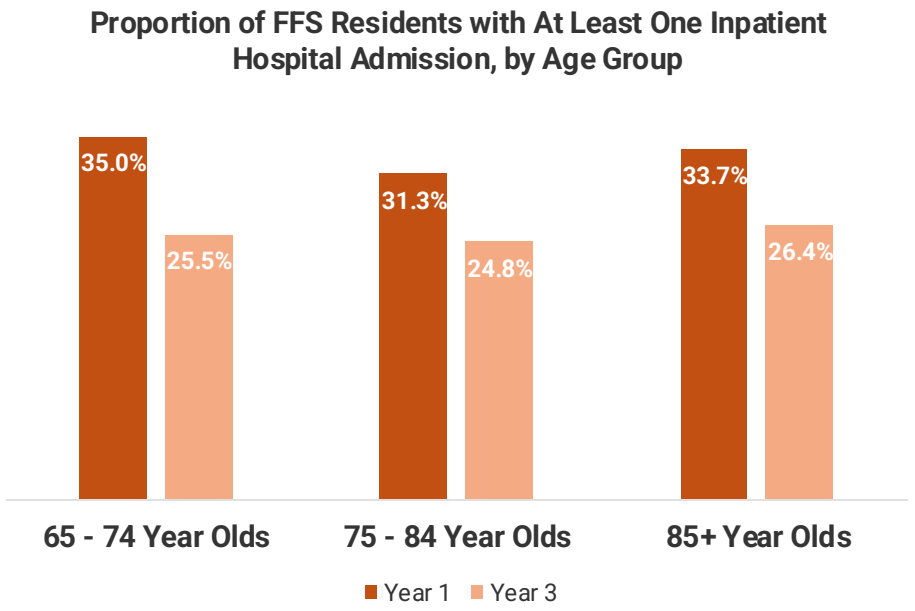
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

The proportion of senior housing residents with at least one inpatient hospital admission decreased from Year 1 to Year 3

The average proportion of senior housing residents with at least one hospital admission decreased from 33.0% in Year 1 to 25.7% in Year 3—a 22.1% reduction



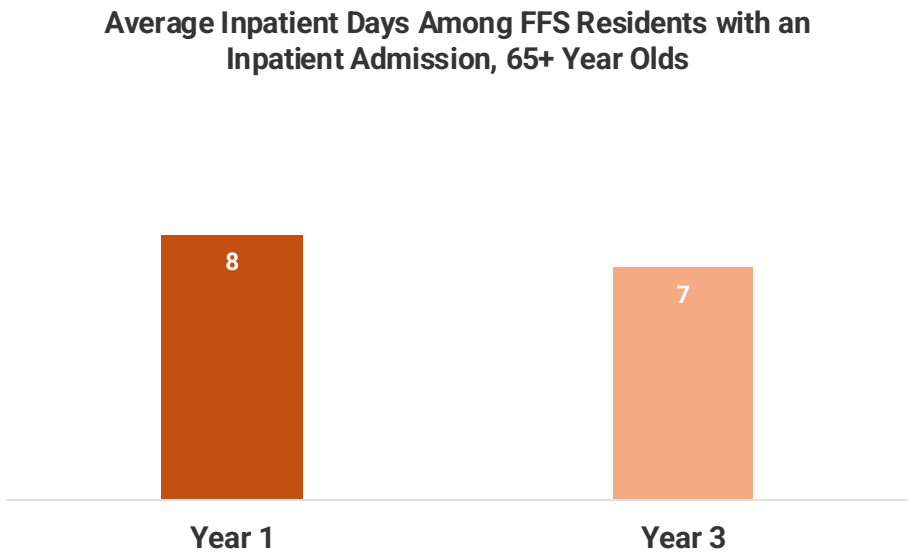
The average proportion of senior housing residents with an inpatient hospital admission declined across all age groups; reductions ranged from 21-27%



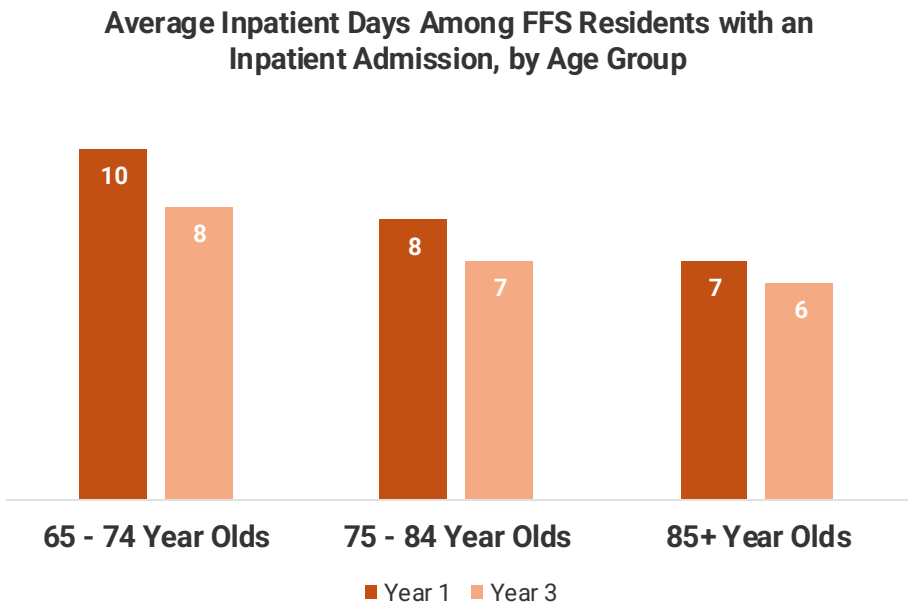
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Senior housing residents that had an inpatient stay experienced fewer inpatient days from Year 1 to Year 3

On average, the number of inpatient days among the residents that had an inpatient stay decreased by from 8 days in Year 1 to 7 days in Year 3



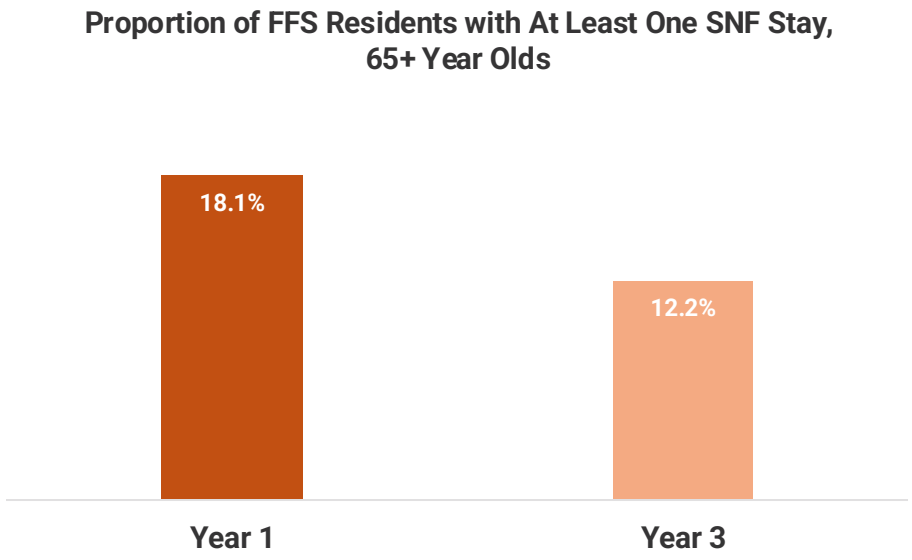
On average, residents age 65-74 with an inpatient stay had the highest inpatient utilization in both periods; average inpatient utilization decreased from Year 1 to Year 3 across all age groups



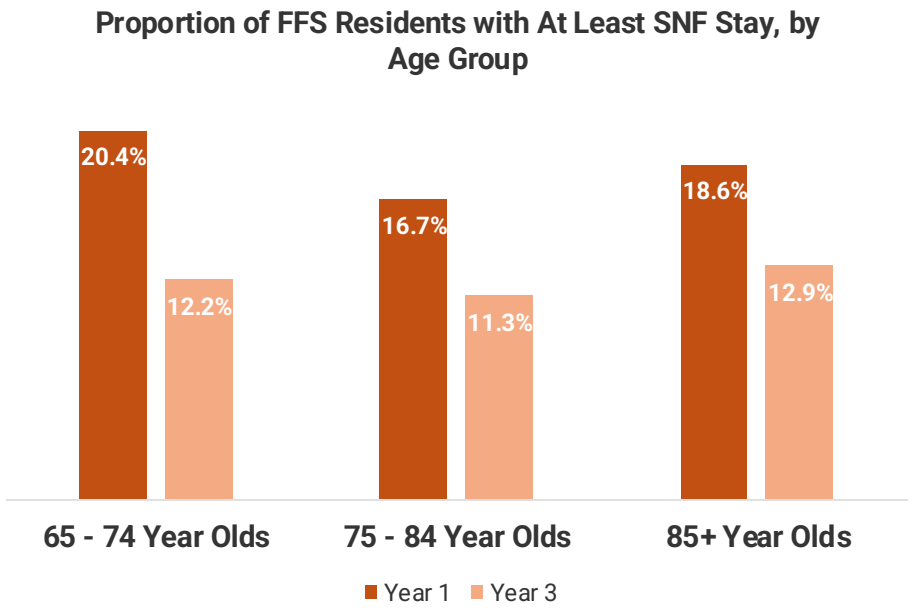
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

The proportion of senior housing residents with at least one Skilled Nursing Facility (SNF) stay decreased from Year 1 to Year 3

The average proportion of senior housing residents with at least one SNF stay decreased from 18.1% in Year 1 to 12.2% in Year 3—a 32% reduction



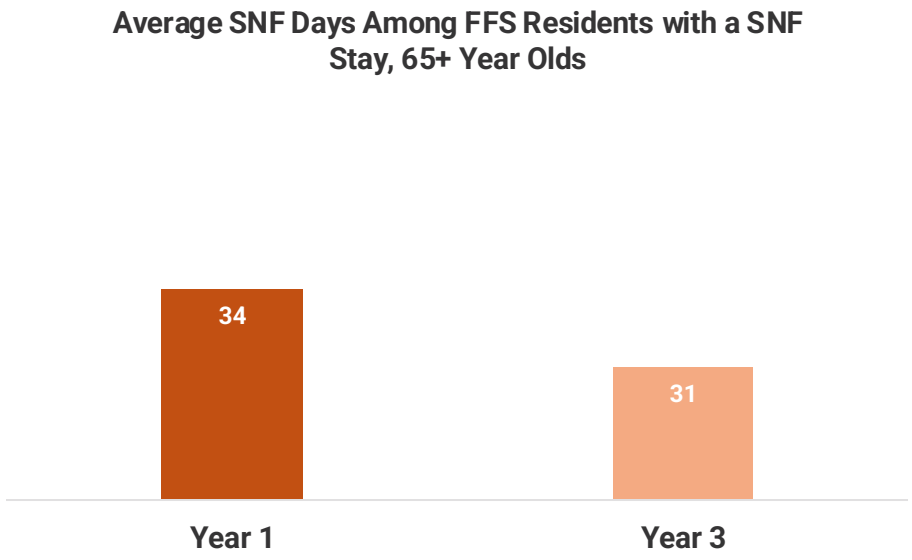
The average proportion of senior housing residents with a SNF stay declined across all age groups; reductions ranged from 30-40%



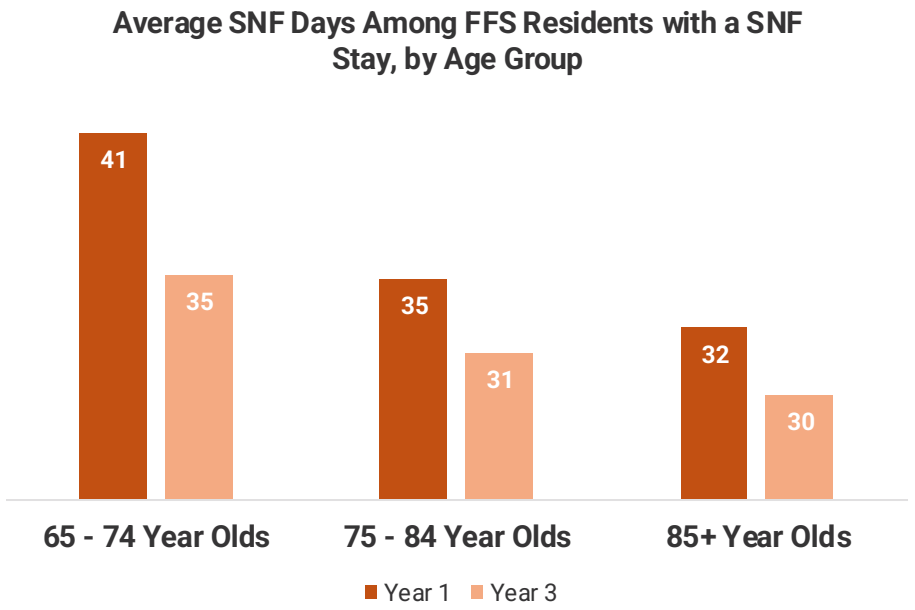
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Senior housing residents who had a Skilled Nursing Facility (SNF) stay experienced fewer SNF days from Year 1 to Year 3

Among residents with a SNF day, average SNF days decreased from 34 to 31 days—a 10% reduction



Among residents with a SNF stay, 65-74 year olds had the highest SNF utilization in both Year 1 and Year 3; all age groups had reduced SNF utilization over time



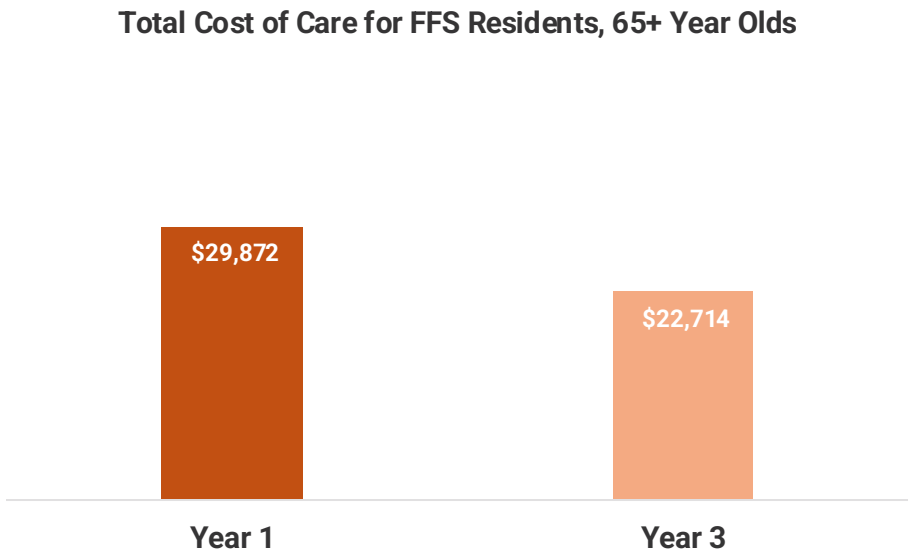
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Cost of Care

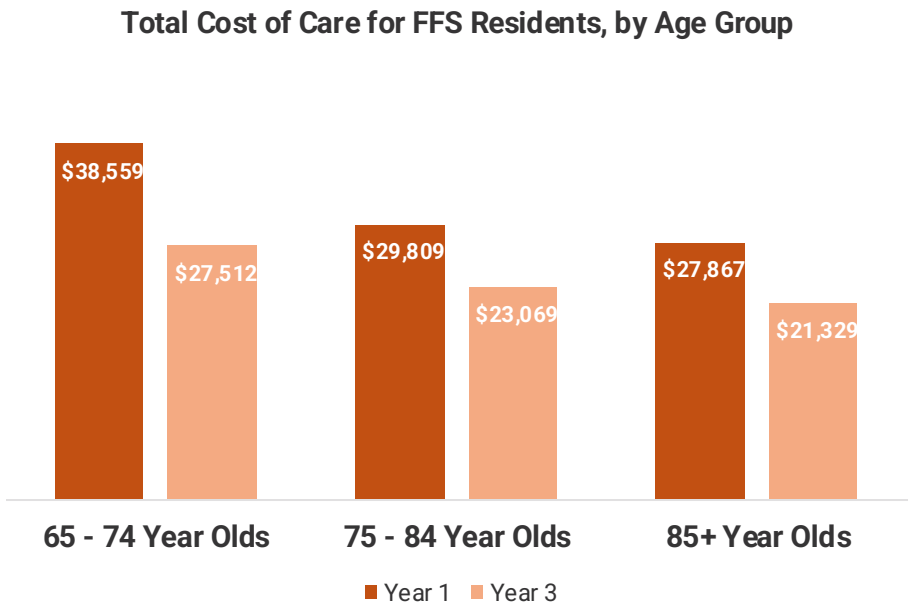
NORC at the University of Chicago

On average, residents' total cost of care decreased by more than $7k from Year 1 to Year 3

On average, senior housing residents' total cost of care declined from $29.9k in Year 1 to $22.7k in Year 3—a 24% reduction



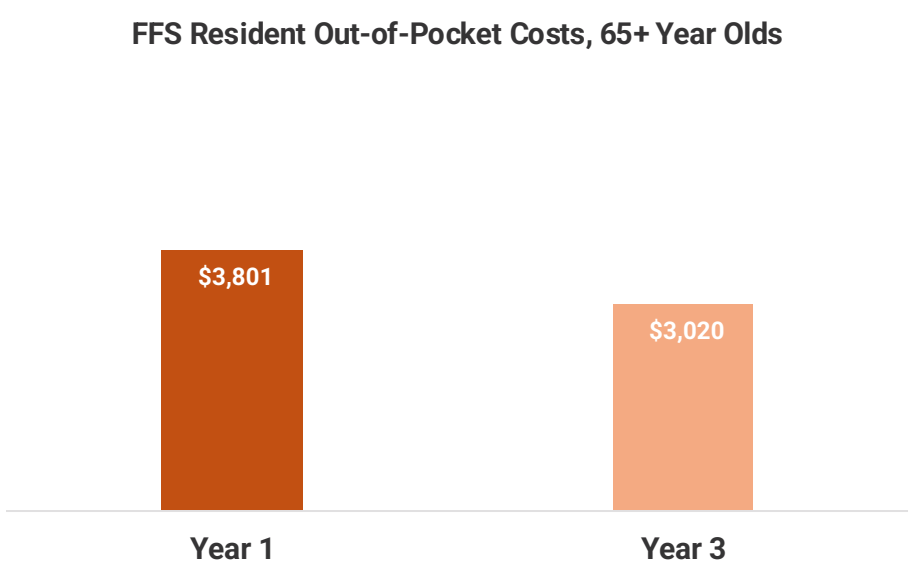
All senior housing age groups experienced reduction in their total Medicare cost of care from Year 1 to Year 3; 65–74-year-old residents had the highest total cost of care in both years, and the greatest reduction between years



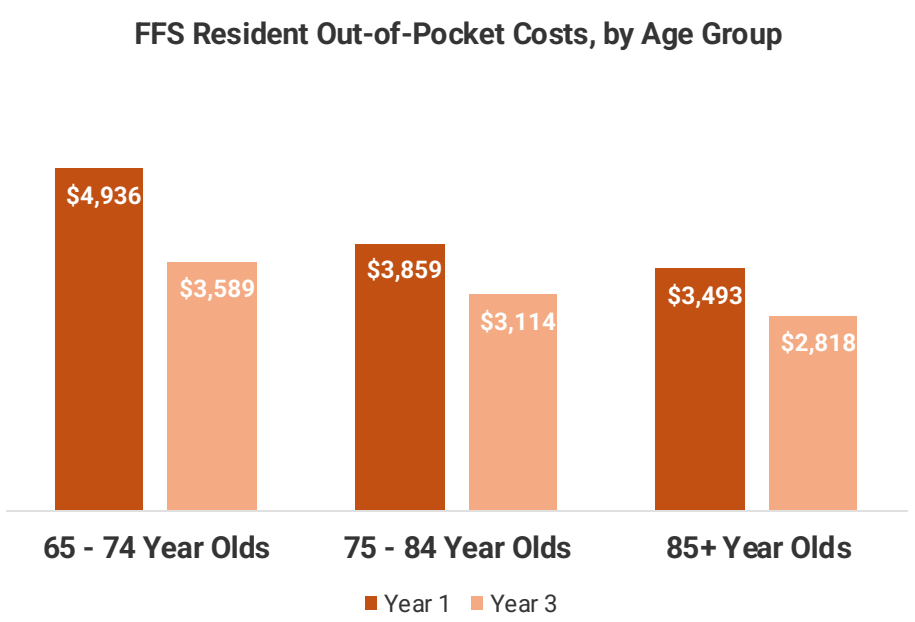
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

On average, resident out-of-pocket (OOP) costs decreased by nearly $1k from Year 1 to Year 3

On average, senior housing residents' OOP costs declined from $3.8k in Year 1 to $3.0k in Year 3—a 21% reduction



All senior housing age groups experienced reduction in their OOP costs from Year 1 to Year 3; 65–74-year-old residents had the highest OOP costs in both years and greatest reduction between years



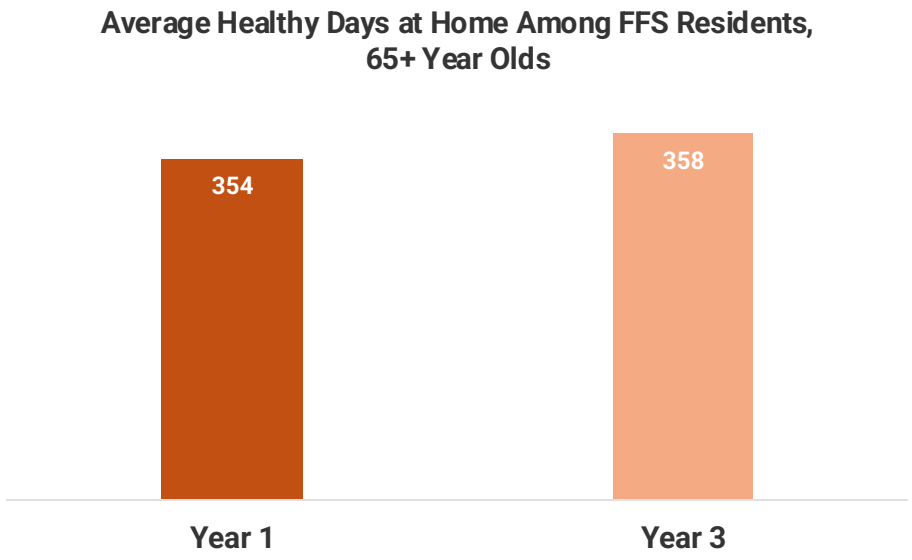
Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

Health Outcomes

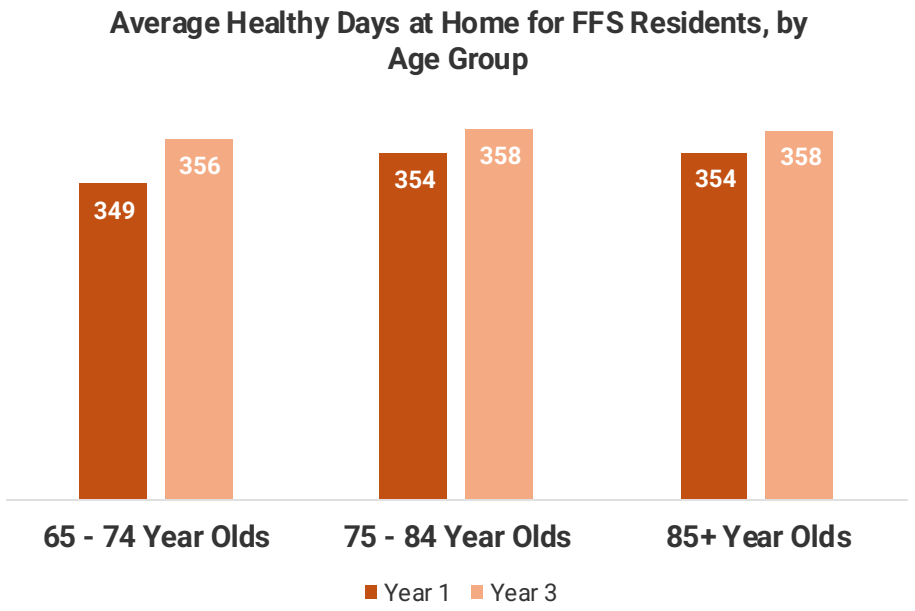
NORC at the University of Chicago

Senior housing residents spend most of the year healthy at home—and out of higher-cost, higher-acuity health care settings

Senior housing residents experienced a high proportion of healthy days at home*—and an increasing proportion of healthy days at home between Year 1 and Year 3



Senior housing residents experienced a high proportion of healthy days at home* across age groups; all age groups experienced an increase in healthy days at home between Year 1 and Year 3



Values shown are rounded; exact figures differ slightly. Overall results were weighted to match the Year 1 age distribution; alternative approaches did not yield material differences.

* "Healthy days at home" is defined as the total number of days in the measurement year minus days spent in inpatient hospital stays, emergency department visits, skilled nursing facilities.

Study Limitations

The Care for Older Adults with Neurodegenerative Disease (NDD) and Value of Longer Stays studies were limited to senior housing communities included in the NIC MAP® database with at least 11 residents who met each study criteria—including age, residency, continuous Medicare enrollment, and health conditions as relevant.

Each study was subsequently limited to residents of select senior housing property types:

- The **Care for Older Adults with NDD** research study includes residents of Assisted Living and Memory Care communities. Non-congregate and nursing home comparison groups were drawn from the local area (5-digit ZIP) surrounding qualifying senior housing communities.

- The **Value of Longer Stays** research study includes Independent Living, Assisted Living, and Memory Care residents; it does not include Continuous Care Retirement Communities (CCRCs).

For the NDD Study, risk adjustment was conducted using entropy balancing to create comparison groups resembling the senior housing population. However, additional regression-based risk adjustment may be needed to support fair comparisons along specific dimensions (e.g., Fee-for-Service vs. Medicare Advantage, risk-adjusted inpatient readmission rates).

For the Longer Stays study, results are provided for eligible senior housing residents who remained in senior housing through up to six years. Attrition over time, due to move-out or death, limits simple significance testing (i.e., t-tests or paired t-tests) and calls for more robust regression approaches.

Thank you.

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