UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 or 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For fiscal year ended December 31, 2021

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 or 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file numbers: 001-34465

SELECT MEDICAL HOLDINGS CORPORATION

(Exact name of Registrant as specified in its Charter)

Delaware	**20-1764048**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification Number)

4714 Gettysburg Road, P.O. Box 2034
Mechanicsburg, PA, 17055
(Address of Principal Executive Offices and Zip Code)
(717) 972-1100
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, $0.001 par value per share	SEM	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **NONE**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding twelve months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding twelve months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐	Non-accelerated filer	☐	Smaller reporting company	☐	Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of the registrant's voting stock held by non-affiliates at June 30, 2021 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $4,691,969,579, based on the closing price per share of common stock on that date of $42.26 as reported on the New York Stock Exchange. Shares of common stock known by the registrant to be beneficially owned by directors and officers of the registrant subject to the reporting and other requirements of Section 16 of the Securities Exchange Act of 1934 are not included in the computation. The registrant, however, has made no determination that such persons are "affiliates" within the meaning of Rule 12b-2 under the Securities Exchange Act of 1934.

As of February 1, 2022, the number of shares of Holdings' Common Stock, $0.001 par value, outstanding was 133,884,817.

Unless the context indicates otherwise, any reference in this report to "Holdings" refers to Select Medical Holdings Corporation and any reference to "Select" refers to Select Medical Corporation, the wholly owned operating subsidiary of Holdings, and any of Select's subsidiaries. Any reference to "Concentra" refers to Concentra Group Holdings Parent, LLC ("Concentra Group Holdings Parent") and its subsidiaries, including Concentra Inc. References to the "Company," "we," "us," and "our" refer collectively to Holdings, Select, and Concentra.

Documents Incorporated by Reference

Listed hereunder are the documents, any portions of which are incorporated by reference and the Parts of this Form 10-K into which such portions are incorporated:

1. The registrant's definitive proxy statement for use in connection with the 2022 Annual Meeting of Stockholders to be held on or about April 30, 2022 to be filed within 120 days after the registrant's fiscal year ended December 31, 2021, portions of which are incorporated by reference into Part III of this Form 10-K. Such definitive proxy statement, except for the parts therein which have been specifically incorporated by reference, should not be deemed "filed" for the purposes of this form 10-K.

SELECT MEDICAL HOLDINGS CORPORATION

ANNUAL REPORT ON FORM 10-K

FOR THE YEAR ENDED DECEMBER 31, 2021

PART I

Forward-Looking Statements

This annual report on Form 10-K contains forward-looking statements within the meaning of the federal securities laws. Statements that are not historical facts, including statements about our beliefs and expectations, are forward-looking statements. Forward-looking statements include statements preceded by, followed by or that include the words "may," "could," "would," "should," "believe," "expect," "anticipate," "plan," "target," "estimate," "project," "intend," and similar expressions. These statements include, among others, statements regarding our expected business outlook, anticipated financial and operating results, including the potential impact of the coronavirus disease 2019 ("COVID-19") pandemic on those financial and operating results, our business strategy and means to implement our strategy, our objectives, the amount and timing of capital expenditures, the likelihood of our success in expanding our business, financing plans, budgets, working capital needs, and sources of liquidity.

Forward-looking statements are only predictions and are not guarantees of performance. These statements are based on our management's beliefs and assumptions, which in turn are based on currently available information. Important assumptions relating to the forward-looking statements include, among others, assumptions regarding our services, the expansion of our services, competitive conditions, and general economic conditions. These assumptions could prove inaccurate. Forward-looking statements also involve known and unknown risks and uncertainties, which could cause actual results to differ materially from those contained in any forward-looking statement. Many of these factors are beyond our ability to control or predict. Such factors include, but are not limited to, the following:

- developments related to the COVID-19 pandemic including, but not limited to, the duration and severity of the pandemic, additional measures taken by government authorities and the private sector to limit the spread of COVID-19, and further legislative and regulatory actions which impact healthcare providers, including actions that may impact the Medicare program;
- changes in government reimbursement for our services and/or new payment policies may result in a reduction in revenue, an increase in costs, and a reduction in profitability;
- the failure of our Medicare-certified long term care hospitals or inpatient rehabilitation facilities to maintain their Medicare certifications may cause our revenue and profitability to decline;
- the failure of our Medicare-certified long term care hospitals and inpatient rehabilitation facilities operated as "hospitals within hospitals" to qualify as hospitals separate from their host hospitals may cause our revenue and profitability to decline;
- a government investigation or assertion that we have violated applicable regulations may result in sanctions or reputational harm and increased costs;
- acquisitions or joint ventures may prove difficult or unsuccessful, use significant resources, or expose us to unforeseen liabilities;
- our plans and expectations related to our acquisitions and our ability to realize anticipated synergies;
- private third-party payors for our services may adopt payment policies that could limit our future revenue and profitability;
- the failure to maintain established relationships with the physicians in the areas we serve could reduce our revenue and profitability;
- shortages in qualified nurses, therapists, physicians, or other licensed providers, or the inability to attract or retain healthcare professionals due to the heightened risk of infection related to the COVID-19 pandemic, could increase our operating costs significantly or limit our ability to staff our facilities;
- competition may limit our ability to grow and result in a decrease in our revenue and profitability;
- the loss of key members of our management team could significantly disrupt our operations;
- the effect of claims asserted against us could subject us to substantial uninsured liabilities;
- a security breach of our or our third-party vendors' information technology systems may subject us to potential legal and reputational harm and may result in a violation of the Health Insurance Portability and Accountability Act of 1996 or the Health Information Technology for Economic and Clinical Health Act; and
- other factors discussed from time to time in our filings with the Securities and Exchange Commission (the "SEC"), including factors discussed under the heading "Risk Factors" of this annual report on Form 10-K.

Except as required by applicable law, including the securities laws of the United States and the rules and regulations of the SEC, we are under no obligation to publicly update or revise any forward-looking statements, whether as a result of any new information, future events, or otherwise. You should not place undue reliance on our forward-looking statements. Although we believe that the expectations reflected in forward-looking statements are reasonable, we cannot guarantee future results or performance.

Investors should also be aware that while we do, from time to time, communicate with securities analysts, it is against our policy to disclose to securities analysts any material non-public information or other confidential commercial information. Accordingly, stockholders should not assume that we agree with any statement or report issued by any securities analyst irrespective of the content of the statement or report. Thus, to the extent that reports issued by securities analysts contain any projections, forecasts or opinions, such reports are not the responsibility of the Company.

Item 1. *Business.*

Overview

We began operations in 1997 and, based on the number of facilities, are one of the largest operators of critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, and occupational health centers in the United States. As of December 31, 2021, we had operations in 46 states and the District of Columbia. As of December 31, 2021, we operated 104 critical illness recovery hospitals in 28 states, 30 rehabilitation hospitals in 12 states, and 1,881 outpatient rehabilitation clinics in 38 states and the District of Columbia. As of December 31, 2021, Concentra operated 518 occupational health centers in 41 states. Concentra also provides contract services at employer worksites.

We manage our Company through four business segments: our critical illness recovery hospital segment, our rehabilitation hospital segment, our outpatient rehabilitation segment, and our Concentra segment. We had revenue of $6,204.5 million for the year ended December 31, 2021. Of this total, we earned approximately 36% of our revenue from our critical illness recovery hospital segment, approximately 14% from our rehabilitation hospital segment, approximately 17% from our outpatient rehabilitation segment, and approximately 28% from our Concentra segment. We also recognized revenue associated with employee leasing services provided to the Company's non-consolidating subsidiaries; these revenues are included as part of our other activities.

Our critical illness recovery hospital segment consists of hospitals designed to serve the needs of patients recovering from critical illnesses, often with complex medical needs, and our rehabilitation hospital segment consists of hospitals designed to serve patients that require intensive physical rehabilitation care. Patients are typically admitted to our critical illness recovery hospitals and rehabilitation hospitals from general acute care hospitals. Our outpatient rehabilitation segment consists of clinics that provide physical, occupational, and speech rehabilitation services. Our Concentra segment consists of occupational health centers and contract services provided at employer worksites that deliver occupational medicine, physical therapy, and consumer health services. See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations" and "Notes to Consolidated Financial Statements—Note 15. Segment Information" beginning on F-28 for financial information for each of our segments for the past three fiscal years.

Critical Illness Recovery Hospitals

We are a leading operator of critical illness recovery hospitals in the United States, which are certified by Medicare as long term care hospitals ("LTCHs"). As of December 31, 2021, we operated 104 critical illness recovery hospitals in 28 states. For the years ended December 31, 2019, 2020, and 2021, approximately 49%, 43% and 37%, respectively, of the revenue of our critical illness recovery hospital segment came from Medicare reimbursement. As of December 31, 2021, we employed approximately 14,500 people in our critical illness recovery hospital segment, consisting primarily of registered nurses, respiratory therapists, physical therapists, occupational therapists, and speech therapists.

We operate the majority of our critical illness recovery hospitals as a hospital within a hospital (an "HIH"). A critical illness recovery hospital that operates as an HIH typically leases space from a general acute care hospital, or "host hospital," and operates as a separately licensed hospital within the host hospital, or on the same campus as the host hospital. In contrast, a free-standing critical illness recovery hospital does not operate on a host hospital campus. We operated 104 critical illness recovery hospitals at December 31, 2021, of which 75 were operated as HIHs and 29 were operated as free-standing hospitals.

Patients are typically admitted to our critical illness recovery hospitals from general acute care hospitals, likely following an intensive care unit stay, and suffer from chronic critical illness. These patients have highly specialized needs, with serious and complex medical conditions involving multiple organ systems. These conditions are often a result of complications related to heart failure, complex infectious disease, respiratory failure and pulmonary disease, complex surgery requiring prolonged recovery, renal disease, neurological events, and trauma. Given their complex medical needs, these patients require a longer length of stay than patients in a general acute care hospital and benefit from being treated in a critical illness recovery hospital that is designed to meet their unique medical needs. For the year ended December 31, 2021, the average length of stay for patients in our critical illness recovery hospitals was 30 days.

Additionally, we continually seek to increase our admissions by demonstrating our quality outcomes and, by doing so, expanding and improving our relationships with the physicians and general acute care hospitals in the markets where we operate. We maintain a strong focus on the provision of high-quality medical care within our facilities. The Joint Commission ("TJC"), DNV GL Healthcare USA, Inc. ("DNV"), and the Center for Improvement in Healthcare Quality ("CIHQ") are independent accreditation organizations that establish standards related to the operation and management of healthcare facilities. As of December 31, 2021, we operated 104 critical illness recovery hospitals, 101 of which were accredited by TJC. Two of our critical illness recovery hospitals were accredited by DNV and one of our critical illness recovery hospitals was accredited by CIHQ. Also as of December 31, 2021, all of our critical illness recovery hospitals were certified as LTCHs. Each of our critical illness recovery hospitals must regularly demonstrate to a survey team conformance to the applicable standards established by TJC, DNV, CIHQ, or the Medicare program, as applicable.

When a patient is referred to one of our critical illness recovery hospitals by a physician, case manager, discharge planner, or payor, a clinical assessment is performed to determine patient eligibility for admission. Based on the determinations reached in this clinical assessment, an admission decision is made.

Upon admission, an interdisciplinary team meets to perform a comprehensive review of the patient's condition. The interdisciplinary team is composed of a number of clinicians and may include any or all of the following: an attending physician; a registered nurse; a physical, occupational, and speech therapist; a respiratory therapist; a dietitian; a pharmacist; and a case manager. Upon completion of an initial evaluation by each member of the treatment team, an individualized treatment plan is established and initiated. Case management coordinates all aspects of the patient's hospital stay and serves as a liaison to the insurance carrier's case management staff as appropriate. The case manager specifically communicates clinical progress, resource utilization, and treatment goals to the patient, the treatment team, and the payor.

Each of our critical illness recovery hospitals has a distinct medical staff that is composed of physicians from multiple specialties that have successfully completed the required privileging and credentialing process. In general, physicians on the medical staff are not directly employed but are more commonly independent, practicing at multiple hospitals in the community. Attending physicians conduct daily rounds on their patients while consulting physicians provide consulting services based on the specific medical needs of our patients. Each critical illness recovery hospital develops on-call arrangements with individual physicians to help ensure that a physician is available to care for our patients. When determining the appropriate composition of the medical staff of a critical illness recovery hospital, we consider the size of the critical illness recovery hospital, services provided by the critical illness recovery hospital, if applicable, the size and capabilities of the medical staff of the general acute care hospital that hosts that HIH and, if applicable, the proximity of an acute care hospital to the free-standing critical illness recovery hospital. The medical staff of each of our critical illness recovery hospitals meets the applicable requirements set forth by Medicare, the hospital's applicable accrediting organizations, and the state in which that critical illness recovery hospital is located.

Our critical illness recovery hospital segment is led by a president, chief operating officer, chief medical officer, chief nursing officer, and chief quality officer. Each of our critical illness recovery hospitals has an onsite management team consisting of a chief executive officer, a medical director, a chief nursing officer, and a director of business development. These teams manage local strategy and day-to-day operations, including oversight of clinical care and treatment. They also assume primary responsibility for developing relationships with the general acute care providers and clinicians in the local areas we serve that refer patients to our critical illness recovery hospitals. We provide our critical illness recovery hospitals with centralized accounting, treasury, payroll, legal, operational support, human resources, compliance, management information systems, and billing and collection services. The centralization of these services improves efficiency and permits staff at our critical illness recovery hospitals to focus their time on patient care.

For a description of government regulations and Medicare payments made to our critical illness recovery hospitals, see "—Government Regulations" and "Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes."

Critical Illness Recovery Hospital Strategy

The key elements of our critical illness recovery hospital strategy are to:

Focus on Specialized Inpatient Services. We serve highly acute patients and patients with debilitating injuries and rehabilitation needs that cannot be adequately cared for in a less medically intensive environment, such as a skilled nursing facility. Patients admitted to our critical illness recovery hospitals require long stays, benefiting from a more specialized and targeted clinical approach. Our care model is distinct from what patients experience in general acute care hospitals.

Provide High-Quality Care and Service. Our critical illness recovery hospitals serve a critical role in comprehensive healthcare delivery. Through our specialized treatment programs and staffing models, we treat patients with acute, highly complex, and specialized medical needs. Our treatment programs focus on specific patient needs and medical conditions, such as ventilator weaning protocols, comprehensive wound care assessments and treatment protocols, medication review and antibiotic stewardship, infection control prevention, and customized mobility, speech, and swallow programs. Our staffing models seek to ensure that patients have the appropriate clinical resources over the course of their stay. We maintain quality assurance programs to support and monitor quality of care standards and to meet regulatory requirements and maintain Medicare certifications. We believe that we are recognized for providing quality care and service, which helps develop brand loyalty in the local areas we serve.

Our treatment programs are continuously reassessed and updated based on peer-reviewed literature. This approach provides our clinicians access to the best practices and protocols that we have found to be effective in treating various conditions in this population such as respiratory failure, non-healing wounds, brain injury, renal dysfunction, and complex infectious diseases. In addition, we customize these programs to provide a treatment plan tailored to meet our patients' unique needs. The collaborative team-based approach coupled with the intense focus on patient safety and quality affords these highly complex patients the best opportunity to recover from catastrophic illness. This comprehensive care model is ultimately measured by the functional recovery of each of our patients.

Our critical illness recovery hospitals demonstrated a critical role in caring for patients during the COVID-19 pandemic. Our critical illness recovery hospitals were and continue to be in a position to enhance and promote recovery of patients with COVID-19, as many patients with severe manifestations of COVID-19 require prolonged mechanical ventilation. We have developed specialized strategies for liberation from prolonged mechanical ventilation, promoting physical recovery through innovative therapies and nutrition programs while reducing risk of adverse ventilator-associated events including pneumonia and infection. Our critical illness recovery hospitals demonstrated rapid preparation and implementation of modifications that supported the treatment of active COVID-19 patients and patients recovering from moderate-to-severe response to COVID-19 infection. Successful treatment resulted in a significant increase in the proportion of COVID-19 patients who were discharged to home and lower level of care compared to non-COVID-19 patients. We have demonstrated that our critical illness recovery hospitals can substitute for ICU beds in regions with high COVID-19 surge levels and as a post-ICU provider for patients who require longer-term care while recovering from severe complications from COVID-19.

The quality of the patient care we provide is continually monitored using several measures, including clinical outcomes data and analyses and patient satisfaction surveys. Quality metrics from our critical illness recovery hospitals are used to create monthly, quarterly, and annual reporting for our leadership team. In order to benchmark ourselves against other hospitals, we collect our clinical and patient satisfaction information and compare it to national standards and the results of other healthcare organizations. We are required to report quality measures to individual states based on unique requirements and laws. We also submit required quality data elements to the Center for Medicare & Medicaid Services ("CMS"). See "—Government Regulations—Other Medicare Regulations—Medicare Quality Reporting."

Control Operating Costs. We continually seek to improve operating efficiency and control costs at our critical illness recovery hospitals by standardizing operations and centralizing key administrative functions. These initiatives include:

- centralizing administrative functions such as accounting, finance, treasury, payroll, legal, operational support, human resources, compliance, and billing and collection;
- standardizing management information systems to assist in capturing the medical record, accounting, billing, collections, and data capture and analysis; and
- centralizing sourcing and contracting to receive discounted prices for pharmaceuticals, medical supplies, and other commodities used in our operations.

Increase Commercial Volume. We have focused on continued expansion of our relationships with commercial insurers to increase our volume of patients with commercial insurance in our critical illness recovery hospitals. We believe that commercial payors seek to contract with our hospitals because we offer our patients high-quality, cost-effective care at more attractive rates than general acute care hospitals. We also offer commercial enrollees customized treatment programs not typically offered in general acute care hospitals.

Pursue Opportunistic Acquisitions. We may grow our network of critical illness recovery hospitals through opportunistic acquisitions. When we acquire a critical illness recovery hospital or a group of related facilities, a team of our professionals is responsible for formulating and executing an integration plan. We seek to improve financial performance at such facilities by adding clinical programs that attract commercial payors, centralizing administrative functions, and implementing our standardized resource management programs.

Rehabilitation Hospitals

Our rehabilitation hospitals provide comprehensive physical medicine, as well as rehabilitation programs and services, which serve to optimize patient health, function, and quality of life. As of December 31, 2021, we operated 30 rehabilitation hospitals in 12 states. For the years ended December 31, 2019, 2020, and 2021, approximately 50%, 47% and 49% respectively, of the revenue of our rehabilitation hospital segment came from Medicare reimbursement. As of December 31, 2021, we employed approximately 11,700 people in our rehabilitation hospital segment, consisting primarily of registered nurses, respiratory therapists, physical therapists, occupational therapists, speech therapists, neuropsychologists, and other psychologists.

Patients at our rehabilitation hospitals have specialized needs, with serious and often complex medical conditions requiring rehabilitative healthcare services in an inpatient setting. These conditions require targeted therapy and rehabilitation treatment, including comprehensive rehabilitative services for brain and spinal cord injuries, strokes, amputations, neurological disorders, orthopedic conditions, pediatric congenital or acquired disabilities, and cancer. Given their complex medical needs and gradual and prolonged recovery, these patients generally require a longer length of stay than patients in a general acute care hospital. For the year ended December 31, 2021, the average length of stay for patients in our rehabilitation hospitals was 14 days.

Additionally, we continually seek to increase our admissions by demonstrating our quality outcomes and, by doing so, expanding and improving our relationships with the physicians and general acute care hospitals in the markets where we operate. We maintain a strong focus on the provision of high-quality medical care within our facilities. As of December 31, 2021, we operated 30 rehabilitation hospitals, all of which were accredited by TJC. Also as of December 31, 2021, all of our rehabilitation hospitals were certified as Medicare providers as inpatient rehabilitation facilities (“IRFs”). 23 of our rehabilitation hospitals also received accreditation from the Commission on Accreditation of Rehabilitation Facilities (“CARF”), an independent, not-for-profit organization that establishes standards related to the operation of medical rehabilitation facilities. Each of our rehabilitation hospitals must regularly demonstrate to a survey team conformance to the applicable standards established by TJC, the Medicare program, or CARF, as applicable.

When a patient is referred to one of our rehabilitation hospitals by a physician, case manager, discharge planner, health maintenance organization, or insurance company, we perform a clinical assessment of the patient to determine if the patient meets criteria for admission. Based on the determinations reached in this clinical assessment, an admission decision is made.

Upon admission, an interdisciplinary team reviews a patient’s condition. The interdisciplinary team is composed of a number of clinicians and may include any or all of the following: an attending physician; a registered nurse; a physical, occupational, and speech therapist; a respiratory therapist; a dietitian; a pharmacist; and a case manager. Upon completion of an initial evaluation by each member of the treatment team, an individualized treatment plan is established and implemented. The case manager coordinates all aspects of the patient’s hospital stay and serves as a liaison with the insurance carrier’s case management staff when appropriate. The case manager communicates progress, resource utilization, and treatment goals between the patient, the treatment team, and the payor.

Each of our rehabilitation hospitals has a multi-specialty medical staff that is composed of physicians who have completed the privileging and credentialing process required by that rehabilitation hospital and have been approved by the governing board of that rehabilitation hospital. Physicians on the medical staff of our rehabilitation hospitals are generally not directly employed by our rehabilitation hospitals, but instead have staff privileges at one or more hospitals. At each of our rehabilitation hospitals, attending physicians conduct rounds on their patients on a regular basis and consulting physicians provide consulting services based on the medical needs of our patients. Our rehabilitation hospitals also have on-call arrangements with physicians to help ensure that a physician is available to care for our patients. We staff our rehabilitation hospitals with the number of physicians, therapists, and other medical practitioners that we believe is appropriate to address the varying needs of our patients. When determining the appropriate composition of the medical staff of a rehabilitation hospital, we consider the size of the rehabilitation hospital, services provided by the rehabilitation hospital, and, if applicable, the proximity of an acute care hospital to the free-standing rehabilitation hospital. The medical staff of each of our rehabilitation hospitals meets the applicable requirements set forth by Medicare, the facility’s applicable accrediting organizations, and the state in which that rehabilitation hospital is located.

Our rehabilitation hospital segment is led by a president, chief operating officer, chief medical officer, chief academic officer, chief nursing officer, and chief quality officer. Each of our rehabilitation hospitals has an onsite management team consisting of a chief executive officer, a medical director, a chief nursing officer, a director of therapy services, and a director of business development. These teams manage local strategy and day-to-day operations, including oversight of clinical care and treatment. They also assume primary responsibility for developing relationships with the general acute care providers and clinicians in the local areas we serve that refer patients to our rehabilitation hospitals. We provide our facilities within our rehabilitation hospital segment with centralized accounting, treasury, payroll, legal, operational support, human resources, compliance, management information systems, and billing and collection services. The centralization of these services improves efficiency and permits the staff at our rehabilitation hospitals to focus their time on patient care.

For a description of government regulations and Medicare payments made to our rehabilitation hospitals, see "—Government Regulations" and "Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes."

Rehabilitation Hospital Strategy

The key elements of our rehabilitation hospital strategy are to:

Focus on Specialized Inpatient Services. We serve patients with debilitating injuries and rehabilitation needs that cannot be adequately cared for in a less medically intensive environment, such as a skilled nursing facility. Generally, patients in our rehabilitation hospitals require longer stays and can benefit from more specialized and intensive clinical care than patients treated in general acute care hospitals and require more intensive therapy than that provided in outpatient rehabilitation clinics.

Provide High-Quality Care and Service. Our rehabilitation hospitals serve a critical role in comprehensive healthcare delivery. Through our specialized treatment programs and staffing models, we treat patients with complex and specialized medical needs. Our specialized treatment programs focus on specific patient needs and medical conditions, such as rehabilitation programs for brain trauma and spinal cord injuries. We also focus on specific programs of care designed to restore strength, improve physical and cognitive function, and promote independence in activities of daily living for patients who have suffered complications from strokes, amputations, cancer, and neurological and orthopedic conditions. Our staffing models seek to ensure that patients have the appropriate clinical resources over the course of their stay. We maintain quality assurance programs to support and monitor quality of care standards and to meet regulatory requirements and maintain Medicare certifications. We believe that we are recognized for providing quality care and service, which helps develop brand loyalty in the local areas we serve.

Our treatment programs, which are continuously reassessed and updated, benefit patients because they give our clinicians access to the best practices and protocols that we have found to be most effective in treating various conditions such as brain and spinal cord injuries, strokes, and neuromuscular disorders. In addition, we combine or modify these programs to provide a treatment plan tailored to meet our patients' unique needs. We measure the outcomes and successes of our patients' recovery in order to provide the best possible patient care and service.

Our rehabilitation hospitals demonstrated a critical role in caring for patients during the COVID-19 pandemic. Our rehabilitation hospitals were and continue to be in a position to enhance and promote recovery of patients with COVID-19, as many patients with severe manifestations of COVID-19 suffer from complex medical conditions and severe deconditioning. Our rehabilitation hospitals demonstrated rapid preparation and implementation of modifications that supported the treatment of active COVID-19 patients and patients recovering from moderate-to-severe response to COVID-19 infection. We have demonstrated that our rehabilitation hospitals can support short term acute care hospitals in regions as a post-ICU provider for patients who require specialized therapies while recovering from severe complications from COVID-19.

The quality of the patient care we provide is continually monitored using several measures, including clinical outcomes data and analyses and patient satisfaction surveys. Quality metrics from our rehabilitation hospitals are used to create monthly, quarterly, and annual reporting for our leadership team. In order to benchmark ourselves against other hospitals, we collect our clinical and patient satisfaction information and compare it to national standards and the results of other healthcare organizations. We are required to report quality measures to individual states based on unique requirements and laws. We also submit required quality data elements to CMS. See "—Government Regulations—Other Medicare Regulations—Medicare Quality Reporting."

Control Operating Costs. We continually seek to improve operating efficiency and control costs at our rehabilitation hospitals by standardizing operations and centralizing key administrative functions. These initiatives include:

- centralizing administrative functions such as accounting, finance, treasury, payroll, legal, operational support, human resources, compliance, and billing and collection;
- standardizing management information systems to assist in capturing the medical record, accounting, billing, collections, and data capture and analysis; and
- centralizing sourcing and contracting to receive discounted prices for pharmaceuticals, medical supplies, and other commodities used in our operations.

Increase Commercial Volume. We have focused on continued expansion of our relationships with commercial insurers to increase our volume of patients with commercial insurance in our rehabilitation hospitals. We believe that commercial payors seek to contract with our rehabilitation hospitals because we offer our patients high-quality, cost-effective care at more attractive rates than general acute care hospitals. We also offer commercial enrollees customized and comprehensive rehabilitation treatment programs not typically offered in general acute care hospitals.

Develop Rehabilitation Hospitals through Pursuing Joint Ventures with Large Healthcare Systems. By leveraging the experience of our senior management and development team, we believe that we are well positioned to expand our portfolio of joint ventured operations. When we identify joint venture opportunities, our development team conducts an extensive review of the area's referral patterns and commercial insurance rates to determine the general reimbursement trends and payor mix. Once discussions commence with a healthcare system, we refine the specific needs of a joint venture, which could include working capital, the construction of new space, or the leasing and renovation of existing space. A joint venture typically consists of us and the healthcare system contributing certain post-acute care businesses into a newly formed entity. We typically function as the manager and hold either a majority or minority ownership interest. We bring clinical expertise and clinical programs that attract commercial payors and implement our standardized resource management programs, which may improve the clinical outcome and enhance the financial performance of the joint venture.

Pursue Opportunistic Acquisitions. We may grow our network of rehabilitation hospitals through opportunistic acquisitions. When we acquire a rehabilitation hospital or a group of related facilities, a team of our professionals is responsible for formulating and executing an integration plan. We seek to improve financial performance at such facilities by adding clinical programs that attract commercial payors, centralizing administrative functions, and implementing our standardized resource management programs.

Outpatient Rehabilitation

We are the largest operator of outpatient rehabilitation clinics in the United States based on number of facilities, with 1,881 facilities throughout 38 states and the District of Columbia as of December 31, 2021. Our outpatient rehabilitation clinics are typically located in a medical complex or retail location. Our outpatient rehabilitation segment employed approximately 11,200 people as of December 31, 2021.

In our outpatient rehabilitation clinics, we provide physical, occupational, and speech rehabilitation programs and services. We also provide certain specialized programs such as functional programs for work related injuries, hand therapy, post-concussion rehabilitation, pediatric rehabilitation, cancer rehabilitation, and athletic training services. In 2020, we developed and launched our national Recovery and Reconditioning program design to rehabilitate those patients suffering side effects from COVID-19. The typical patient in one of our outpatient rehabilitation clinics suffers from musculoskeletal impairments that restrict his or her ability to perform normal activities of daily living. These impairments are often associated with accidents, sports injuries, work related injuries, or post-operative orthopedic and other medical conditions. Our rehabilitation programs and services are designed to help these patients minimize physical and cognitive impairments and maximize functional ability. We also provide services designed to prevent short term disabilities from becoming chronic conditions. Our rehabilitation services are provided by our professionals including licensed physical therapists, occupational therapists, and speech-language pathologists.

Outpatient rehabilitation patients are generally referred or directed to our clinics by a physician, employer, or health insurer who believes that a patient, employee, or member can benefit from the level of therapy we provide in an outpatient setting. Although individuals in all states may have some form of direct access to physical therapy services, the level of direct access varies based on provisions and limitations in each jurisdiction. In recent years, all states have enacted laws that allow individuals to seek outpatient physical rehabilitation services without a physician order. In our outpatient rehabilitation segment, for the year ended December 31, 2021, approximately 82% of our revenue comes from commercial payors, including healthcare insurers, managed care organizations, workers' compensation programs, contract management services, and private pay sources. We believe that our services are attractive to healthcare payors who are seeking to provide high-quality and cost-effective care to their enrollees. The balance of our reimbursement is derived from Medicare and other government sponsored programs.

For a description of government regulations and Medicare payments made to our outpatient rehabilitation services, see "—Government Regulations" and "Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes."

Outpatient Rehabilitation Strategy

The key elements of our outpatient rehabilitation strategy are to:

Provide High-Quality Care and Service. We are focused on providing a high level of service to our patients throughout their entire course of treatment. We collect patient reported outcomes that allow us to assess each patient's functional improvement. To measure satisfaction with our service we have developed surveys for both patients and physicians. Our clinics utilize the feedback from these surveys to continuously refine and improve service levels. We believe that by focusing on quality care and offering a high level of customer service we develop brand loyalty which allows us to strengthen our relationships with referring physicians, employers, and health insurers to drive additional patient volume.

Increase Market Share. We strive to establish a leading presence within the local areas we serve. We use analytics to assess underserved needs in rehabilitation markets. We then target those areas for additional growth. To increase our presence, we seek to open new clinics in our existing markets. We have also entered into joint ventures with hospital systems that have resulted in an increase in the number of facilities that we operate. This allows us to realize economies of scale, heightened brand loyalty, and workforce continuity. We also focus on increasing our workers' compensation and commercial/managed care payor mix.

Expand Rehabilitation Programs and Services. Through our local clinical directors of operations and clinic managers within their service areas, we assess the healthcare needs of the areas we serve. Based on these assessments, we implement additional clinical programs and services (such as telehealth and home physical therapy) specifically targeted to meet demand in the local community. In designing these programs we benefit from the knowledge we gain through our national network of clinics. This knowledge is used to design programs that optimize treatment methods and measure changes in health status, clinical outcomes, and patient satisfaction.

Optimize Payor Contract Reimbursements. We review payor contracts scheduled for renewal and potential new payor contracts to assure reasonable reimbursements for the services we provide. Before we enter into a new contract with a commercial payor, we assess the reasonableness of the reimbursements by analyzing past and projected patient volume and clinic capacity. We create a retention strategy for the top performing contracts and a renegotiation strategy for contracts that do not meet our defined criteria. We believe that our national footprint and our strong reputation enable us to negotiate favorable reimbursement rates with commercial insurers.

Maintain Strong Community and Employee Relations. We believe that the relationships between our employees and the referral sources in their communities are critical to our success. Our referral sources, such as physicians and healthcare case managers, send their patients to our clinics based on three factors: the quality of our care, the customer service we provide, and their familiarity with our therapists. We seek to retain and motivate our therapists by implementing a performance-based bonus program, a defined career path with the ability to be promoted from within, timely communication on company developments, and internal training programs. We also focus on empowering our employees by giving them a high degree of autonomy in determining local area strategy. We seek to identify therapists who are potential business leaders. This management approach reflects the unique nature of each local area in which we operate and the importance of encouraging our employees to assume responsibility for their clinic's financial and operational performance.

Pursue Opportunistic Acquisitions. We may grow our network of outpatient rehabilitation facilities through opportunistic acquisitions. We believe our size and centralized infrastructure allow us to take advantage of operational efficiencies and improve financial performance at acquired facilities.

Concentra

We are the largest provider of occupational health services in the United States based on the number of facilities. As of December 31, 2021, we operated 518 occupational health centers and 134 onsite clinics at employer worksites throughout 42 states. In some of our occupational health centers we also provide urgent care services. On September 1, 2020, Concentra sold its Department of Veterans Affairs community-based outpatient clinic ("CBOC") business. We deliver occupational medicine, consumer health, physical therapy, and wellness services in our occupational health centers and our onsite clinics located at the workplaces of our employer customers. Our Concentra segment employed approximately 10,800 people as of December 31, 2021.

We offer a range of occupational and consumer health services through our occupational health centers and onsite clinics. Occupational health services include workers' compensation injury care as well as employer services, clinical testing, wellness programs, and preventative care. Consumer health consists of non-employer, patient-directed treatment of injuries and illnesses. Our consumer health service offerings include urgent care, wellness programs, and preventative care.

Occupational medicine refers to the diagnosis and treatment of work-related injuries (workers' compensation), compliance services, such as preventive services, including pre-employment, fitness-for-duty, and post-accident physical examinations and substance abuse screening. Utilization is driven by the needs of labor-intensive industries such as transportation, distribution/ warehousing, manufacturing, construction, healthcare, police/fire, and other occupations that have historically posed a higher than average risk of workplace injury or that require a workplace physical. Workers' compensation is the form of insurance that provides medical coverage to employees with work-related illnesses or injuries.

Workers' compensation is administered on a state-by-state basis and each state is responsible for implementing and regulating its own workers' compensation program. Because workers' compensation benefits are mandated by law and subject to extensive regulation, insurers, third-party administrators, and employers do not have the same flexibility to alter benefits as they have with other health benefit programs. In addition, because programs vary by state, it is difficult for insurance companies and multi-state employers to adopt uniform policies to administer, manage, and control the costs of benefits across states. As a result, managing the cost of workers' compensation requires approaches that are tailored to the specific regulatory environments in which the employer operates. For the year ended December 31, 2021, approximately 56% of our Concentra segment revenue came from workers' compensation payments.

Acquisition of Additional Membership Interests in Concentra Group Holdings Parent

In a series of transactions which culminated on December 24, 2021, Select acquired substantially all of the outstanding membership interests of Concentra Group Holdings Parent that it did not already own from Welsh, Carson, Anderson & Stowe XII, L.P. ("WCAS"), Dignity Health Holding Corporation ("DHHC") and certain other sellers, in exchange for an aggregate purchase price of approximately $1.2 billion (the "Concentra Interest Purchases"), of which $660.7 million was paid during the year ended December 31, 2021. Upon consummation of the Concentra Interest Purchases, Select owns in the aggregate approximately 99.3% of the outstanding membership interests of Concentra Group Holdings Parent on a fully diluted basis and 100.0% of the outstanding voting membership interests of Concentra Group Holdings Parent.

Concentra Strategy

The key elements of our Concentra strategy are to:

Provide High-Quality Care and Service. We strive to provide a high level of service to our patients and our employer customers. We measure and monitor patient and employer satisfaction and focus on treatment programs to provide the best clinical outcomes in a consistent manner. Our programs and services have proven that aggressive treatment and management of workers injuries can more rapidly restore employees to better health which reduces workers' compensation indemnity claim costs for our employer customers.

Focus on Occupational Medicine. Our history as an industry leader in the provision of occupational medicine services provides the platform for Concentra to grow this service offering. Complementary service offerings help drive additional growth in this business line.

Pursue Direct Employer Relationships. We believe we provide occupational health services in a cost-effective manner to our employer customers. By establishing direct relationships with these customers, we seek to reduce overall costs of their workers' compensation claims, while improving employee health, and getting their employees back to work faster.

Increase Presence in the Areas We Serve. We strive to establish a strong presence within the local areas we serve. To increase our presence, we seek to expand our services and programs and to open new occupational health centers and employer onsite locations. This allows us to realize economies of scale, heightened brand loyalty, and workforce continuity.

Pursue Opportunistic Acquisitions. We may grow our network and expand our geographic reach through opportunistic acquisitions. We believe our size and centralized infrastructure allow us to take advantage of operational efficiencies and improve financial performance at acquired facilities.

Other

Other activities include our corporate administration and shared services, as well as employee leasing services with our non-consolidating subsidiaries. We also hold minority investments in other healthcare related businesses. These include investments in companies that provide specialized technology and services to healthcare entities, as well as providers of complementary services.

Our Competitive Strengths

We believe that the success of our business model is based on a number of competitive strengths, including our position as a leading operator in each of our business segments, our proven financial performance, our strong cash flow, our significant scale, our experience in completing and integrating acquisitions, our partnerships with large healthcare systems, our ability to capitalize on acquisition opportunities, and our experienced management team.

Leading Operator in Distinct but Complementary Lines of Business. We believe that we are a leading operator in our business segments based on number of facilities in the United States. Our leadership position and reputation as a high-quality, cost-effective healthcare provider in each of our business segments allows us to attract patients and employees, aids us in our marketing efforts to referral sources, and helps us negotiate payor contracts. In our critical illness recovery hospital segment, we operated 104 critical illness recovery hospitals in 28 states as of December 31, 2021. In our rehabilitation hospital segment, we operated 30 rehabilitation hospitals in 12 states as of December 31, 2021. In our outpatient rehabilitation segment, we operated 1,881 outpatient rehabilitation clinics in 38 states and the District of Columbia as of December 31, 2021. In our Concentra segment, we operated 518 occupational health centers in 41 states as of December 31, 2021. With these leading positions in the areas we serve, we believe that we are well-positioned to benefit from the rising demand for medical services due to an aging population in the United States, which will drive growth across our business segments.

Proven Financial Performance and Strong Cash Flow. We have established a track record of improving the financial performance of our facilities due to our disciplined approach to revenue growth, expense management, and focus on free cash flow generation. This includes regular review of specific financial metrics of our business to determine trends in our revenue generation, expenses, billing, and cash collection. Based on the ongoing analysis of such trends, we make adjustments to our operations to optimize our financial performance and cash flow.

Significant Scale. By building significant scale in each of our business segments, we have been able to leverage our operating costs by centralizing administrative functions at our corporate office.

Experience in Successfully Completing and Integrating Acquisitions. Since our inception in 1997 through 2021, we completed ten significant acquisitions, including the acquisitions of Physiotherapy, Concentra, and U.S. HealthWorks. We believe that we have improved the operating performance of these businesses over time by applying our standard operating practices and by realizing efficiencies from our centralized operations and management.

Experience in Partnering with Large Healthcare Systems. Over the past several years we have partnered with large healthcare systems to provide post-acute care services. We believe that we provide operating expertise to these ventures through our experience in operating critical illness recovery hospitals, rehabilitation hospitals, and outpatient rehabilitation facilities and have improved and expanded the level of post-acute care services provided in these communities, as well as the financial performance of these operations.

Well-Positioned to Capitalize on Acquisition Opportunities. We are well-positioned to pursue selective acquisitions within each of our business segments to augment our internal growth. Many of the nation's critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation facilities, and occupational health centers are operated by independent operators lacking national or broad regional scope. We believe that our geographically diversified portfolio of facilities provide us with a footprint to strengthen and grow our businesses in the markets we operate and in new markets that need the services we provide.

Experienced and Proven Management Team. Prior to co-founding our company with our current Executive Chairman and Co-Founder, our Vice Chairman and Co-Founder founded and operated three other healthcare companies focused on inpatient and outpatient rehabilitation services. The other members of our senior management team also have extensive experience in the healthcare industry, with an average of almost 25 years in the business. In recent years, we have reorganized our operations to expand executive talent and promote management continuity.

Sources of Revenue

The following table presents the approximate percentages by payor source of revenue received for healthcare services we provided for the periods indicated:

	Year Ended December 31,		
Revenue by Payor Source	**2019**	**2020**	**2021**
Medicare	25.9 %	25.0 %	22.9 %
Commercial insurance[1]	32.3 %	34.8 %	36.2 %
Workers' Compensation	21.4 %	19.2 %	19.0 %
Private and other[2]	17.5 %	19.4 %	20.4 %
Medicaid	2.9 %	1.6 %	1.5 %
Total	100.0 %	100.0 %	100.0 %

(1) Primarily includes commercial healthcare insurance carriers, health maintenance organizations, preferred provider organizations, and managed care programs.

(2) Primarily includes management services, employer and other contracted services, self-payors, and non-patient related payments. Revenues included in this category from self-pay patients represent less than 1% of total revenue for all periods.

Government Sources

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. As of December 31, 2021, we operated 104 critical illness recovery hospitals, all of which were certified by Medicare as LTCHs. Also as of December 31, 2021, we operated 30 rehabilitation hospitals, all of which were certified by Medicare as IRFs. Our outpatient rehabilitation clinics regularly receive Medicare payments for their services. Additionally, many of our critical illness recovery hospitals and rehabilitation hospitals participate in state Medicaid programs. Amounts received under the Medicare and Medicaid programs are generally less than the customary charges for the services provided. In recent years, there have been significant changes made to the Medicare and Medicaid programs. Since a significant portion of our revenues come from patients covered under the Medicare program, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in the Medicare program. See "—Government Regulations—Overview of U.S. and State Government Reimbursements."

Non-Government Sources

Our non-government sources of revenue include insurance companies, workers' compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies, and employers, as well as patients directly.

Human Capital Management

Overview

At December 31, 2021, we had approximately 50,500 employees, including approximately 35,900 full-time and 14,600 part-time and per-diem employees. Our critical illness recovery hospital segment employees totaled approximately 14,500, rehabilitation hospital segment employees totaled approximately 11,700, outpatient rehabilitation segment employees totaled approximately 11,200, and Concentra segment employees totaled approximately 10,800. Approximately 2,300 of the remaining employees performed corporate management, administration, and other support services primarily at our Mechanicsburg, Pennsylvania headquarters.

Our workforce is predominantly non-union, with less than 50 employees represented by one labor union. We consider our employee relations to be good and believe that our employees are essential contributors to our success. In some markets, the shortage of clinical personnel is a significant operating issue facing healthcare providers. Shortages of nurses and other clinical personnel, including therapists, may, from time to time, require us to increase use of more costly temporary personnel, which we refer to as "contract labor," and other types of premium pay programs.

Our hospitals are staffed by licensed physicians who are usually not employed by us. Any licensed physician may apply to be accepted to the medical staff of any of our hospitals, but the hospital's medical staff and the appropriate governing board of the hospital, in accordance with established credentialing criteria, must approve acceptance to the staff. Members of the medical staffs of our hospitals often also serve on the medical staffs of other hospitals and may terminate their affiliation with one of our hospitals at any time. Within our hospital divisions, approximately 12,000 physicians are credentialed to treat and provide services to our patients. In addition, some physicians or group practices provide administrative and/or clinical services in our hospitals under contracts.

Select Medical developed a cultural framework we call "The Select Medical Way." One of the key tenants of this framework is to deliver a superior employee experience. We devote considerable time and resources to attract, engage and retain talented employees to successfully operate our business and achieve our goals. Each of the key areas on which we focus to achieve our human capital objectives is described below.

Talent Acquisition and Retention

We have several key strategies to attract and hire top talent across the markets that we serve. These strategies include robust employee referral programs, recruitment marketing through social media and our internal campaign technology, promotion of virtual hiring events and partnering with local nursing schools for clinical rotations and new graduate nursing and therapy programs. Our recruitment and selection processes seek to ensure that we hire employees who have the level of education, experience and professional licensure that align with the organization's strategic objectives. We have developed several programs to advance technical and clinical skills, enable career growth and improve retention for clinical and operational employees. Using our online platform, we have developed an extensive catalog of online learning classes for both instructor-led and asynchronous learning covering technical, professional and management-related topics. In addition, to promote business continuity, we create specific succession plans for our key operational and support management and executive positions.

Diversity and Inclusion

We strive to foster a culture of inclusion and equality. Our employees and patients are a valued and integral part of our organization, and we stand in solidarity with those who respect and share our values, care for others and condemn racism. We are committed to providing regular employee education and training on respect, equality, empathy and compassion, and we evaluate and update these resources on an ongoing basis. Additionally, any agency or contracted individual working within our facilities receives orientation and training on our expectations and standards for care. We take pride in our recruitment efforts that seek to attract the best and brightest talent from around the country. We are committed to having a workforce that reflects diversity at all levels, and we partner with several organizations to help attract diverse talent. In order to help us achieve these goals, we have established a diversity task force that oversees affirmative action planning and provides strategic recommendations to help ensure our goals for a diverse and inclusive workplace remain robust and actionable.

Employee Engagement and Wellness

We demonstrate our care for our employees through our safety, benefit and employee resource programs. We strive to create and sustain a culture of employee safety in each of our facilities.

We have emphasized, particularly within our critical illness recovery hospital and inpatient rehabilitation segments, a communications tool called the "10-Foot Circle of Employee Safety." This tool is meant to help leaders and staff focus on areas of our work which cause workplace injuries. This program has resulted in significant reductions of employee injuries at work. We have also implemented an Employee Assistance Program ("EAP") which has become a valuable resource for employees needing no cost or low cost counseling/mental health services, legal support, or family assistance. Our EAP provides access to resources for individuals dealing with grief, anxiety, and other concerns relevant to and at the forefront of our communities. We offer robust benefit programming with health coaching on diverse topics like weight management, smoking cessation, and maintaining and improving health goals, and we offer training to our employees to help them develop their skills. We utilize surveys of our employees that are focused on areas such as employee engagement, operational reliability and suggestions for improvement. Additionally, we offer extensive supportive programs to individuals facing serious health concerns, including but not limited to, high blood pressure/heart conditions, diabetes and cancer.

Workforce Compensation and Pay Equity

We provide competitive compensation and benefits, including a retirement savings plan with matching opportunities, comprehensive healthcare and insurance benefits, health savings and flexible spending accounts, paid time off and family leave. We have key processes that seek to ensure our pay and benefits remain competitive across all of our disciplines. Using an electronic platform for both performance reviews and compensation review, each employee's performance assessment and compensation go through multiple layers of review annually to promote equitable, market competitive and performance-based compensation. For external benchmarking, we use third party commercially available compensation surveys, as well as the Department of Labor wage data.

Select Medical Charitable Foundation

We have operated a private, non-profit charitable foundation known as the Select Medical Charitable Foundation since 2004. The Foundation is funded primarily by donations by our employees. The Foundation provides financial assistance to employees significantly impacted by natural disasters such as hurricanes, tornadoes and wildfires. Eligibility is application-based with grant distribution determined by the Foundation Review Committee, comprised of colleagues across the organization.

Impact of the COVID-19 Pandemic

Our industry has been on the front line in the battle against COVID-19. This has resulted in a high demand for registered nurses and respiratory therapists, which in turn has placed increased pressure on the importance of recruiting and retaining high quality employees. We have taken several steps in response to these demands to achieve our human capital objectives, such as base rate of pay increases and increasing incentives for staff in markets that have been particularly impacted by the COVID-19 pandemic, and providing a meaningful amount of paid time off for employees who cannot work for COVID-19 related reasons.

Competition

Critical Illness Recovery Hospitals and Rehabilitation Hospitals

Our critical illness recovery hospitals and our rehabilitation hospitals both compete on the basis of the quality of the patient services we provide, the outcomes we achieve for our patients, and the prices we charge for our services. The primary competitive factors in both of our critical illness recovery hospital and rehabilitation hospital segments include quality of services, charges for services, and responsiveness to the needs of patients, families, payors, and physicians. Other companies operate critical illness recovery hospitals and rehabilitation hospitals that compete with our own hospitals, including large operators of similar facilities, such as ScionHealth and Encompass Health Corporation, and rehabilitation units and step-down units operated by acute care hospitals in the markets we serve. The competitive position of a critical illness recovery hospital or a rehabilitation hospital is also affected by the ability of its management to negotiate contracts with purchasers of group healthcare services, including private employers, managed care companies, preferred provider organizations, and health maintenance organizations. Such organizations attempt to obtain discounts from established critical illness recovery hospital or rehabilitation hospital charges. The importance of obtaining contracts with preferred provider organizations, health maintenance organizations, and other organizations which finance healthcare, and its effect on a critical illness recovery hospital's or rehabilitation hospital's competitive position, vary from area to area depending on the number and strength of such organizations.

Outpatient Rehabilitation Clinics

Our outpatient rehabilitation clinics face a highly fragmented and competitive environment. The primary competitors that provide outpatient rehabilitation services include physician-owned physical therapy clinics, dedicated locally owned and managed outpatient rehabilitation clinics, and hospital or university owned or affiliated ventures, as well as national and regional providers in select areas, including Athletico Physical Therapy, ATI Physical Therapy, U.S. Physical Therapy, and Upstream Rehabilitation. Some of these competing clinics have longer operating histories and greater name recognition in these communities than our clinics, and they may have stronger relations with physicians in these communities on whom we rely for patient referrals. Because the barriers to entry are not substantial and current customers have the flexibility to move easily to new healthcare service providers, we believe that new outpatient physical therapy competitors can emerge relatively quickly.

Concentra

Our Concentra segment's occupational health services and consumer health businesses face a highly fragmented and competitive environment. The primary competitors that provide occupational health services have typically been independent physicians, hospital emergency departments, and hospital-owned or hospital-affiliated medical facilities. Because the barriers to entry are not substantial and Concentra's current customers have the flexibility to move easily to new healthcare service providers, we believe that new competitors to Concentra can emerge relatively quickly. Furthermore, urgent care clinics in the local communities Concentra serves provide services similar to those Concentra offers, and, in some cases, competing facilities are more established or newer than Concentra's, may offer a broader array of services to patients than Concentra's, and may have larger or more specialized medical staffs to treat and serve patients.

Government Regulations

General

The healthcare industry is required to comply with many complex laws and regulations at the federal, state, and local government levels. These laws and regulations require that hospitals and facilities furnishing outpatient services (including outpatient rehabilitation clinics, Concentra occupational health centers and onsite clinics) comply with various requirements and standards. These laws and regulations include those relating to the adequacy of medical care, facilities and equipment, personnel, operating policies and procedures, and recordkeeping, as well as standards for reimbursement, fraud and abuse prevention, and health information privacy and security. These laws and regulations are extremely complex, often overlap and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid, and other federal and state healthcare programs.

Facility Licensure

Our healthcare facilities are subject to state and local licensing statutes and regulations ranging from the adequacy of medical care to compliance with building codes and environmental protection laws. In order to assure continued compliance with these various regulations, governmental and other authorities periodically inspect our facilities, both at scheduled intervals and in response to complaints from patients and others. While our facilities intend to comply with existing licensing standards, there can be no assurance that regulatory authorities will determine that all applicable requirements are fully met at any given time. In addition, the state and local licensing laws are subject to changes or new interpretations that could impose additional burdens on our facilities. A determination by an applicable regulatory authority that a facility is not in compliance with these requirements could lead to the imposition of corrective action, assessment of fines and penalties, or loss of licensure, Medicare enrollment, certification or accreditation. These consequences could have an adverse effect on our company.

Some states require us to get approval under certificate of need regulations when we create, acquire, or expand our facilities or services, or alter the ownership of such facilities, whether directly or indirectly. The certificate of need regulations vary from state to state, and are subject to change and new interpretation. If we fail to show public need and obtain approval in these states for our new facilities or changes to the ownership structure of existing facilities, we may be subject to civil or even criminal penalties, lose our facility license, or become ineligible for reimbursement.

Professional Licensure, Corporate Practice and Fee-Splitting Laws

Healthcare professionals at our critical illness recovery hospitals, our rehabilitation hospitals, and our facilities furnishing outpatient services are required to be individually licensed or certified under applicable state law. We take steps to help ensure our employees and agents possess all necessary licenses and certifications.

Some states prohibit the "corporate practice of medicine," which restricts business corporations from practicing medicine through the direct employment of physicians or from exercising control over medical decisions by physicians. Some states similarly prohibit the "corporate practice of therapy." The laws relating to corporate practice vary from state to state and are not fully developed in each state in which we have facilities. Typically, however, professional corporations owned and controlled by licensed professionals are exempt from corporate practice restrictions and may employ physicians or therapists to furnish professional services. Also, in some states, hospitals are permitted to employ physicians.

Some states also prohibit entities from engaging in certain financial arrangements, such as fee-splitting, with physicians or therapists. The laws relating to fee-splitting also vary from state to state and are not fully developed. Generally, these laws restrict business arrangements that involve a physician or therapist sharing medical fees with a referral source, but in some states these laws have been interpreted to extend to management agreements between physicians or therapists and business entities under some circumstances.

We believe that each of our facilities, licensed physicians, and therapists comply with any current corporate practice and fee-splitting laws of the state in which they are located. In states where we are prohibited by the corporate practice of medicine from directly employing licensed physicians, we typically enter into management agreements with professional corporations that are owned by licensed physicians, which, in turn, employ or contract with physicians who provide professional medical services in our facilities. Under those management agreements, we perform only non-medical administrative services, do not exercise control over the practice of medicine by the physicians, and structure compensation to avoid fee-splitting. In those states that apply the corporate practice of therapy prohibition, we either contract to obtain therapy services from an entity permitted to employ therapists or we manage the physical therapy practice owned by licensed therapists through which the therapy services are provided.

Although we believe that our facilities comply with corporate practice and fee-splitting laws, if new regulations or judicial or administrative interpretations establish that our facilities do not comply with these laws, we could be subject to civil and perhaps criminal penalties. In addition, if any of our facilities is determined not to comply with corporate practice and fee-splitting laws, certain of our agreements relating to the facility may be determined to be unenforceable, including our management agreements with the professional corporations furnishing physician services or our payment arrangements with insurers or employers. Future interpretations of corporate practice and fee-splitting laws, the enactment of new legislation, or the adoption of new regulations relating to these laws could cause us to have to restructure our business operations or close our facilities in a particular state. Any such penalties, determinations of unenforceability, or interpretations could have a material adverse effect on our business.

Medicare Enrollment and Certification

In order to participate in the Medicare program and receive Medicare reimbursement, each facility must comply with the applicable regulations of the United States Department of Health and Human Services relating to, among other things, the type of facility, its equipment, its personnel, and its standards of medical care, as well as compliance with all applicable state and local laws and regulations. As of December 31, 2021, all of the critical illness recovery hospitals we operated were certified by Medicare as LTCHs. As of December 31, 2021, all of the rehabilitation hospitals we operated were certified by Medicare as IRFs. In addition, we provide the majority of our outpatient rehabilitation services through outpatient rehabilitation clinics certified by Medicare as rehabilitation agencies or "rehab agencies," which operate as outpatient rehabilitation providers for the purposes of the Medicare program. Our Concentra occupational health centers furnishing outpatient services are generally enrolled in Medicare as suppliers.

Accreditation

Our critical illness recovery hospitals and our rehabilitation hospitals receive accreditation from TJC, DNV, CIHQ and/or CARF. As of December 31, 2021, all of the 104 critical illness recovery hospitals and all of the 30 rehabilitation hospitals we operated were accredited by TJC, DNV, or CIHQ. In addition, 23 of our rehabilitation hospitals have also received accreditation from CARF.

Workers' Compensation

Workers' compensation is a state mandated, comprehensive insurance program that requires employers to fund or insure medical expenses, lost wages, and other costs resulting from work related injuries and illnesses. Workers' compensation benefits and arrangements vary from state to state, and are often highly complex. In some states, payment for services covered by workers' compensation programs are subject to cost containment features, such as requirements that all workers' compensation injuries be treated through a managed care program, or the imposition of fee schedules or payment caps for services furnished to injured employees. Some state workers' compensation laws limit the ability of an employer to select the providers furnishing care to injured employees. Several states require that physicians furnishing non-emergency services to workers' compensation patients must register with the applicable state agency and undergo special continuing education and training. Workers' compensation programs may also impose other requirements that affect the operations of our facilities furnishing outpatient services. Revenue generated directly from workers' compensation programs represented approximately 56% of our revenue from our Concentra segment, 16% of our revenue from our outpatient rehabilitation segment, 1% of our revenue from our critical illness recovery hospital segment, and 2% of our revenue from our rehabilitation hospital segment for the year ended December 31, 2021.

Our facilities furnishing outpatient services are reimbursed for services furnished to injured workers by payors pursuant to the applicable state workers' compensation statutes. Most of the states in which we maintain operations reimburse providers for services payable under workers' compensation laws pursuant to a treatment-specific fee schedule with established maximum reimbursement levels. In states without such fee schedules, healthcare providers are often reimbursed based on "usual and customary" fees benchmarked by market data and negotiated by providers with payors and networks.

Inadequate increases to the applicable fee schedule amounts for our services, and changes in state workers' compensation laws, including cost containment initiatives, could have a negative impact on the operations and financial performance of those facilities.

Overview of U.S. and State Government Reimbursements

Medicare Program in General

The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and CMS. The table below shows the percentage of revenue generated directly from the Medicare program for each of our segments and our company as a whole for the fiscal years ended December 31, 2019, 2020 and 2021.

	Year Ended December 31,		
Medicare Revenue by Segment	**2019**	**2020**	**2021**
Critical illness recovery hospital	49.4 %	43.3 %	37.1 %
Rehabilitation hospital	49.6 %	47.0 %	48.6 %
Outpatient rehabilitation	16.4 %	14.9 %	15.9 %
Concentra	0.1 %	0.1 %	0.1 %
Total Company	25.9 %	25.0 %	22.9 %

The Medicare program reimburses various types of providers, including LTCHs, IRFs, and outpatient rehabilitation providers, using different payment methodologies. The Medicare reimbursement systems specific to LTCHs, IRFs, and outpatient rehabilitation providers, as described herein, are different than the system applicable to general acute care hospitals. If any of our hospitals fail to comply with requirements for payment under Medicare reimbursement systems for LTCHs or IRFs, as applicable, that hospital will be paid under the system applicable to general acute care hospitals. For general acute care hospitals, Medicare payments for inpatient care are made under the inpatient prospective payment system ("IPPS") under which a hospital receives a fixed payment amount per discharge (adjusted for area wage differences) using Medicare severity diagnosis-related groups ("MS-DRGs"). The general acute care hospital MS-DRG payment rate is based upon the national average cost of treating a Medicare patient's condition, based on severity levels of illness, in that type of facility. Although the average length of stay varies for each MS-DRG, the average stay of all Medicare patients in a general acute care hospital is substantially less than the average length of stay in LTCHs and IRFs. Thus, the prospective payment system for general acute care hospitals creates an economic incentive for those hospitals to discharge medically complex Medicare patients to a post-acute care setting as soon as clinically possible. Effective October 1, 2005, CMS expanded its post-acute care transfer policy under which general acute care hospitals are paid on a per diem basis rather than the full MS-DRG rate if a patient is discharged early to certain post-acute care settings, including LTCHs and IRFs. When a patient is discharged from selected MS-DRGs to, among other providers, an LTCH or IRF, the general acute care hospital may be reimbursed below the full MS-DRG payment if the patient's length of stay is at least one day less than the geometric mean length of stay for the MS-DRG.

Medicare Reimbursement of LTCH Services

The Medicare payment system for LTCHs is based on a prospective payment system specifically applicable to LTCHs ("LTCH-PPS"). The policies and payment rates under LTCH-PPS are subject to annual updates and revisions. Under LTCH-PPS, each patient discharged from an LTCH is assigned to a distinct "MS-LTC-DRG," which is a Medicare severity long-term care diagnosis-related group for LTCHs, and an LTCH is generally paid a pre-determined fixed amount applicable to the assigned MS-LTC-DRG (adjusted for area wage differences), subject to exceptions for short stay and high cost outlier patients (described below). CMS assigns relative weights to each MS-LTC-DRG to reflect their relative use of medical care resources. The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in an LTCH.

Standard Federal Rate

Payment under the LTCH-PPS is dependent on determining the patient classification, that is, the assignment of the case to a particular MS-LTC-DRG, the weight of the MS-LTC-DRG, and the standard federal payment rate. There is a single standard federal rate that encompasses both the inpatient operating costs, which includes a labor and non-labor component, and capital-related costs that CMS updates on an annual basis. LTCH-PPS also includes special payment policies that adjust the payments for some patients based on the patient's length of stay, the facility's costs, whether the patient was discharged and readmitted, and other factors.

Patient Criteria

The Bipartisan Budget Act of 2013, enacted December 26, 2013, established a dual-rate LTCH-PPS for Medicare patients discharged from an LTCH. Specifically, for Medicare patients discharged in cost reporting periods beginning on or after October 1, 2015, LTCHs are reimbursed at the LTCH-PPS standard federal payment rate only if, immediately preceding the patient's LTCH admission, the patient was discharged from a "subsection (d) hospital" (generally, a short-term acute care hospital paid under IPPS) and either the patient's stay included at least three days in an intensive care unit or coronary care unit at the subsection (d) hospital, or the patient was assigned to an MS-LTC-DRG for cases receiving at least 96 hours of ventilator services in the LTCH. In addition, to be paid at the LTCH-PPS standard federal payment rate, the patient's discharge from the LTCH may not include a principal diagnosis relating to psychiatric or rehabilitation services. For any Medicare patient who does not meet these criteria, the LTCH will be paid a "site-neutral" payment rate, which will be the lower of: (i) the IPPS comparable per-diem payment rate capped at the MS-DRG payment rate plus any outlier payments; or (ii) 100 percent of the estimated costs for services.

The site neutral payment rate for those patients not paid at the LTCH-PPS standard federal payment rate is subject to a transition period. During the transition period (applicable to hospital cost reporting periods beginning on or after October 1, 2015 through September 30, 2019), a blended rate was paid for Medicare patients not meeting the new criteria that is equal to 50% of the site neutral payment rate amount and 50% of the standard federal payment rate amount. For discharges in cost reporting periods beginning on or after October 1, 2019, only the site neutral payment rate will apply for Medicare patients not meeting the new criteria. For hospital discharges beginning on or after October 1, 2017 through September 30, 2026, the IPPS comparable per diem payment amount (including any applicable outlier payment) used to determine the site neutral payment rate is reduced by 4.6% after any annual payment rate update.

In addition, for cost reporting periods beginning on or after October 1, 2019, LTCHs must maintain an "LTCH discharge payment percentage" of at least 50% to continue to be reimbursed for Medicare fee-for-service patients at the dual rates of the LTCH-PPS. The "LTCH discharge payment percentage" is a ratio, expressed as a percentage, of Medicare fee-for-service (FFS) discharges not paid the site neutral payment rate (*i.e.*, those meeting LTCH patient criteria) to the total number of Medicare FFS discharges occurring during the cost reporting period. If this percentage is lower than 50%, the LTCH is notified that all of its Medicare FFS discharges will be subject to payment adjustment beginning in the cost reporting period after it was notified. The payment adjustment will result in reimbursement at an IPPS equivalent payment rate. However, the LTCH will not be subject to this payment adjustment if it maintains an LTCH discharge payment percentage of at least 50% during a 6-month "probationary-cure period" immediately before the cost reporting period when the payment adjustment would apply, and during that cost reporting period. An LTCH that has been subject to this payment adjustment will be reinstated at the regular dual rates of the LTCH-PPS in the cost reporting period that begins after the LTCH is notified that its LTCH discharge payment percentage is at least 50%.

Payment adjustments, including the interrupted stay policy (discussed herein), apply to LTCH discharges regardless of whether the case is paid at the standard federal payment rate or the site-neutral payment rate. However, short stay outlier payment adjustments do not apply to cases paid at the site-neutral payment rate. CMS calculates the annual recalibration of the MS-LTC-DRG relative payment weighting factors using only data from LTCH discharges that meet the criteria for exclusion from the site-neutral payment rate. In addition, CMS applies the IPPS fixed-loss amount for high cost outliers to site-neutral cases, rather than the LTCH-PPS fixed-loss amount. CMS calculates the LTCH-PPS fixed-loss amount using only data from cases paid at the LTCH-PPS payment rate, excluding cases paid at the site-neutral rate.

Short Stay Outlier Policy

CMS established a different payment methodology for Medicare patients with a length of stay less than or equal to five-sixths of the geometric average length of stay for that particular MS-LTC-DRG, referred to as a short stay outlier ("SSO"). SSO cases are paid based on a per diem rate derived from blending 120% of the MS-LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital IPPS. Under this policy, as the length of stay of a SSO case increases, the percentage of the per diem payment amounts based on the full MS-LTCH-DRG standard federal payment rate increases and the percentage of the payment based on the IPPS comparable amount decreases.

High Cost Outliers

Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. Cases with unusually high costs, referred to as "high cost outliers," receive a payment adjustment to reflect the additional resources utilized. CMS provides an additional payment if the estimated costs for the patient exceed the adjusted MS-LTC-DRG payment plus a fixed-loss amount that is established in the annual payment rate update.

Interrupted Stays

An interrupted stay is defined as a case in which an LTCH patient, upon discharge, is admitted to a general acute care hospital, IRF or skilled nursing facility/swing-bed and then returns to the same LTCH within a specified period of time. If the length of stay at the receiving provider is equal to or less than the applicable fixed period of time, it is considered to be an interrupted stay case and the case is treated as a single discharge for the purposes of payment to the LTCH. For interrupted stays of three days or less, Medicare payments for any test, procedure, or care provided to an LTCH patient on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH.

Freestanding, HIH, and Satellite LTCHs

LTCHs may be organized and operated as freestanding facilities or as HIHs. As its name suggests, a freestanding LTCH is not located on the campus of another hospital. For such purpose, "campus" means the physical area immediately adjacent to a hospital's main buildings, other areas, and structures that are not strictly contiguous to a hospital's main buildings but are located within 250 yards of its main buildings, and any other areas determined, on an individual case basis by the applicable CMS regional office, to be part of a hospital's campus. Conversely, an HIH is an LTCH that is located on the campus of another hospital. An LTCH, whether freestanding or an HIH, that uses the same Medicare provider number of an affiliated "primary site" LTCH is known as a "satellite." Under Medicare policy, a satellite LTCH generally must be located within 35 miles of its primary site LTCH and be administered by such primary site LTCH. A primary site LTCH may have more than one satellite LTCH. CMS sometimes refers to a satellite LTCH that is freestanding as a "remote location." LTCH HIHs and satellites must comply with certain requirements to show that they operate as part of the main LTCH, and not the co-located hospital. Most or all of these requirements no longer apply to LTCHs that are located on the same campus as an IRF, an inpatient psychiatric facility, or any other hospital excluded from the IPPS, provided that an IPPS hospital is not also located on that campus.

Facility Certification Criteria

The LTCH-PPS regulations define the criteria that must be met in order for a hospital to be certified as an LTCH. To be eligible for payment under the LTCH-PPS, a hospital must be primarily engaged in providing inpatient services to Medicare beneficiaries with medically complex conditions that require a long hospital stay. In addition, by definition, LTCHs must meet certain facility criteria, including: (i) instituting a review process that screens patients for appropriateness of an admission and validates the patient criteria within 48 hours of each patient's admission, evaluates regularly their patients for continuation of care, and assesses the available discharge options; (ii) having active physician involvement with patient care that includes a physician available on-site daily and additional consulting physicians on call; and (iii) having an interdisciplinary team of healthcare professionals to prepare and carry out an individualized treatment plan for each patient.

An LTCH must have an average inpatient length of stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days. LTCH cases paid at the site-neutral rate and Medicare Advantage cases are excluded from the LTCH average length of stay calculation. LTCHs that fail to exceed an average length of stay of 25 days during any cost reporting period may be paid under the general acute care hospital IPPS if not corrected within established time frames. CMS, through its contractors, determines whether an LTCH has maintained an average length of stay of greater than 25 days during each annual cost reporting period.

Prior to qualifying under the payment system applicable to LTCHs, a new LTCH initially receives payments under the general acute care hospital IPPS. The LTCH must continue to be paid under this system for a minimum of six months while meeting certain Medicare LTCH requirements, the most significant requirement being an average length of stay for Medicare patients (including both Medicare covered and non-covered days) greater than 25 days.

Annual Payment Rate Update

Fiscal Year 2020. On August 16, 2019, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2020 (affecting discharges and cost reporting periods beginning on or after October 1, 2019 through September 30, 2020). Certain errors in the final rule were corrected in a document published October 8, 2019. The standard federal rate was set at $42,678, an increase from the standard federal rate applicable during fiscal year 2019 of $41,559. The update to the standard federal rate for fiscal year 2020 included a market basket increase of 2.9%, less a productivity adjustment of 0.4%. The standard federal rate also included an area wage budget neutrality factor of 1.0020203. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $26,778, a decrease from the fixed-loss amount in the 2019 fiscal year of $27,121. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $26,552, an increase from the fixed-loss amount in the 2019 fiscal year of $25,743. For LTCH discharges occurring in cost reporting periods beginning in fiscal year 2020, site neutral payment rate cases began to be paid fully on the site neutral payment rate, rather than the transitional blended rate. However, the Coronavirus Aid, Relief and Economic Security Act ("CARES Act") waived the site neutral payment rate for patients admitted during the COVID-19 emergency period and in response to the public health emergency, as discussed below.

Fiscal Year 2021. On September 18, 2020, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2021 (affecting discharges and cost reporting periods beginning on or after October 1, 2020 through September 30, 2021). Certain errors in the final rule were corrected in a document published December 7, 2020. The standard federal rate was set at $43,755, an increase from the standard federal rate applicable during fiscal year 2020 of $42,678. The update to the standard federal rate for fiscal year 2021 included a market basket increase of 2.3% with no productivity adjustment. The standard federal rate also included an area wage budget neutrality factor of 1.0016837. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $27,195, an increase from the fixed-loss amount in the 2020 fiscal year of $26,778. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $29,064, an increase from the fixed-loss amount in the 2020 fiscal year of $26,552.

Fiscal Year 2022. On August 13, 2021, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2022 (affecting discharges and cost reporting periods beginning on or after October 1, 2021 through September 30, 2022). The standard federal rate was set at $44,714, an increase from the standard federal rate applicable during fiscal year 2021 of $43,755. The update to the standard federal rate for fiscal year 2022 included a market basket increase of 2.6%, less a productivity adjustment of 0.7%. The standard federal rate also included an area wage budget neutrality factor of 1.002848. As a result of the CARES Act, all LTCH cases are paid at the standard federal rate during the public health emergency. If the public health emergency ends during fiscal year 2022, then CMS will return to using the site-neutral payment rate for reimbursement of cases that do not meet the LTCH patient criteria. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $33,015, a significant increase from the fixed-loss amount in the 2021 fiscal year of $27,195. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $30,988, an increase from the fixed-loss amount in the 2021 fiscal year of $29,064.

Medicare Reimbursement of IRF Services

IRFs are paid under a prospective payment system specifically applicable to this provider type, which is referred to as "IRF-PPS." Under the IRF-PPS, each patient discharged from an IRF is assigned to a case mix group ("IRF-CMG") containing patients with similar clinical conditions that are expected to require similar amounts of resources. An IRF is generally paid a pre-determined fixed amount applicable to the assigned IRF-CMG (subject to applicable case adjustments related to length of stay and facility level adjustments for location and low income patients). The payment amount for each IRF-CMG is intended to reflect the average cost of treating a Medicare patient's condition in an IRF relative to patients with conditions described by other IRF-CMGs. The IRF-PPS also includes special payment policies that adjust the payments for some patients based on the patient's length of stay, the facility's costs, whether the patient was discharged and readmitted and other factors.

Facility Certification Criteria

Our rehabilitation hospitals must meet certain facility criteria to be classified as an IRF by the Medicare program, including: (i) a provider agreement to participate as a hospital in Medicare; (ii) a pre-admission screening procedure; (iii) ensuring that patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services; (iv) a full-time, qualified director of rehabilitation; (v) a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and (vi) a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment. Failure to comply with any of the classification criteria may result in the denial of claims for payment or cause a hospital to lose its status as an IRF and be paid under the prospective payment system that applies to general acute care hospitals.

Patient Classification Criteria

In order to qualify as an IRF, a hospital must demonstrate that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 60% required intensive rehabilitation services for one or more of 13 conditions specified by regulation. Compliance with the 60% Rule is demonstrated through either medical review or the "presumptive" method, in which a patient's diagnosis codes are compared to a "presumptive compliance" list. Beginning October 1, 2017, the 60% Rule's presumptive methodology was revised to (i) include certain International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10-CM") diagnosis codes for patients with traumatic brain injury and hip fracture conditions and (ii) count IRF cases that contain two or more of the ICD-10-CM codes from three major multiple trauma lists in the specified combinations.

Annual Payment Rate Update

Fiscal Year 2020. On August 8, 2019, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2020 (affecting discharges and cost reporting periods beginning on or after October 1, 2019 through September 30, 2020). The standard payment conversion factor for discharges for fiscal year 2020 was set at $16,489, an increase from the standard payment conversion factor applicable during fiscal year 2019 of $16,021. The update to the standard payment conversion factor for fiscal year 2020 included a market basket increase of 2.9%, less a productivity adjustment of 0.4%. CMS decreased the outlier threshold amount for fiscal year 2020 to $9,300 from $9,402 established in the final rule for fiscal year 2019.

Fiscal Year 2021. On August 10, 2020, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2021 (affecting discharges and cost reporting periods beginning on or after October 1, 2020 through September 30, 2021). The standard payment conversion factor for discharges for fiscal year 2021 was set at $16,856, an increase from the standard payment conversion factor applicable during fiscal year 2020 of $16,489. The update to the standard payment conversion factor for fiscal year 2021 included a market basket increase of 2.4% with no productivity adjustment. CMS decreased the outlier threshold amount for fiscal year 2021 to $7,906 from $9,300 established in the final rule for fiscal year 2020.

Fiscal Year 2022. On August 4, 2021, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2022 (affecting discharges and cost reporting periods beginning on or after October 1, 2021 through September 30, 2022). The standard payment conversion factor for discharges for fiscal year 2022 was set at $17,240, an increase from the standard payment conversion factor applicable during fiscal year 2021 of $16,856. The update to the standard payment conversion factor for fiscal year 2022 included a market basket increase of 2.6%, less a productivity adjustment of 0.7%. CMS increased the outlier threshold amount for fiscal year 2022 to $9,491 from $7,906 established in the final rule for fiscal year 2021.

Medicare Reimbursement of Outpatient Rehabilitation Clinic Services

Outpatient rehabilitation providers enroll in Medicare as a rehabilitation agency, a clinic, or a public health agency. The Medicare program reimburses outpatient rehabilitation providers based on the Medicare physician fee schedule. For services provided in 2017 through 2019, a 0.5% update was applied each year to the fee schedule payment rates, subject to an adjustment beginning in 2019 under the Merit-Based Incentive Payment System ("MIPS"). In 2019, CMS added physical and occupational therapists to the list of MIPS eligible clinicians. For these therapists in private practice, payments under the fee schedule are subject to adjustment in a later year based on their performance in MIPS according to established performance standards. Calendar year 2021 is the first year that payments are adjusted, based upon the therapist's performance under MIPS in 2019. Providers in facility-based outpatient therapy settings are excluded from MIPS eligibility and therefore not subject to this payment adjustment.

For services provided in 2020 through 2025, a 0.0% percent update will be applied each year to the fee schedule payment rates, subject to adjustments under MIPS and the alternative payment models ("APMs"). In 2026 and subsequent years, eligible professionals participating in APMs who meet certain criteria would receive annual updates of 0.75%, while all other professionals would receive annual updates of 0.25%. Each year from 2019 through 2024 eligible clinicians who receive a significant share of their revenues through an advanced APM (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus. The bonus payment for APM participation is intended to encourage participation and testing of new APMs and to promote the alignment of incentives across payors.

In the 2020 Medicare physician fee schedule final rule, CMS revised coding, documentation guidelines, and increased the valuation for the evaluation and management ("E/M") office visit codes, beginning in 2021. Because the Medicare physician fee schedule is budget-neutral, any revaluation of E/M services that will increase spending by more than $20 million will require a budget neutrality adjustment. To increase values for the E/M codes while maintaining budget neutrality under the fee schedule, CMS cut the values of other codes to make up the difference, beginning in 2021. In the 2021 Medicare physician fee schedule final rule, CMS increased the values for the E/M office visit codes and cuts to other specialty codes to maintain budget neutrality. As a result, therapy services provided in our outpatient rehabilitation clinics received an estimated 3.6% decrease in payment from Medicare in calendar year 2021. The Consolidated Appropriations Act, 2021, provided relief in the form of a one-time 3.75% increase in payments in calendar year 2021 for therapy services and other services paid under the physician fee schedule.

In the calendar year 2022 physician fee schedule final rule, CMS announced that Medicare payments for the therapy specialty are expected to decrease 1% in 2022. After CMS issued the final rule, Congress passed the Protecting Medicare and American Farmers from Sequester Cuts Act, which provided in Section 3 a one-time 3% increase in payments in calendar year 2022 to offset most of the 3.75% cut to payments for therapy services and other services paid under the physician fee schedule. In the final rule, CMS also adopted its plan to transition the MIPS program to MIPS Value Pathways ("MVPs"). CMS will begin the transition to MVPs in 2023 with an initial set of MVPs in which reporting is voluntary. Beginning in 2026, multispecialty groups must form subgroups to report MVPs. CMS plans to develop more MVPs from 2024 to 2027 and is considering that MVP reporting would become mandatory in 2028. Each MVP would include population health claims-based measures and require clinicians to report on the Promoting Interoperability performance category measures. In addition, MVP participants would select certain quality measures and improvement activities and then report data for such measures and activities.

Therapy Caps

Outpatient therapy providers reimbursed under the Medicare physician fee schedule have historically been subject to annual limits for therapy expenses. The Bipartisan Budget Act of 2018 repealed the annual limits on outpatient therapy but the law preserves the former therapy cap amounts as thresholds above which claims must include a modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. For calendar year 2022, this modifier threshold amount is $2,150. The $2,150 threshold is applied to physical therapy and speech therapy services combined and separately applied to occupational therapy. This amount is indexed annually by the Medicare Economic Index. Claims for services over the modifier threshold amounts without the modifier are denied. Along with the modifier threshold, the Bipartisan Budget Act of 2018 retained the targeted medical review process that was established in the Medicare Access and CHIP Reauthorization Act of 2015. For calendar year 2018 through calendar year 2028, all therapy claims exceeding $3,000 are subject to a targeted manual medical review process. The $3,000 threshold is applied to physical therapy and speech therapy services combined and separately applied to occupational therapy. Beginning in 2028 and in each calendar year thereafter, the threshold amount for claims requiring targeted manual medical review will increase by the percentage increase in the Medicare Economic Index.

Modifiers to Identify Services of Physical Therapy Assistants or Occupational Therapy Assistants

In the Medicare Physician Fee Schedule final rule for calendar year 2019, CMS established two new modifiers (CQ and CO) to identify services furnished in whole or in part by physical therapy assistants ("PTAs") or occupational therapy assistants ("OTAs"). These modifiers were mandated by the Bipartisan Budget Act of 2018, which requires that claims for outpatient therapy services furnished in whole or part by therapy assistants on or after January 1, 2020 include the appropriate modifier. In the final 2020 Medicare physician fee schedule rule, CMS clarified that when the physical therapist is involved for the entire duration of the service and the PTA provides skilled therapy alongside the physical therapist, the CQ modifier is not required. Also, when the same service (code) is furnished separately by the physical therapist and PTA, CMS will apply the de minimis standard to each 15-minute unit of codes, not on the total physical therapist and PTA time of the service, allowing the separate reporting, on two different claim lines, of the number of units to which the new modifiers apply and the number of units to which the modifiers do not apply. In the calendar year 2022 physician fee schedule final rule, CMS implemented the final part of the requirements in the Bipartisan Budget Act of 2018 regarding PTA and OTA services. For dates of service on and after January 1, 2022, CMS will pay for physical therapy and occupational therapy services provided by PTAs and OTAs at 85% of the otherwise applicable Part B payment amount. CMS also modified the de minimis standard for calendar year 2022. Specifically, CMS will allow a timed service to be billed without the CQ or CO modifier when a PTA or OTA participates in providing care, but the physical therapist or occupational therapist meets the Medicare billing requirements without including the PTA's or OTA's minutes. This occurs when the physical therapist or occupational therapist provides more minutes than the 15-minute midpoint.

Other Requirements for Payment

Historically, outpatient rehabilitation services have been subject to scrutiny by the Medicare program for, among other things, medical necessity for services, appropriate documentation for services, supervision of therapy aides and students, and billing for single rather than group therapy when services are furnished to more than one patient. CMS has issued guidance to clarify that services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist. Likewise, CMS has reiterated that Medicare does not pay for services provided by aides regardless of the level of supervision. CMS also has issued instructions that outpatient physical and occupational therapy services provided simultaneously to two or more individuals by a practitioner should be billed as group therapy services.

Medicaid Reimbursement of LTCH and IRF Services

The Medicaid program is designed to provide medical assistance to individuals unable to afford care. The program is governed by the Social Security Act of 1965, funded jointly by each individual state and the federal government and administered by state agencies. Medicaid payments are made under a number of different systems, which include cost based reimbursement, prospective payment systems, or programs that negotiate payment levels with individual hospitals. In addition, Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies, and certain government funding limitations, all of which may increase or decrease the level of program payments to our hospitals. Revenue generated directly from the Medicaid program represented approximately 3% of our critical illness recovery hospital segment revenue and 2% of our rehabilitation hospital segment revenue for the year ended December 31, 2021.

Other Healthcare Regulations

Federal Healthcare Program Changes in Response to the COVID-19 Pandemic

The Secretary of Health and Human Services ("HHS") has authorized a number of waivers or modifications of certain requirements under Medicare, Medicaid and the Children's Health Insurance Program ("CHIP") pursuant to section 1135 of the Social Security Act in response to the COVID-19 outbreak in the United States. For a description of such waivers and modifications, see "Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes."

Medicare COVID-19 Vaccination Mandate for Health Care Staff

On November 5, 2021, CMS issued an interim final rule amending the Medicare conditions of participation for twenty-one provider types, including hospitals, to require that Medicare and Medicaid-certified providers implement COVID-19 vaccination requirements for their staff. Hospitals that do not comply with these requirements may be subject to enforcement actions, including termination of their Medicare and Medicaid provider agreements. Two groups of states filed lawsuits challenging the interim final rule and obtained preliminary injunctions from two federal district courts that prevented CMS from enforcing the new vaccination requirements. However, on January 13, 2022, the Supreme Court of the United States issued an order staying these injunctions. As a result of the Supreme Court's order, CMS has resumed implementation and enforcement of the new vaccination requirements in all states.

Health care workers at facilities in the groups of states that filed lawsuits challenging the requirements have until February 14, 2022 to get their first dose of a COVID-19 vaccination, and until March 15, 2022 to get their second dose, unless they have a qualifying religious or medical exemption. These states include: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia, and Wyoming. CMS's guidance states that a facility with more than 80% of its staff vaccinated, and a plan to achieve a 100% staff vaccination rate within 60 days of February 14, 2022, will be considered in compliance with the new rule. Similarly, a facility with more than 90% of its staff vaccinated on March 15, 2022, and a plan to achieve a 100% staff vaccination rate within 30 days, will be considered in compliance with the rule. By April 14, 2022, facilities in these states must achieve and maintain a 100% staff vaccination rate.

The state of Texas filed a separate lawsuit challenging the vaccination mandate and also obtained a preliminary injunction preventing CMS from enforcing the interim final rule. However, Texas' preliminary injunction was not specifically at issue in the Supreme Court's January 13, 2022 order. Nonetheless, Texas moved to dismiss its lawsuit on January 18, 2022. CMS is requiring that facilities in Texas meet the same requirements discussed above by February 22, 2022, March 21, 2022, and April 20, 2022, respectively.

Facilities located in all other states were not covered by the preliminary injunctions issued by the federal district courts. Accordingly, CMS is still requiring that these facilities meet the same requirements discussed above by January 27, 2022, February 28, 2022, and March 30, 2022, respectively.

Medicare Quality Reporting

LTCHs and IRFs are subject to mandatory quality reporting requirements. LTCHs and IRFs that do not submit the required quality data will be subject to a 2% reduction in their annual payment update. The reduction can result in payment rates less than the prior year. However, the reduction will not carry over into the subsequent fiscal years.

Our LTCHs and IRFs are required to collect and report patient assessment data and clinical measures on each Medicare beneficiary who receives inpatient services in our facilities. We began reporting this data on October 1, 2012. CMS began making this data available to the public on the CMS website in December 2016. CMS has added cross-setting quality measures to compare quality and resource data across post-acute settings pursuant to the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act").

Medicare Hospital Wage Index Adjustment

As part of the methodology for determining prospective payments to LTCHs and IRFs, CMS adjusts the standard payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. This adjustment factor is the hospital wage index. CMS currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas established by the Office of Management and Budget.

Physician-Owned Hospital Limitations

CMS regulations include a number of hospital ownership and physician referral provisions, including certain obligations requiring physician-owned hospitals to disclose ownership or investment interests held by the referring physician or his or her immediate family members. In particular, physician-owned hospitals must furnish to patients, on request, a list of physicians or immediate family members who own or invest in the hospital. Moreover, a physician-owned hospital must require all physician owners or investors who are also active members of the hospital's medical staff to disclose in writing their ownership or investment interests in the hospital to all patients they refer to the hospital. CMS can terminate the Medicare provider agreement of a physician-owned hospital if it fails to comply with these disclosure provisions or with the requirement that a hospital disclose in writing to all patients whether there is a physician on-site at the hospital, 24 hours per day, seven days per week.

Under the transparency and program integrity provisions of the ACA, the exception to the federal self-referral law (the "Stark Law") that permits physicians to refer patients to hospitals in which they have an ownership or investment interest has been dramatically curtailed. Only hospitals with physician ownership and a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the percentage of physician ownership or investment interests held in the hospital after March 23, 2010. In addition, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, unless meeting specific exceptions related to the hospital's location and patient population. In order to retain their exemption from the general ban on self-referrals, our physician-owned hospitals are required to adopt specific measures relating to conflicts of interest, bona fide investments and patient safety. As of December 31, 2021, we operated four hospitals that are owned in-part by physicians.

Medicare Recovery Audit Contractors

CMS contracts with third-party organizations, known as Recovery Audit Contractors ("RACs") to identify Medicare underpayments and overpayments, and to authorize RACs to recoup any overpayments. RACs are paid on a contingency fee basis. The contingency fee is a percentage of improper overpayment recoveries or underpayments identified by the RAC. The RAC must return the contingency fee if an improper payment determination is reversed on appeal. RACs conduct audit activities nationwide in four regions of the country that cover all 50 states on a combined basis. RAC audits of our Medicare reimbursement may lead to assertions that we have been overpaid, require us to incur additional costs to respond to requests for records and pursue the reversal of payment denials through appeals, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict the impact of future RAC reviews on our results of operations or cash flows.

Fraud and Abuse Enforcement

Various federal and state laws prohibit the submission of false or fraudulent claims, including claims to obtain payment under Medicare, Medicaid, and other government healthcare programs. Penalties for violation of these laws include civil and criminal fines, imprisonment, and exclusion from participation in federal and state healthcare programs. In recent years, federal and state government agencies have increased the level of enforcement resources and activities targeted at the healthcare industry. In addition, the federal False Claims Act and similar state statutes allow individuals to bring lawsuits on behalf of the government, in what are known as qui tam or "whistleblower" actions, alleging false or fraudulent Medicare or Medicaid claims or other violations of the statute. The use of these private enforcement actions against healthcare providers has increased dramatically in recent years, in part because the individual filing the initial complaint is entitled to share in a portion of any settlement or judgment. Revisions to the False Claims Act enacted in 2009 expanded significantly the scope of liability, provided for new investigative tools, and made it easier for whistleblowers to bring and maintain False Claims Act suits on behalf of the government. See "—Legal Proceedings."

From time to time, various federal and state agencies, such as the Office of Inspector General of the Department of Health and Human Services ("OIG") issue a variety of pronouncements, including fraud alerts, the OIG's Annual Work Plan, and other reports, identifying practices that may be subject to heightened scrutiny. These pronouncements can identify issues relating to LTCHs, IRFs, or outpatient rehabilitation services or providers. For example, the OIG recently announced that it will (1) determine whether Medicare appropriately paid hospitals' inpatient claims subject to the post-acute care transfer policy, (2) determine whether Medicare paid new hospitals for claimed capital costs in accordance with Federal regulations, (3) determine whether Medicare appropriately paid inpatient hospital claims for mechanical ventilation services, and (4) examine whether Medicaid paid IRFs correctly when patients are discharged prematurely to receive home health services. We monitor government publications applicable to us to supplement and enhance our compliance efforts.

We endeavor to conduct our operations in compliance with applicable laws, including healthcare fraud and abuse laws. If we identify any practices as being potentially contrary to applicable law, we will take appropriate action to address the matter, including, where appropriate, disclosure to the proper authorities, which may result in a voluntary refund of monies to Medicare, Medicaid, or other governmental healthcare programs.

Remuneration and Fraud Measures

The federal anti-kickback statute prohibits some business practices and relationships under Medicare, Medicaid, and other federal healthcare programs. These practices include the payment, receipt, offer, or solicitation of remuneration in connection with, to induce, or to arrange for, the referral of patients covered by a federal or state healthcare program. Violations of the anti-kickback law may be punished by: a criminal fine of up to $100,000 or up to ten years imprisonment for each violation, or both; civil monetary penalties of $20,000, $30,000 or $100,000 per violation, depending on the type of violation; damages of up to three times the total amount of remuneration; and exclusion from participation in federal or state healthcare programs.

The Stark Law prohibits referrals for designated health services by physicians under the Medicare and Medicaid programs to other healthcare providers in which the physicians have an ownership or compensation arrangement unless an exception applies. Sanctions for violating the Stark Law include returning program reimbursements, civil monetary penalties of up to $15,000 per prohibited service provided, assessments equal to three times the dollar value of each such service provided, and exclusion from the Medicare and Medicaid programs and other federal and state healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. In addition, many states have adopted or may adopt similar anti-kickback or anti-self-referral statutes. Some of these statutes prohibit the payment or receipt of remuneration for the referral of patients, regardless of the source of the payment for the care. While we do not believe our arrangements are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing the provisions of these prohibitions will not assert that one or more of our arrangements are in violation of the provisions of such laws and regulations.

Provider-Based Status

The designation "provider-based" refers to circumstances in which a subordinate facility (such as a separately certified Medicare provider, a department of a provider, or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included on the "main" provider's cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. As of December 31, 2021, we operated 19 critical illness recovery hospitals and seven rehabilitation hospitals that were treated as provider-based satellites of certain of our other facilities. In addition, 263 of the outpatient rehabilitation clinics we operated were provider-based and operated as departments of the rehabilitation hospitals we operated. We also provide rehabilitation management and staffing services to hospital rehabilitation departments that may be treated as provider-based. These facilities are required to satisfy certain operational standards in order to retain their provider-based status.

Health Information Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandates the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the healthcare industry, while maintaining the privacy and security of health information. Among the standards that the Department of Health and Human Services has adopted or will adopt pursuant to HIPAA are standards for electronic transactions and code sets, unique identifiers for providers (referred to as National Provider Identifier), employers, health plans and individuals, security and electronic signatures, privacy, and enforcement. If we fail to comply with the HIPAA requirements, we could be subject to criminal penalties and civil sanctions. The privacy, security and enforcement provisions of HIPAA were enhanced by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), which was included in the ARRA. Among other things, HITECH establishes security breach notification requirements, allows enforcement of HIPAA by state attorneys general, and increases penalties for HIPAA violations.

The Department of Health and Human Services has adopted standards in three areas in which we are required to comply that affect our operations.

Standards relating to the privacy of individually identifiable health information govern our use and disclosure of protected health information and require us to impose those rules, by contract, on any business associate to whom such information is disclosed.

Standards relating to electronic transactions and code sets require the use of uniform standards for common healthcare transactions, including healthcare claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments, and coordination of benefits.

Standards for the security of electronic health information require us to implement various administrative, physical, and technical safeguards to preserve the integrity and confidentiality of electronic protected health information.

We maintain a Privacy and Security Committee that is charged with evaluating and monitoring our compliance with HIPAA. The Privacy and Security Committee monitors regulations promulgated under HIPAA as they have been adopted to date and as additional standards and modifications are adopted. Although health information standards have had a significant effect on the manner in which we handle health data and communicate with payors, the cost of our compliance has not had a material adverse effect on our business, financial condition, or results of operations. We cannot estimate the cost of compliance with standards that have not been issued or finalized by the Department of Health and Human Services.

In addition to HIPAA, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state. Lawsuits, including class actions and action by state attorneys general, directed at companies that have experienced a privacy or security breach also can occur. Although our policies and procedures are aimed at complying with privacy and security requirements and minimizing the risks of any breach of privacy or security, there can be no assurance that a breach of privacy or security will not occur. If there is a breach, we may be subject to various penalties and damages and may be required to incur costs to mitigate the impact of the breach on affected individuals.

IMPACT Act

In October 2014, President Obama signed the Improving Medicare Post-Acute Care Transformation Act ("IMPACT Act" into law. The IMPACT Act made a number of changes and additions to Medicare quality reporting for LTCHs, IRFs, skilled nursing facilities ("SNFs"), and home health agencies ("HHAs"). In addition, the IMPACT Act requires HHS and the Medicare Payment Advisory Commission ("MedPAC") to develop a technical prototype for a unified post-acute care ("PAC") prospective payment system ("PPS") that could replace the four existing payment systems for LTCHs, IRFs, SNFs, and HHAs.

The IMPACT Act directed HHS to begin requiring providers to report certain standardized patient assessment data to CMS. HHS had to adopt this reporting requirement by October 1, 2018, for LTCHs, IRFs, and SNFs, and by January 1, 2019, for HHAs. The IMPACT Act also required CMS to adopt and implement new cross-setting quality measures addressing, at a minimum, the following quality domains: (1) functional status, cognitive function, and changes in function and cognitive function; (2) skin integrity and changes in skin integrity; (3) medication reconciliation; (4) incidence of major falls; and (5) providing for the transfer of health information and treatment preferences of the patient upon transition from a hospital or critical access hospital to another setting, including a PAC provider or the individual's home, or upon transition from a PAC provider to another setting including a different PAC provider, hospital, critical access hospital, or the individual's home. Next, the IMPACT Act required that by October 1, 2016, for SNFs, IRFs and LTCHs, and by January 1, 2017, for HHAs, CMS specify resource use and other measures for inclusion in the applicable reporting provisions. At a minimum, the resource use measures must include the following resource use domains: (1) resource use measures, including total estimated Medicare spending per beneficiary; (2) discharge to community; and (3) measures to reflect all-condition risk-adjusted hospitalization rates of potentially preventable readmission rates. CMS began implementing the IMPACT Act's data reporting requirements in the FY 2016 rulemakings for LTCHs, IRFs, SNFs, and HHAs.

In addition to the new reporting requirements, the IMPACT Act outlined a process for the potential development of a unified PAC PPS. The IMPACT Act does not require CMS to adopt a unified PAC PPS, nor does it provide CMS with specific authority to implement a new payment system. However, the IMPACT Act does require HHS and MedPAC to submit a series of reports to Congress with recommendations and a technical prototype for a PAC PPS. These recommendations and prototypes could become the basis of future legislation that would create a unified PAC PPS to replace some or all of the existing Medicare payment systems for LTCHs, IRFs, SNFs, and HHAs. MedPAC submitted the first report to Congress in June 2016. The report included recommended features for a unified PAC payment system. The Secretary of HHS will submit the next report to Congress with recommendations and a technical prototype. The Secretary's report is due no later than two years after CMS has collected two years of data on the quality measures required by the IMPACT Act. After the Secretary's report, MedPAC is to submit a second report to Congress with recommendations and a technical prototype for a new PAC payment system. The Secretary is expected to issue his report to Congress sometime in 2022. However, a bipartisan bill introduced in the House of Representatives in April 2021 would require the Secretary to first collect eight quarters of IMPACT Act data, including standardized patient assessment data, quality measure data, resource use and claims data, before submitting his report to Congress. The legislation would require that the eight quarters of data could not include any month in which the COVID-19 public health emergency, or a similar nationwide public health emergency, is ongoing. The recommendations and technical prototype in the Secretary's report would also need to account for the role and value of each PAC provider-type during public health emergencies, including the COVID-19 public health emergency by, for example, looking at the proportion and acuity levels of COVID-19 patients treated in each PAC setting. If enacted, the Secretary's report would not be submitted before the later of January 1, 2024 or two years after the Secretary collects eight quarters of data.

Price Transparency

Starting January 1, 2021, new regulations went into effect requiring hospitals to provide clear and accessible pricing information online regarding the items and services they provide. First, a new regulation requires hospitals to provide a machine readable file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. Second, hospitals must provide a consumer-friendly display of standard charges for at least 300 "shoppable services" that consumers can schedule in advance. If a hospital does not offer 300 "shoppable services," then the hospital must provide the consumer-friendly display of standard charges for all of the "shoppable services" that it does provide. For each "shoppable service," hospitals must provide: discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. For hospitals that do not comply with these requirements, CMS may issue a warning notice, request a corrective action plan, and impose a civil monetary penalty that is publicized on the CMS website. These regulations were promulgated by the Trump administration and, on July 9, 2021, President Biden issued an Executive Order directing HHS to support the new price transparency regulations. On November 16, 2021, CMS issued a final rule that increased the maximum fines for hospitals that do not comply with the price transparency regulations. In 2021, non-compliant hospitals are subject to a fine of $300 per day. Beginning on January 1, 2022, non-compliant hospitals with 30 or fewer beds are still subject to a fine of $300 per day, not to exceed $2,007,500 per hospital per year. However, beginning January 1, 2022, non-complaint hospitals with 31 or more beds are subject to a fine in an amount that is equal to the number of hospital beds times 10, not to exceed $5,500 per day and $2,007,500 per year for each hospital. The maximum fine amounts are subject to increase annually using a multiplier determined by the Office of Management and Budget. CMS also revised its price transparency regulations to require that starting January 1, 2022, hospitals must make their standard charge information easily accessible without barriers. This includes providing the charge information in manner so that it can be accessed by automated searches and direct file downloads.

Surprise Billing

On July 13, 2021, HHS, the Department of the Treasury, the Department of Labor and the Office of Personnel Management published an interim final rule with comment period to implement certain provisions of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021. The interim final rule includes new regulations aimed at limiting surprise medical bills issued by health care providers to consumers. The HHS regulations adopted by this interim final rule are effective January 1, 2022 and apply to hospital emergency departments, freestanding emergency departments, health care providers and facilities, and providers of air ambulance services. The new regulations do not apply to patients covered by Medicare, Medicaid, Indian Health Services, Veterans Affairs health care, or TRICARE because these programs already prohibit balance billing.

Starting January 1, 2022, the interim final rule's new regulations will apply to patients with health insurance coverage from a group health plan (including a self-insured group health plan) or from an individual market health insurance issuer. First, if a plan provides coverage for emergency services, the interim final rule requires that emergency services must be covered: (1) without prior authorization; (2) regardless of whether the provider is an in-network provider or an in-network emergency facility; and (3) regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period. Second, the interim final rule includes new limits on patient cost-sharing obligations for out-of-network services. Specifically, patient cost-sharing amounts for emergency services provided by out-of-network emergency facilities and out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities, must be calculated based on one of the following amounts: (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) a specified state law if there is no such All-Payer Model Agreement; or (3) if neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan or issuer's median contracted rate. Third, the interim final rule prohibits non-participating providers, health care facilities, and providers of air ambulance services from balance billing participants, beneficiaries, and enrollees in certain situations. Fourth, the interim final rule establishes that the total amount to be paid to an out-of-network provider or facility, including any cost-sharing, is based on: (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) a specified state law if there is no such All-Payer Model Agreement; or (3) an amount agreed upon by the plan or issuer and the provider or facility if there is no such Agreement or state law. If none of these three circumstances apply, then the amount is determined by an independent dispute resolution ("IDR") entity. Fifth, a new regulation requires providers and facilities to make publicly available and provide patients with a one-page notice regarding the requirements and prohibitions applicable to the provider or facility regarding balance billing, any applicable state balance billing prohibitions or limitations, and information on how to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements described in the notice. Finally, the interim final rule establishes a process for HHS to receive and resolve complaints regarding information that any health care provider, provider of air ambulance services, or health care facility may be failing to meet the requirements set forth in the interim final rule. Because these new regulations were adopted through an interim final rule with comment period, they may be modified after CMS reviews public comments. The comment period closed on September 7, 2021.

In a separate interim final rule published on October 7, 2021, HHS, the Department of the Treasury, the Department of Labor and the Office of Personnel Management adopted regulations that will govern the IDR process that will be available to providers and insurers that are unable to agree on the payment rate for out-of-network providers. These new regulations are effective starting on January 1, 2022. The new IDR process presumes that the qualifying payment amount ("QPA") is the appropriate payment rate for an out-of-network service. Accordingly, the new IDR regulations require arbitrators to choose the offer that is closest to the QPA, unless the arbitrator determines that a party has credible information demonstrating that the QPA is "materially different" from the appropriate out-of-network rate for the item or service. The factors the arbitrator may consider to determine if the QPA is not the appropriate rate include: (1) the provider's training, experience, and quality and outcome measurements; (2) the provider's market share in the region; (3) patient acuity or the complexity of furnishing the item or service to the patient; (4) the provider's teaching status, case mix, and scope of services offered; and (5) whether the provider or the plan engaged in good faith efforts to enter into a network agreement. Separate regulations in this interim final rule address a dispute resolution process for uninsured patients who receive a good faith estimate of expected charges from a provider, but are then billed an amount that substantially exceeds the estimated charges. When the provider's billed charges are more than $400 greater than the good faith estimate, an uninsured patient may initiate a patient-provider dispute resolution process by submitting a notification to HHS within 120 days of receiving the provider's bill. The dispute resolution entity will then examine whether the provider has credible information demonstrating that the excess charges are attributable to unforeseen circumstances that the provider could not have reasonably anticipated when the provider made the good faith estimate. The regulations for both the provider-insurer IDR process and the provider-patient dispute resolution process could be revised in response to comments submitted to the agencies issuing this interim final rule. The comment period closed on December 6, 2021.

Compliance Program

Our Compliance Program

We maintain a written code of conduct (the "Code of Conduct") that provides guidelines for principles and regulatory rules that are applicable to our patient care and business activities. The Code of Conduct is reviewed and amended as necessary and is the basis for our company-wide compliance program. These guidelines are implemented by our compliance officer, our compliance and audit committee, and are communicated to our employees through education and training. We also have established a reporting system, auditing and monitoring programs, and a disciplinary system as a means for enforcing the Code of Conduct's policies.

Compliance and Audit Committee

Our compliance and audit committee is made up of members of our senior management and in-house counsel. The compliance and audit committee meets, at a minimum, on a quarterly basis and reviews the activities, reports, and operation of our compliance program. In addition, our Privacy and Security Committee provides reports to the compliance and audit committee. Our vice president of compliance and audit services meets with the compliance and audit committee, at a minimum, on a quarterly basis to provide an overview of the activities and operation of our compliance program.

Operating Our Compliance Program

We focus on integrating compliance responsibilities with operational functions. We recognize that our compliance with applicable laws and regulations depends upon individual employee actions as well as company operations. As a result, we have adopted an operations team approach to compliance. Our corporate executives, with the assistance of corporate experts, designed the programs of the compliance and audit committee. We utilize facility leaders for employee-level implementation of our Code of Conduct. This approach is intended to reinforce our company-wide commitment to operate in accordance with the laws and regulations that govern our business.

Compliance Issue Reporting

In order to facilitate our employees' ability to report known, suspected, or potential violations of our Code of Conduct, we have developed a system of reporting. This reporting, anonymous or attributable, may be accomplished through our toll-free compliance hotline, compliance e-mail address, or our compliance post office box. Our compliance officer and the compliance and audit committee are responsible for reviewing and investigating each compliance incident in accordance with the compliance and audit services department's investigation policy.

Compliance Monitoring and Auditing / Comprehensive Training and Education

Monitoring reports and the results of compliance for each of our business segments are reported to the compliance and audit committee, at a minimum, on a quarterly basis. We train and educate our employees regarding the Code of Conduct, as well as the legal and regulatory requirements relevant to each employee's work environment. New and current employees are required to acknowledge and certify that the employee has read, understood, and has agreed to abide by the Code of Conduct. Additionally, all employees are required to re-certify compliance with the Code of Conduct on an annual basis.

Policies and Procedures Reflecting Compliance Focus Areas

We review our policies and procedures for our compliance program from time to time in order to improve operations and to promote compliance with requirements of standards, laws, and regulations and to reflect the ongoing compliance focus areas which have been identified by the compliance and audit committee.

Internal Audit

We have a compliance and audit department, which has an internal audit function. Our vice president of compliance and audit services manages the combined compliance and audit department and meets with the audit and compliance committee of our board of directors, at a minimum, on a quarterly basis to discuss audit results and provide an overview of the activities and operation of our compliance program.

Available Information

We are subject to the information and periodic reporting requirements of the Securities Exchange Act of 1934 and, in accordance therewith, file periodic reports, proxy statements, and other information, including our Code of Conduct, with the SEC. Such periodic reports, proxy statements, and other information are available on the SEC's website at www.sec.gov.

Our website address is www.selectmedicalholdings.com and can be used to access free of charge, through the investor relations section, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and any amendments to those reports, as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. The information on our website is not incorporated as a part of this annual report.

Executive Officers of the Registrant

The following table sets forth the names, ages and titles, as well as a brief account of the business experience, of each person who was an executive officer of the Company as of February 24, 2022:

Name	Age	Position
Robert A. Ortenzio	64	Executive Chairman and Co-Founder
Rocco A. Ortenzio	89	Vice Chairman and Co-Founder
David S. Chernow	64	President and Chief Executive Officer
Martin F. Jackson	67	Executive Vice President and Chief Financial Officer
John A. Saich	53	Executive Vice President and Chief Administrative Officer
Michael E. Tarvin	61	Executive Vice President, General Counsel and Secretary
Scott A. Romberger	61	Senior Vice President and Chief Accounting Officer
Robert G. Breighner, Jr.	53	Vice President, Compliance and Audit Services and Corporate Compliance Officer
Thomas P. Mullin	38	Executive Vice President, Hospital Operations

Robert A. Ortenzio has served as our Executive Chairman and Co-Founder since January 1, 2014. Mr. Ortenzio co-founded Select and has served as a director of Select since February 1997, and became a director of the Company in February 2005. Mr. Ortenzio served as the Company's Chief Executive Officer from January 1, 2005 to December 31, 2013 and as Select's President and Chief Executive Officer from September 2001 to January 1, 2005. Mr. Ortenzio also served as Select's President and Chief Operating Officer from February 1997 to September 2001. Mr. Ortenzio also currently serves on the board of directors of Concentra Group Holdings Parent. He was an Executive Vice President and a director of Horizon/CMS Healthcare Corporation from July 1995 until July 1996. In 1986, Mr. Ortenzio co-founded Continental Medical Systems, Inc., and served in a number of different capacities, including as a Senior Vice President from February 1986 until April 1988, as Chief Operating Officer from April 1988 until July 1995, as President from May 1989 until August 1996 and as Chief Executive Officer from July 1995 until August 1996. Before co-founding Continental Medical Systems, Inc., he was a Vice President of Rehab Hospital Services Corporation. Mr. Ortenzio is the son of Rocco A. Ortenzio, our Vice Chairman and Co-Founder.

Rocco A. Ortenzio has served as our Vice Chairman and Co-Founder since January 1, 2014. Mr. Ortenzio co-founded Select and served as Select's Chairman and Chief Executive Officer from February 1997 until September 2001. Mr. Ortenzio served as Select's Executive Chairman from September 2001 until December 2013, and Executive Chairman of the Company from February 2005 until December 2013. In 1986, he co-founded Continental Medical Systems, Inc., and served as its Chairman and Chief Executive Officer until July 1995. In 1979, Mr. Ortenzio founded Rehab Hospital Services Corporation, and served as its Chairman and Chief Executive Officer until June 1986. In 1969, Mr. Ortenzio founded Rehab Corporation and served as its Chairman and Chief Executive Officer until 1974. Mr. Ortenzio is the father of Robert A. Ortenzio, the Company's Executive Chairman and Co-Founder.

David S. Chernow has served as our President and Chief Executive Officer since January 1, 2014. Mr. Chernow has served as our President and previously held various executive officer titles since September 2010. Mr. Chernow served as a director of the Company from January 2002 until February 2005 and from August 2005 until September 2010. Mr. Chernow also serves on the board of directors of Concentra Group Holdings Parent. From May 2007 to February 2010, Mr. Chernow served as the President and Chief Executive Officer of Oncure Medical Corp., one of the largest providers of free-standing radiation oncology care in the United States. From July 2001 to June 2007, Mr. Chernow served as the President and Chief Executive Officer of JA Worldwide, a nonprofit organization dedicated to the education of young people about business (formerly, Junior Achievement, Inc.). From 1999 to 2001, he was the President of the Physician Services Group at US Oncology, Inc. Mr. Chernow co-founded American Oncology Resources in 1992 and served as its Chief Development Officer until the time of the merger with Physician Reliance Network, Inc., which created US Oncology, Inc. in 1999.

Martin F. Jackson has served as our Executive Vice President and Chief Financial Officer since February 2007. He served as our Senior Vice President and Chief Financial Officer from May 1999 to February 2007. Mr. Jackson also serves on the board of directors of Concentra Group Holdings Parent. Mr. Jackson previously served as a Managing Director in the Health Care Investment Banking Group for CIBC Oppenheimer from January 1997 to May 1999. Prior to that time, he served as Senior Vice President, Health Care Finance with McDonald & Company Securities, Inc. from January 1994 to January 1997. Prior to 1994, Mr. Jackson held senior financial positions with Van Kampen Merritt, Touche Ross, Honeywell and L'Nard Associates.

John A. Saich has served as our Executive Vice President and Chief Administrative Officer since October 1, 2018. He served as our Executive Vice President and Chief Human Resources Officer from December 2010 to September 2018. He served as our Senior Vice President, Human Resources from February 2007 to December 2010. He served as our Vice President, Human Resources from November 1999 to January 2007. He joined the Company as Director, Human Resources and HRIS in February 1998. Previously, Mr. Saich served as Director of Benefits and Human Resources for Integrated Health Services in 1997 and as Director of Human Resources for Continental Medical Systems, Inc. from August 1993 to January 1997.

Michael E. Tarvin has served as our Executive Vice President, General Counsel and Secretary since February 2007. He served as our Senior Vice President, General Counsel and Secretary from November 1999 to February 2007. He served as our Vice President, General Counsel and Secretary from February 1997 to November 1999. He was Vice President—Senior Counsel of Continental Medical Systems from February 1993 until February 1997. Prior to that time, he was Associate Counsel of Continental Medical Systems from March 1992. Mr. Tarvin was an associate at the Philadelphia law firm of Drinker Biddle & Reath LLP from September 1985 until March 1992.

Scott A. Romberger has served as our Senior Vice President and Chief Accounting Officer since January 2021. He served as our Senior Vice President, Controller and Chief Accounting Officer from February 2007 to January 2021. He served as our Vice President, Controller and Chief Accounting Officer from December 2000 to February 2007. In addition, he served as our Vice President and Controller from February 1997 to December 2000. Prior to February 1997, he was Vice President—Controller of Continental Medical Systems from January 1991 until January 1997. Prior to that time, he served as Acting Corporate Controller and Assistant Controller of Continental Medical Systems from June 1990 and December 1988, respectively. Mr. Romberger is a certified public accountant and was employed by a national accounting firm from April 1985 until December 1988.

Robert G. Breighner, Jr. has served as our Vice President, Compliance and Audit Services since August 2003. He served as our Director of Internal Audit from November 2001 to August 2003. Previously, Mr. Breighner was Director of Internal Audit for Susquehanna Pfaltzgraff Co. from June 1997 until November 2001. Mr. Breighner held other positions with Susquehanna Pfaltzgraff Co. from May 1991 until June 1997.

Thomas P. Mullin has served as our Executive Vice President, Hospital Operations since August 2020. He served as the President of our Specialty Hospital Divisions from November 2018 to August 2020. He served as Chief Operating Officer of our Specialty Hospital Divisions from January 2018 to November 2018. He served as Chief Operating Officer of our CIRH Division from October 2016 to January 2018. Mr. Mullin served as Senior Vice President, Business and Market Development in our CIRH Division from July 2015 to September 2016. He served as Regional Vice President in our CIRH Division from September 2014 to July 2015. He held other positions in our CIRH Division from June 2008 to September 2014.

Item 1A. ***Risk Factors***.

In addition to the factors discussed elsewhere in this Form 10-K, the following are important factors which could cause actual results or events to differ materially from those contained in any forward-looking statements made by or on behalf of us.

Risks Related to Our Business

The unpredictable effects of the COVID-19 pandemic, including the duration and extent of disruption on our operations, creates uncertainties about our future operating results and financial condition.

Over the past two years, the COVID-19 pandemic has had an impact on our business and results of operations, financial position, and cash flows. Its continuing impact on our business operations and financial condition will depend on a number of evolving factors and future developments that we are not able to predict, including, but not limited to, the duration of the outbreak; further actions by governmental authorities and the private sector to limit the spread of COVID-19; continued encouragement to social distance; and the economic impact of containment efforts on patients and communities we serve. Though availability of vaccines and reopening of state and local economies has improved the outlook for recovery from COVID-19's impacts, the impact of the Delta or Omicron variant or other new, more contagious or lethal variants that may emerge, the effectiveness of COVID-19 vaccines against the Delta, Omicron, or other variants and the related responses by governments, including reinstated government-imposed lockdowns or other measures, cannot be predicted at this time.

Our critical illness recovery hospitals and rehabilitation hospitals may continue to experience constrained staffing levels and increased operating costs resulting from increased usage of contract clinical labor due to the overwhelming need for healthcare professionals, particularly in areas that are heavily impacted by the COVID-19 pandemic. Moreover, a shortage in labor due to quarantined employees, employees choosing not to return to work and increased labor costs could result from the latest variants of COVID-19. Our hospitals may experience increased operating costs resulting from shortages of medical supplies, including personal protective equipment, and supply chain disruptions. The payments we have received under the Public Health and Social Services Emergency Fund, also referred to as the Provider Relief Fund, for health care related expenses and lost revenues attributable to the COVID-19 pandemic have partially mitigated these issues. It is expected, however, that additional Provider Relief Funds will not be available to offset increased operating costs our hospitals have experienced and may continue to experience in the future.

In our outpatient rehabilitation clinics and Concentra centers, we may experience declines in demand for our services if governmental authorities resume mandates requiring the temporary closure of non-essential and non-life sustaining businesses. Our outpatient rehabilitation clinics may experience reductions in patient volume if governmental authorities suspend elective surgeries that normally increase the demand for outpatient services or if the operations of our referral sources experience disruption as a result of the COVID-19 pandemic. Our clinics may experience a decline in workers' compensation injury visits and our Concentra centers may experience a reduction in workers' compensation and employer services visits as a result of business furloughs, employee quarantines, government vaccine mandates, or the temporary cessation or reduction of business operations.

Adverse economic conditions in the U.S. or globally could adversely affect us.

We are subject to the risks arising from adverse conditions in the general economy. A U.S. or global recession or prolonged economic downturn could negatively impact our current and prospective patients, adversely affect the financial ability of health insurers to pay claims, adversely impact our ability to pay our expenses, and limit our ability to obtain financing for our operations. Healthcare spending in the U.S. could be negatively affected in the event of a downturn in economic conditions. For example, U.S. patients who have lost their jobs or healthcare coverage may no longer be covered by an employer-sponsored health insurance plan, and patients reducing their overall spending may elect to decrease the frequency of visits to our facilities or forgo elective treatments or procedures, thereby reducing demand for our services.

We could experience significant increases in costs for healthcare professionals due to labor shortages or union activity.

We have experienced and may continue to experience increased operating costs due to increased employee-related costs. A number of factors contribute to increased labor costs, such as constrained staffing due to a shortage of healthcare workers, increased dependence on contract clinical workers, the loss of unvaccinated employees in jurisdictions requiring vaccination, federal unemployment subsidies, including unemployment benefits offered in response to the COVID-19 pandemic, and other government regulations, which include laws and regulations related to workers' health and safety.

Our critical illness recovery hospitals and our rehabilitation hospitals are highly dependent on nurses, our outpatient rehabilitation division is highly dependent on therapists for patient care, and Concentra is highly dependent upon the ability of its affiliated professional groups to recruit and retain qualified physicians and other licensed providers. The market for qualified healthcare professionals is highly competitive. We have sometimes experienced difficulties in attracting and retaining qualified healthcare personnel and sometimes are forced to use agency clinical staff in our facilities, which can increase our costs and lower our margins. We cannot assure we will be able to attract and retain qualified healthcare professionals in the future. Additionally, the cost of attracting and retaining qualified healthcare personnel may be higher than we anticipate, and as a result, our profitability could decline. Labor shortages have also become more pronounced as a result of the COVID-19 pandemic. Increased turnover rates within our employee base can lead to decreased efficiency and increased costs, such as increased overtime to meet demand and increased wage rates to attract and retain employees. There is no guarantee that the increase in labor costs will not continue in the future and, as a result, our profitability could decline.

In addition, United States healthcare providers are continuing to see an increase in the amount of union activity. Though we cannot predict the degree to which we will be affected by future union activity, there may be legislative or executive actions that could result in increased union activity.

If the frequency of workplace injuries and illnesses decline, Concentra's results may be negatively affected.

Approximately 56% of Concentra's revenue in 2021 was generated from the treatment of workers' compensation claims. Concentra's business model is based, in part, on its ability to expand its relative share of the market for the treatment of claims for workplace injuries and illnesses. A recession or prolonged economic contraction as a result of the COVID-19 pandemic could cause the workforce to decline, which may cause declines in workers' compensation claims. In addition, because of the greater access to health insurance and the fact that the United States economy has continued to shift from a manufacturing-based to a service-based economy along with general improvements in workplace safety, workers are generally healthier and less prone to work injuries. Increases in employer-sponsored wellness and health promotion programs have led to fitter and healthier employees who may be less likely to injure themselves on the job. If workplace injuries and illnesses decline at a greater rate than the increase in total employment, or if total employment declines at a greater rate than the increase in incident rates, the number of claims in the workers' compensation market will decrease and may adversely affect Concentra's business.

If Concentra loses several significant employer customers or payor contracts, its results may be adversely affected.

Concentra's results may decline if it loses several significant employer customers or payor contracts. One or more of Concentra's significant employer customers could be acquired. Additionally, Concentra could lose significant employer customers or payor contracts due to competitive pricing pressures or other reasons. The loss of several significant employer customers or payor contracts could cause a material decline in Concentra's profitability and operating performance.

If there are changes in the rates or methods of Medicare reimbursements for our services, our revenue and profitability could decline.

Approximately 26% of our revenue for the year ended December 31, 2019, 25% of our revenue for the year ended December 31, 2020, and 23% of our revenue for the year ended December 31, 2021, came from the highly regulated federal Medicare program.

In recent years, through legislative and regulatory actions, the federal government has made substantial changes to various payment systems under the Medicare program. President Obama signed into law comprehensive reforms to the healthcare system, including changes to the methods for, and amounts of, Medicare reimbursement. Additional reforms or other changes to these payment systems, including modifications to the conditions on qualification for payment, bundling payments to cover both acute and post-acute care, or the imposition of enrollment limitations on new providers, may be proposed or could be adopted, either by Congress or CMS.

If revised regulations are adopted, the availability, methods, and rates of Medicare reimbursements for services of the type furnished at our facilities could change. Reductions in Medicare reimbursements could also adversely affect payments under some of our commercial payor contracts that follow Medicare payment methodologies. For example, the rules and regulations related to patient criteria for our critical illness recovery hospitals could become more stringent and reduce the number of patients we admit. Some of these changes and proposed changes could adversely affect our business strategy, operations, and financial results. In addition, there can be no assurance that any increases in Medicare reimbursement rates established by CMS will fully reflect increases in our operating costs.

We conduct business in a heavily regulated industry, and changes in regulations, new interpretations of existing regulations, or violations of regulations may result in increased costs or sanctions that reduce our revenue and profitability.

The healthcare industry is subject to extensive federal, state, and local laws and regulations relating to: (i) facility and professional licensure, including certificates of need; (ii) conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse, and physician self-referral; (iii) addition of facilities and services and enrollment of newly developed facilities in the Medicare program; (iv) payment for services; and (v) safeguarding protected health information.

Both federal and state regulatory agencies inspect, survey, and audit our facilities to review our compliance with these laws and regulations. While our facilities intend to comply with existing licensing, Medicare certification requirements, and accreditation standards, there can be no assurance that these regulatory authorities will determine that all applicable requirements are fully met at any given time. A determination by any of these regulatory authorities that a facility is not in compliance with these requirements could lead to the imposition of requirements that the facility takes corrective action, assessment of fines and penalties, or loss of licensure, Medicare certification, or accreditation. These consequences could have an adverse effect on our company.

In addition, there have been heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry. The ongoing investigations relate to, among other things, various referral practices, billing practices, and physician ownership. In the future, different interpretations or enforcement of these laws and regulations could subject us to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, and capital expenditure programs. These changes may increase our operating expenses and reduce our operating revenues. If we fail to comply with these extensive laws and government regulations, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties, or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to any related investigation or other enforcement action.

If our critical illness recovery hospitals fail to maintain their certifications as LTCHs or if our facilities operated as HIHs fail to qualify as hospitals separate from their host hospitals, our revenue and profitability may decline.

As of December 31, 2021, we operated 104 critical illness recovery hospitals, all of which are currently certified by Medicare as LTCHs. LTCHs must meet certain conditions of participation to enroll in, and seek payment from, the Medicare program as an LTCH, including, among other things, maintaining an average length of stay for Medicare patients in excess of 25 days. An LTCH that fails to maintain this average length of stay for Medicare patients in excess of 25 days during a single cost reporting period is generally allowed an opportunity to show that it meets the length of stay criteria during a subsequent cure period. If the LTCH can show that it meets the length of stay criteria during this cure period, it will continue to be paid under the LTCH-PPS. If the LTCH again fails to meet the average length of stay criteria during the cure period, it will be paid under the general acute care IPPS at rates generally lower than the rates under the LTCH-PPS.

While CMS has issued temporary waivers that exempt LTCHs from the 25 day average length of stay requirement for all cost reporting periods that include the COVID-19 pandemic health emergency, to the extent such waivers are lifted, LTCHs will again be required to comply with this rule. See "*Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes*."

Similarly, our HIHs must meet conditions of participation in the Medicare program, which include additional criteria establishing separateness from the hospital with which the HIH shares space. If our critical illness recovery hospitals fail to meet or maintain the standards for certification as LTCHs, they will receive payment under the general acute care hospitals IPPS which is generally lower than payment under the system applicable to LTCHs. Payments at rates applicable to general acute care hospitals would result in our hospitals receiving significantly less Medicare reimbursement than they currently receive for their patient services.

Decreases in Medicare reimbursement rates received by our outpatient rehabilitation clinics may reduce our future revenue and profitability.

Our outpatient rehabilitation clinics receive payments from the Medicare program under the Medicare physician fee schedule. In the calendar year 2022 physician fee schedule final rule, CMS announced that Medicare payments for the therapy specialty are expected to decrease 1% in 2022. After CMS issued the final rule, Congress passed the Protecting Medicare and American Farmers from Sequester Cuts Act, which provided in Section 3 a one-time 3% increase in payments in calendar year 2022 to offset most of the 3.75% cut to payments for therapy services and other services paid under the physician fee schedule that otherwise would have occurred in calendar year 2022.

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 requires that payments under the physician fee schedule be adjusted starting in 2019 based on performance in a MIPS and additional incentives for participation in APMs. The specifics of the MIPS and incentives for participation in APMs will be subject to future notice and comment rule-making. In 2019, CMS added physical and occupational therapists to the list of MIPS eligible clinicians. For these therapists in private practice, payments under the fee schedule are subject to adjustment in a later year based on their performance in MIPS according to established performance standards. Calendar year 2021 is the first year that payments are adjusted, based upon the therapist's performance under MIPS in 2019. Each year from 2019 through 2024 eligible clinicians who receive a significant share of their revenues through an advanced APM (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus. The bonus payment for APM participation is intended to encourage participation and testing of new APMs and to promote the alignment of incentives across payors. Providers in facility-based outpatient therapy settings are excluded from MIPS eligibility and therefore not subject to this payment adjustment. It is unclear what impact, if any, the MIPS and incentives for participation in alternative payment models will have on our business and operating results, but any resulting administrative burden or decrease in payment may reduce our future revenue and profitability.

In the calendar year 2022 physician fee schedule final rule, CMS also adopted its plan to transition the MIPS program to MVPs. CMS will begin the transition to MVPs in 2023 with an initial set of MVPs in which reporting is voluntary. Beginning in 2026, multispecialty groups must form subgroups to report MVPs. CMS plans to develop more MVPs from 2024 to 2027 and is considering that MVP reporting would become mandatory in 2028. Each MVP would include population health claims-based measures and require clinicians to report on the Promoting Interoperability performance category measures. In addition, MVP participants would select certain quality measures and improvement activities and then report data for such measures and activities. At this time, it is unclear the impact that the transition to MVPs will have on our business and operating results, however, any resulting administrative burden or decrease in reimbursement rates may reduce our future revenue and profitability.

The nature of the markets that Concentra serves may constrain its ability to raise prices at rates sufficient to keep pace with the inflation of its costs.

Rates of reimbursement for work-related injury or illness visits in Concentra's occupational health services business are established through a legislative or regulatory process within each state that Concentra serves. Currently, 36 states in which Concentra has operations have fee schedules pursuant to which all healthcare providers are uniformly reimbursed. The fee schedules are determined by each state and generally prescribe the maximum amounts that may be reimbursed for a designated procedure. In the states without fee schedules, healthcare providers are generally reimbursed based on usual, customary and reasonable rates charged in the particular state in which the services are provided. Given that Concentra does not control these processes, it may be subject to financial risks if individual jurisdictions reduce rates or do not routinely raise rates of reimbursement in a manner that keeps pace with the inflation of Concentra's costs of service.

If our rehabilitation hospitals fail to comply with the 60% Rule or admissions to IRFs are limited due to changes to the diagnosis codes on the presumptive compliance list, our revenue and profitability may decline.

As of December 31, 2021, we operated 30 rehabilitation hospitals, all of which were certified as Medicare providers and operating as IRFs. Our rehabilitation hospitals must meet certain conditions of participation to enroll in, and seek payment from, the Medicare program as an IRF. Among other things, at least 60% of the IRF's total inpatient population must require treatment for one or more of 13 conditions specified by regulation. This requirement is now commonly referred to as the "60% Rule." Compliance with the 60% Rule is demonstrated through a two-step process. The first step is the "presumptive" method, in which patient diagnosis codes are compared to a "presumptive compliance" list. IRFs that fail to demonstrate compliance with the 60% Rule using this presumptive test may demonstrate compliance through a second step involving an audit of the facility's medical records to assess compliance.

If an IRF does not demonstrate compliance with the 60% Rule by either the presumptive method or through a review of medical records, then the facility's classification as an IRF may be terminated at the start of its next cost reporting period causing the facility to be paid as a general acute care hospital under IPPS. If our rehabilitation hospitals fail to demonstrate compliance with the 60% Rule through both methods and are classified as general acute care hospitals, our revenue and profitability may be adversely affected.

CMS has issued temporary waivers in response to the COVID-19 pandemic that allow IRFs, IRF units and hospitals and units applying to be classified as IRFs to exclude patients admitted solely to respond to the public health emergency from the 60% Rule. If such waivers are lifted, our IRFs will again be required to comply with the requirements of the 60% Rule. See "*Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes*."

As a result of post-payment reviews of claims we submit to Medicare for our services, we may incur additional costs and may be required to repay amounts already paid to us.

We are subject to regular post-payment inquiries, investigations, and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews include medical necessity reviews for Medicare patients admitted to LTCHs and IRFs, and audits of Medicare claims under the Recovery Audit Contractor program. These post-payment reviews may require us to incur additional costs to respond to requests for records and to pursue the reversal of payment denials, and ultimately may require us to refund amounts paid to us by Medicare that are determined to have been overpaid.

Most of our critical illness recovery hospitals are subject to short-term leases, and the loss of multiple leases close in time could materially and adversely affect our business, financial condition, and results of operations.

We lease most of our critical illness recovery hospitals under short-term leases with terms of less than ten years. These leases often do not have favorable renewal options and generally cannot be renewed or extended without the written consent of the landlords thereunder. If we cannot renew or extend a significant number of our existing leases, or if the terms for lease renewal or extension offered by landlords on a significant number of leases are unacceptable to us, then the loss of multiple leases close in time could materially and adversely affect our business, financial condition, and results of operations.

Our facilities are subject to extensive federal and state laws and regulations relating to the privacy of individually identifiable information.

HIPAA required the United States Department of Health and Human Services to adopt standards to protect the privacy and security of individually identifiable health information. The department released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. The privacy regulations extensively regulate the use and disclosure of individually identifiable health information. The regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. The security regulations require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically. HITECH, which was signed into law in February 2009, enhanced the privacy, security, and enforcement provisions of HIPAA by, among other things, establishing security breach notification requirements, allowing enforcement of HIPAA by state attorneys general, and increasing penalties for HIPAA violations. Violations of HIPAA or HITECH could result in civil or criminal penalties. For example, HITECH permits HHS to conduct audits of HIPAA compliance and impose penalties even if we did not know or reasonably could not have known about the violation and increases civil monetary penalty amounts up to $50,000 per violation with a maximum of $1.5 million in a calendar year for violations of the same requirement.

In addition to HIPAA, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access, or theft of patient's identifiable health information. State statutes and regulations vary from state to state. Lawsuits, including class actions and action by state attorneys general, directed at companies that have experienced a privacy or security breach also can occur.

In the conduct of our business, we process, maintain, and transmit sensitive data, including our patient's individually identifiable health information. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy laws. Our compliance officer, privacy officer, and information security officer are responsible for implementing and monitoring compliance with our privacy and security policies and procedures at our facilities. We believe that the cost of our compliance with HIPAA and other federal and state privacy laws will not have a material adverse effect on our business, financial condition, results of operations, or cash flows. However, there can be no assurance that a breach of privacy or security will not occur. If there is a breach, we may be subject to various lawsuits, penalties and damages and may be required to incur costs to mitigate the impact of the breach on affected individuals.

We may be adversely affected by a security breach of our, or our third-party vendors', information technology systems, such as a cyber attack, which may cause a violation of HIPAA or HITECH and subject us to potential legal and reputational harm.

In the normal course of business, our information technology systems hold sensitive patient information including patient demographic data, eligibility for various medical plans including Medicare and Medicaid, and protected health information, which is subject to HIPAA and HITECH. Additionally, we utilize those same systems to perform our day-to-day activities, such as receiving referrals, assigning medical teams to patients, documenting medical information, maintaining an accurate record of all transactions, processing payments, and maintaining our employee's personal information. We also contract with third-party vendors to maintain and store our patient's individually identifiable health information. Numerous state and federal laws and regulations address privacy and information security concerns resulting from our access to our patients' and employees' personal information.

Our information technology systems and those of our vendors that process, maintain, and transmit such data are subject to computer viruses, cyber attacks, or breaches. We adhere to policies and procedures designed to promote compliance with HIPAA and other privacy and information security laws and require our third-party vendors to do so as well. Failure to maintain the security and functionality of our information systems and related software, or to defend a cybersecurity attack or other attempt to gain unauthorized access to our or third-party's systems, facilities, or patient health information could expose us to a number of adverse consequences, including but not limited to disruptions in our operations, regulatory and other civil and criminal penalties, reputational harm, investigations and enforcement actions (including, but not limited to, those arising from the SEC, Federal Trade Commission, the OIG or state attorneys general), fines, litigation with those affected by the data breach, loss of customers, disputes with payors, and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations, and liquidity. Although we maintain cyber liability insurance to protect us from losses related to cyber attacks and breaches, not every risk or liability can be insured, and for risks that are insurable, our policy limits and terms of coverage may not be sufficient to cover all actual losses or liabilities incurred.

Furthermore, while our information technology systems, and those of our third-party vendors, are maintained with safeguards protecting against cyber attacks, including passive intrusion protection, firewalls, and virus detection software, these safeguards do not ensure that a significant cyber attack could not occur. A cyber attack that bypasses our information technology security systems, or those of our third-party vendors, could cause the loss of protected health information, or other data subject to privacy laws, the loss of proprietary business information, or a material disruption to our or a third-party vendor's information technology business systems resulting in a material adverse effect on our business, financial condition, results of operations, or cash flows. In addition, our future results could be adversely affected due to the theft, destruction, loss, misappropriation, or release of protected health information, other confidential data or proprietary business information, operational or business delays resulting from the disruption of information technology systems and subsequent clean-up and mitigation activities, negative publicity resulting in reputation or brand damage with clients, members, or industry peers, or regulatory action taken as a result of such incident. We provide our employees annual training and regular reminders on important measures they can take to prevent breaches and other cyber threats. We routinely identify attempts to gain unauthorized access to our systems. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent, or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. For example, it has been widely reported that many well-organized international interests, in certain cases with the backing of sovereign governments, are targeting the theft of patient information through the use of advance persistent threats. Similarly, in recent years, several hospitals have reported being the victim of ransomware attacks in which they lost access to their systems, including clinical systems, during the course of the attacks. While we are not aware of having experienced a material cyber breach or attack to date, we are likely to face attempted attacks in the future. Accordingly, we may be vulnerable to losses associated with the improper functioning, security breach, or unavailability of our information systems as well as any systems used in acquired operations.

Our acquisitions require transitions and integration of various information technology systems, and we regularly upgrade and expand our information technology systems' capabilities. If we experience difficulties with the transition and integration of these systems or are unable to implement, maintain, or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory problems, working capital disruptions, and increases in administrative expenses. While we make significant efforts to address any information security issues and vulnerabilities with respect to the companies we acquire, we may still inherit risks of security breaches or other compromises when we integrate these companies within our business.

Quality reporting requirements may negatively impact Medicare reimbursement.

The IMPACT Act requires the submission of standardized data by certain healthcare providers. Specifically, the IMPACT Act requires, among other significant activities, that LTCHs, IRFs, SNFs, and HHAs report standardized patient assessment data to CMS for cross-setting quality measures, resource use measures, and standardized patient assessment data elements. To the extent that such reporting requirements have been incorporated into the Medicare quality reporting programs, failure to report such data as required will subject providers to a 2% reduction to their annual payment update for the fiscal year that follows the reporting period. As CMS adds new measures to the Medicare quality reporting programs to implement the IMPACT Act, the burden to report data increases. It is expected that when CMS adopts all of the new measures associated with the IMPACT Act, provider reporting obligations will be quite burdensome. The adoption of these and additional quality reporting measures for our hospitals to track and report will require additional time and expense and could affect reimbursement in the future. In healthcare generally, the burdens associated with collecting, recording, and reporting quality data are increasing.

There can be no assurance that all of our hospitals will continue to meet quality reporting requirements in the future which may result in one or more of our hospitals seeing a reduction in its Medicare reimbursements. Regardless, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

CMS also adopted revised discharge planning requirements for hospitals in 2019 that focus on patients' goals and preferences and on preparing them and, as appropriate, their caregivers, to be active partners in their post-discharge care. As part of these updates to the discharge planning process, CMS began requiring that hospitals assist patients in selecting a post-acute care provider by sharing quality measure and resource use measure data from LTCHs, IRFs, SNFs, and HHAs. The collection of data for these quality and resource use measures, and the use of these data in the discharge planning process at hospitals, has the potential to affect admission patterns at our LTCHs and IRFs.

We may be adversely affected by negative publicity which can result in increased governmental and regulatory scrutiny and possibly adverse regulatory changes.

Negative press coverage, including about the industries in which we currently operate, can result in increased governmental and regulatory scrutiny and possibly adverse regulatory changes. Adverse publicity and increased governmental scrutiny can have a negative impact on our reputation with referral sources and patients and on the morale and performance of our employees, both of which could adversely affect our businesses and results of operations.

Current and future acquisitions may use significant resources, may be unsuccessful, and could expose us to unforeseen liabilities.

As part of our growth strategy, we may pursue acquisitions of critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, and other related healthcare facilities and services. These acquisitions, may involve significant cash expenditures, debt incurrence, additional operating losses and expenses, and compliance risks that could have a material adverse effect on our financial condition and results of operations.

We may not be able to successfully integrate our acquired businesses into ours, and therefore, we may not be able to realize the intended benefits from an acquisition. If we fail to successfully integrate acquisitions, our financial condition and results of operations may be materially adversely affected. These acquisitions could result in difficulties integrating acquired operations, technologies, and personnel into our business. Such difficulties may divert significant financial, operational, and managerial resources from our existing operations and make it more difficult to achieve our operating and strategic objectives. We may fail to retain employees or patients acquired through these acquisitions, which may negatively impact the integration efforts. These acquisitions could also have a negative impact on our results of operations if it is subsequently determined that goodwill or other acquired intangible assets are impaired, thus resulting in an impairment charge in a future period.

In addition, these acquisitions involve risks that the acquired businesses will not perform in accordance with expectations; that we may become liable for unforeseen financial or business liabilities of the acquired businesses, including liabilities for failure to comply with healthcare regulations; that the expected synergies associated with acquisitions will not be achieved; and that business judgments concerning the value, strengths, and weaknesses of businesses acquired will prove incorrect, which could have a material adverse effect on our financial condition and results of operations.

Future joint ventures may use significant resources, may be unsuccessful, and could expose us to unforeseen liabilities.

As part of our growth strategy, we have partnered and may partner with large healthcare systems to provide post-acute care services. These joint ventures have included and may involve significant cash expenditures, debt incurrence, additional operating losses and expenses, and compliance risks that could have a material adverse effect on our financial condition and results of operations.

A joint venture involves the combining of corporate cultures and mission. As a result, we may not be able to successfully operate a joint venture, and therefore, we may not be able to realize the intended benefits. If we fail to successfully execute a joint venture relationship, our financial condition and results of operations may be materially adversely affected. A new joint venture could result in difficulties in combining operations, technologies, and personnel. Such difficulties may divert significant financial, operational, and managerial resources from our existing operations and make it more difficult to achieve our operating and strategic objectives. We may fail to retain employees or patients as a result of the integration efforts.

A joint venture is operated through a board of directors that contains representatives of Select and other parties to the joint venture. We may not control the board of certain joint ventures and, as a result, such joint ventures may take certain actions that could have adverse effects on our financial condition and results of operations.

If we fail to compete effectively with other hospitals, clinics, occupational health centers, and healthcare providers in the local areas we serve, our revenue and profitability may decline.

The healthcare business is highly competitive, and we compete with other hospitals, rehabilitation clinics, occupational health centers, and other healthcare providers for patients. If we are unable to compete effectively in the critical illness recovery, rehabilitation hospital, outpatient rehabilitation, and occupational health services businesses, our ability to retain customers and physicians, or maintain or increase our revenue growth, price flexibility, control over medical cost trends, and marketing expenses may be compromised and our revenue and profitability may decline.

Many of our critical illness recovery hospitals and our rehabilitation hospitals operate in geographic areas where we compete with at least one other facility that provides similar services.

Our outpatient rehabilitation clinics face competition from a variety of local and national outpatient rehabilitation providers, including physician-owned physical therapy clinics, dedicated locally owned and managed outpatient rehabilitation clinics, and hospital or university owned or affiliated ventures, as well as national and regional providers in select areas. Other competing outpatient rehabilitation clinics in local areas we serve may have greater name recognition and longer operating histories than our clinics. The managers of these competing clinics may also have stronger relationships with physicians in their communities, which could give them a competitive advantage for patient referrals. Because the barriers to entry are not substantial and current customers have the flexibility to move easily to new healthcare service providers, we believe that new outpatient physical therapy competitors can emerge relatively quickly.

Concentra's primary competitors have typically been independent physicians, hospital emergency departments, and hospital-owned or hospital-affiliated medical facilities. Because the barriers to entry in Concentra's geographic markets are not substantial and its current customers have the flexibility to move easily to new healthcare service providers, new competitors to Concentra can emerge relatively quickly. The markets for Concentra's consumer health business are also fragmented and competitive. If Concentra's competitors are better able to attract patients or expand services at their facilities than Concentra is, Concentra may experience an overall decline in revenue.

Future cost containment initiatives undertaken by private third-party payors may limit our future revenue and profitability.

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs affect our profitability. These payors attempt to control healthcare costs by contracting with hospitals and other healthcare providers to obtain services on a discounted basis. We believe that this trend may continue and may limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments reduce the amounts they pay for services, our profit margins may decline, or we may lose patients if we choose not to renew our contracts with these insurers at lower rates.

If we fail to maintain established relationships with the physicians in the areas we serve, our revenue may decrease.

Our success is partially dependent upon the admissions and referral practices of the physicians in the communities our critical illness recovery hospitals, rehabilitation hospitals, and outpatient rehabilitation clinics serve, and our ability to maintain good relations with these physicians. Physicians referring patients to our hospitals and clinics are generally not our employees and, in many of the local areas that we serve, most physicians have admitting privileges at other hospitals and are free to refer their patients to other providers. If we are unable to successfully cultivate and maintain strong relationships with these physicians, our hospitals' admissions and our facilities' and clinics' businesses may decrease, and our revenue may decline.

Our business operations could be significantly disrupted if we lose key members of our management team.

Our success depends to a significant degree upon the continued contributions of our senior officers and other key employees, and our ability to retain and motivate these individuals. We currently have employment agreements in place with three executive officers and change in control agreements and/or non-competition agreements with several other officers. Many of these individuals also have significant equity ownership in our company. We do not maintain any key life insurance policies for any of our employees. The loss of the services of certain of these individuals could disrupt significant aspects of our business, could prevent us from successfully executing our business strategy, and could have a material adverse effect on our results of operations.

In conducting our business, we are required to comply with applicable laws regarding fee-splitting and the corporate practice of medicine.

Some states prohibit the "corporate practice of medicine" that restricts business corporations from practicing medicine through the direct employment of physicians or from exercising control over medical decisions by physicians. Some states similarly prohibit the "corporate practice of therapy." The laws relating to corporate practice vary from state to state and are not fully developed in each state in which we have facilities. Typically, however, professional corporations owned and controlled by licensed professionals are exempt from corporate practice restrictions and may employ physicians or therapists to furnish professional services. Also, in some states, hospitals are permitted to employ physicians.

Some states also prohibit entities from engaging in certain financial arrangements, such as fee-splitting, with physicians or therapists. The laws relating to fee-splitting also vary from state to state and are not fully developed. Generally, these laws restrict business arrangements that involve a physician or therapist sharing medical fees with a referral source, but in some states, these laws have been interpreted to extend to management agreements between physicians or therapists and business entities under some circumstances.

We believe that the Company's current and planned activities do not constitute fee-splitting or the unlawful corporate practice of medicine as contemplated by these state laws. However, there can be no assurance that future interpretations of such laws will not require structural and organizational modification of our existing relationships with the practices. If a court or regulatory body determines that we have violated these laws or if new laws are introduced that would render our arrangements illegal, we could be subject to civil or criminal penalties, our contracts could be found legally invalid and unenforceable (in whole or in part), or we could be required to restructure our contractual arrangements with our affiliated physicians and other licensed providers.

Significant legal actions could subject us to substantial uninsured liabilities.

Physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability, or related legal theories. Many of these actions involve large claims and significant defense costs. We are also subject to lawsuits under federal and state whistleblower statutes designed to combat fraud and abuse in the healthcare industry. These whistleblower lawsuits are not covered by insurance and can involve significant monetary damages and award bounties to private plaintiffs who successfully bring the suits. See "Legal Proceedings" and Note 21 – Commitments and Contingencies in our audited consolidated financial statements.

We currently maintain professional malpractice liability insurance and general liability insurance coverages through a number of different programs that are dependent upon such factors as the state where we are operating and whether the operations are wholly owned or are operated through a joint venture. For our wholly owned operations, we currently maintain insurance coverages under a combination of policies with a total annual aggregate limit of up to $37.0 million for professional malpractice liability insurance and $40.0 million for general liability insurance. Our insurance for the professional liability coverage is written on a "claims-made" basis, and our commercial general liability coverage is maintained on an "occurrence" basis. These coverages apply after a self-insured retention limit is exceeded. For our joint venture operations, we have designed a separate insurance program that responds to the risks of specific joint ventures. Most of our joint ventures are insured under a master program with an annual aggregate limit of up to $80.0 million, subject to a sublimit aggregate ranging from $23.0 million to $33.0 million for most joint ventures. The policies are generally written on a "claims-made" basis. Each of these programs has either a deductible or self-insured retention limit. We also maintain additional types of liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by our professional and general liability insurance policies. Our insurance policies also do not generally cover punitive damages and are subject to various deductibles and policy limits. We review our insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. See "Business—Government Regulations—Other Healthcare Regulations."

Concentration of ownership among our existing executives and directors may prevent new investors from influencing significant corporate decisions.

Our executives and directors, beneficially own, in the aggregate, approximately 18.0% of Holdings' outstanding common stock as of February 1, 2022. As a result, these stockholders have significant control over our management and policies and are able to exercise influence over all matters requiring stockholder approval, including the election of directors, amendment of our certificate of incorporation, and approval of significant corporate transactions. The directors elected by these stockholders are able to make decisions affecting our capital structure, including decisions to issue additional capital stock, implement stock repurchase programs, and incur indebtedness. This influence may have the effect of deterring hostile takeovers, delaying or preventing changes in control or changes in management, or limiting the ability of our other stockholders to approve transactions that they may deem to be in their best interest.

Risks Related to Our Capital Structure

Our substantial indebtedness may limit the amount of cash flow available to invest in the ongoing needs of our business.

We have a substantial amount of indebtedness. As of December 31, 2021, we had approximately $3,574.0 million of total indebtedness. Our indebtedness could have important consequences to you. For example, it:

- requires us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, reducing the availability of our cash flow to fund working capital, capital expenditures, development activity, acquisitions, and other general corporate purposes;
- increases our vulnerability to adverse general economic or industry conditions;
- limits our flexibility in planning for, or reacting to, changes in our business or the industries in which we operate;
- makes us more vulnerable to increases in interest rates, as borrowings under our senior secured credit facilities are at variable rates, subject to our interest swap agreement;
- limits our ability to obtain additional financing in the future for working capital or other purposes; and
- places us at a competitive disadvantage compared to our competitors that have less indebtedness.

Any of these consequences could have a material adverse effect on our business, financial condition, results of operations, prospects, and ability to satisfy our obligations under our indebtedness. In addition, there would be a material adverse effect on our business, financial condition, results of operations, and cash flows if we were unable to service our indebtedness or obtain additional financing, as needed.

See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources."

Our credit facilities and the indenture governing our 6.250% senior notes require us to comply with certain covenants and obligations, the default of which may result in the acceleration of certain of our indebtedness.

In the case of an event of default under the agreements governing our credit facilities or our Indenture (as defined below), the lenders or noteholders under such agreements could elect to declare all amounts borrowed, together with accrued and unpaid interest and other fees, to be due and payable. If we are unable to obtain a waiver from the requisite lenders or noteholders under such circumstances, these lenders or noteholders could exercise their rights, then our financial condition and results of operations could be adversely affected, and we could become bankrupt or insolvent.

Our credit agreement contains several covenants such as limitations on mergers, consolidations and dissolutions; sales of assets; investments and acquisitions; indebtedness; liens; affiliate transactions; and dividends and restricted payments. Our credit facilities also require us to maintain a leverage ratio (based upon the ratio of indebtedness to consolidated EBITDA as defined in the agreements governing our credit facilities), which is tested quarterly. Failure to comply with any of these covenants would result in an event of default under our credit facilities.

As of December 31, 2021, we were required to maintain our leverage ratio (the ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters) at less than 7.00 to 1.00. At December 31, 2021, our leverage ratio was 3.77 to 1.00.

Our indenture, dated August 1, 2019, by and among Select, the guarantors named therein and U.S. Bank National Association, as trustee (the "Indenture"), contains covenants that, among other things, limit our ability and the ability of certain of our subsidiaries, which unconditionally guarantee on a joint and several basis the senior notes under the Indenture, to (i) grant liens on its assets, (ii) make dividend payments, other distributions or other restricted payments, (iii) incur restrictions on the ability of Select's restricted subsidiaries to pay dividends or make other payments, (iv) enter into sale and leaseback transactions, (v) merge, consolidate, transfer or dispose of substantially all of their assets, (vi) incur additional indebtedness, (vii) make investments, (viii) sell assets, including capital stock of subsidiaries, (ix) use the proceeds from sales of assets, including capital stock of restricted subsidiaries, and (x) enter into transactions with affiliates. In addition, the Indenture requires us, among other things, to provide financial and current reports to holders of the notes or file such reports electronically with the SEC.

Our inability to comply with any of these covenants could result in a default under our credit facilities or our Indenture. In the event of any default under the credit facilities, the revolving lenders could elect to terminate borrowing commitments and declare all borrowings outstanding, together with accrued and unpaid interest and other fees, to be immediately due and payable. In the event of any default under our Indenture, the trustee or holders of 25% of the 6.250% senior notes could declare all outstanding notes immediately due and payable. A breach of a covenant under our credit agreement or Indenture could result in a default under that debt instrument and, due to cross-default provisions, could result in a default under the other debt instrument. A default under our credit facilities or our indenture could have a material adverse effect on our business, financial condition, results of operations, prospects, and may even lead to bankruptcy or insolvency.

Payment of interest on, and repayment of principal of, our indebtedness is dependent in part on cash flow generated by our subsidiaries.

Payment of interest on, and repayment of, principal of our indebtedness will be dependent in part upon cash flow generated by our subsidiaries and their ability to make such cash available to us, by dividend, debt repayment, or otherwise. Our subsidiaries may not be able to, or be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each of our subsidiaries is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. In the event that we do not receive distributions from our subsidiaries, we may be unable to make required principal and interest payments on our indebtedness. In addition, any payment of interest, dividends, distributions, loans, or advances by our subsidiaries to us could be subject to restrictions on dividends or repatriation of distributions under applicable local law, monetary transfer restrictions, and foreign currency exchange regulations in the jurisdictions in which the subsidiaries operate or under arrangements with local partners. Furthermore, the ability of our subsidiaries to make such payments of interest, dividends, distributions, loans, or advances may be contested by taxing authorities in the relevant jurisdictions.

Despite our substantial level of indebtedness, we and our subsidiaries may be able to incur additional indebtedness. This could further exacerbate the risks described above.

We and our subsidiaries may be able to incur additional indebtedness in the future. Although our credit facilities and the Indenture contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. Also, these restrictions do not prevent us or our subsidiaries from incurring obligations that do not constitute indebtedness. As of December 31, 2021, we had $434.7 million of availability under our revolving facility (as defined below) (after giving effect to $160.0 million of outstanding borrowings and $55.3 million of outstanding letters of credit). In addition, to the extent new debt is added to us and our subsidiaries' current debt levels, the substantial leverage risks described above would increase.

Changes in the method of determining London Interbank Offered Rate ("LIBOR"), or the replacement of LIBOR with an alternative reference rate, may adversely affect interest expense related to our debt.

Amounts drawn under our credit facilities bear interest rates at the election of the borrower, in relation to LIBOR or an alternate base rate. On March 5, 2021, the Financial Conduct Authority ("FCA") in the U.K. announced that all LIBOR settings will either cease to be provided or no longer be representative (i) immediately after December 31, 2021, in the case of the one-week and two-month USD LIBOR terms and all sterling, euro, Swiss franc and Japanese yen settings, and (ii) immediately after June 30, 2023, in the case of the one-, three-, six-, and 12-month USD LIBOR terms. It is unclear whether new methods of calculating LIBOR will be established such that it continues to exist. The U.S. Federal Reserve is considering replacing U.S. dollar LIBOR with a newly created index called the Secured Overnight Financing Rate, calculated with a broad set of short-term repurchase agreements backed by treasury securities. Our credit facilities contain certain provisions concerning the possibility that LIBOR may cease to exist, and that an alternative reference rate may be chosen. However, if LIBOR in fact ceases to exist, and no rate is acceptable to Select or JPMorgan Chase Bank, N.A., as agent to our credit agreement, amounts drawn under our credit facilities would be subject to the alternate base rate, which may be a higher interest rate than LIBOR which would increase our interest expense. As a result, we may need to renegotiate our credit facilities and may not be able to do so with terms that are favorable to us. The overall financial market may be disrupted as a result of the phase-out or replacement of LIBOR. Disruption in the financial market or the inability to renegotiate the credit facilities with favorable terms could have a material adverse effect on our business, financial position, and operating results.

At December 31, 2021, we had $2,103.4 million of term loan borrowings outstanding. These borrowings bore interest at a rate that is indexed to one-month LIBOR plus 2.25% during the year ended December 31, 2021. Assuming these borrowings bore interest at a rate equal to the 4.50%, the Alternate Base Rate in effect at December 31, 2021, during the year ended December 31, 2021, we would have experienced an increase in interest expense of $45.0 million during the year ended December 31, 2021.

We may be unable to refinance our debt on terms favorable to us or at all, which would negatively impact our business and financial condition.

We are subject to risks normally associated with debt financing, including the risk that our cash flow will be insufficient to meet required payments of principal and interest. While we intend to refinance all of our indebtedness before it matures, there can be no assurance that we will be able to refinance any maturing indebtedness, that such refinancing will be on terms as favorable to us as the terms of the maturing indebtedness or, if the indebtedness cannot be refinanced, that we will be able to otherwise obtain funds by selling assets or raising equity to make required payments on our maturing indebtedness. Furthermore, if prevailing interest rates or other factors at the time of refinancing result in higher interest rates upon refinancing, then the interest expense relating to that refinanced indebtedness would increase. If we are unable to refinance our indebtedness at or before maturity or otherwise meet our payment obligations, our business and financial condition will be negatively impacted, and we may be in default under our indebtedness. Any default under our credit facilities would permit lenders to foreclose on our assets and would also be deemed a default under the Indenture governing our 6.250% senior notes, which may also result in the acceleration of that indebtedness,.

See “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources.”

Item 1B. ***Unresolved Staff Comments.***

None.

Item 2. ***Properties.***

We currently lease most of our consolidated facilities, including critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, occupational health centers, and our corporate headquarters. We own 23 of our critical illness recovery hospitals, nine of our rehabilitation hospitals, one of our outpatient rehabilitation clinics, and nine of our Concentra occupational health centers throughout the United States. As of December 31, 2021, we leased 81 of our critical illness recovery hospitals, 11 of our rehabilitation hospitals, 1,571 of our outpatient rehabilitation clinics, and 509 of our Concentra occupational health centers.

We lease our corporate headquarters from companies owned by a related party affiliated with us through common ownership or management. As of December 31, 2021, our corporate headquarters is approximately 294,724 square feet and is located in Mechanicsburg, Pennsylvania.

The following is a list by state of the number of facilities we operated as of December 31, 2021.

	Critical Illness Recovery Hospitals[1]	Rehabilitation Hospitals[1]	Outpatient Rehabilitation Clinics[1]	Concentra Occupational Health Centers[2]	Total Facilities
Alabama	1	—	25	—	26
Alaska	—	—	10	1	11
Arizona	3	3	55	16	77
Arkansas	2	—	1	2	5
California	1	1	94	101	197
Colorado	—	—	48	26	74
Connecticut	—	—	61	10	71
Delaware	1	—	12	1	14
District of Columbia	—	—	5	—	5
Florida	12	2	127	31	172
Georgia	5	1	72	15	93
Hawaii	—	—	—	1	1
Illinois	—	—	76	17	93
Indiana	3	—	35	13	51
Iowa	2	—	26	3	31
Kansas	2	—	15	4	21
Kentucky	2	—	63	8	73
Louisiana	—	2	2	3	7
Maine	—	—	33	7	40
Maryland	—	—	68	12	80
Massachusetts	—	—	24	2	26
Michigan	10	—	37	18	65
Minnesota	1	—	29	6	36
Mississippi	4	—	1	—	5
Missouri	3	3	99	15	120
Nebraska	1	—	3	3	7
Nevada	—	1	16	8	25
New Hampshire	—	—	1	3	4
New Jersey	3	4	171	20	198
New Mexico	—	—	—	4	4
North Carolina	2	—	41	8	51
Ohio	15	5	107	17	144
Oklahoma	2	—	29	7	38
Oregon	—	—	—	4	4
Pennsylvania	10	2	242	18	272
Rhode Island	—	—	—	2	2
South Carolina	2	—	25	5	32
South Dakota	1	—	—	—	1
Tennessee	5	—	20	9	34
Texas	3	5	140	54	202
Utah	—	—	—	6	6
Vermont	—	—	—	2	2
Virginia	1	1	43	6	51
Washington	—	—	11	17	28
West Virginia	4	—	6	—	10
Wisconsin	3	—	8	13	24
Total Company	104	30	1,881	518	2,533

(1) Includes managed critical illness recovery hospitals, rehabilitation hospitals, and outpatient rehabilitation clinics, respectively.

(2) Our Concentra segment also had operations in New York.

Item 3. ***Legal Proceedings.***

Refer to the "Litigation" section contained within Note 21 – Commitments and Contingencies of the notes to our consolidated financial statements included herein.

Item 4. ***Mine Safety Disclosures.***

None.

PART II

Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.*

Market Information

Select Medical Holdings Corporation common stock is quoted on the New York Stock Exchange under the symbol "SEM."

Holders

At the close of business on February 1, 2022, Holdings had 133,884,817 shares of common stock issued and outstanding. As of that date, there were 136 registered holders of record. This does not reflect beneficial stockholders who hold their stock in nominee or "street" name through brokerage firms.

Dividend Policy

Holdings' board of directors declared the following dividends during the year ended December 31, 2021:

Declaration Date	Record Date	Payment Date	Dividend Per Share	Amount
				(in thousands)
May 5, 2021	May 19, 2021	June 1, 2021	$ 0.125	$ 16,876
August 4, 2021	August 18, 2021	August 30, 2021	$ 0.125	$ 16,940
November 2, 2021	November 16, 2021	November 29, 2021	$ 0.125	$ 16,784

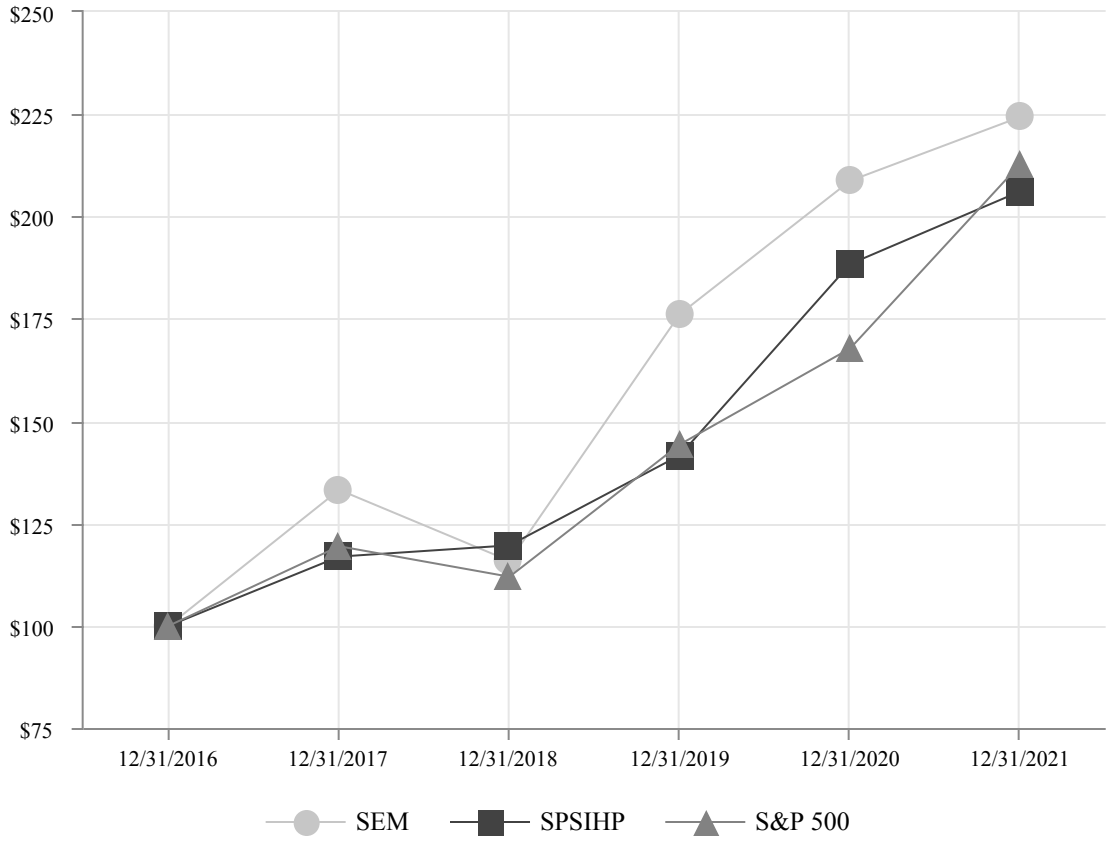
There is no assurance that future dividends will be declared. The declaration and payment of dividends in the future are at the discretion of Holdings' board of directors after taking into account various factors, including, but not limited to, our financial condition, operating results, available cash and current and anticipated cash needs, the terms of our indebtedness, and other factors Holdings' board of directors may deem to be relevant. Additionally, certain contractual agreements we are party to, including our credit agreement and the indenture governing our 6.250% senior notes, restrict our capacity to pay dividends.

Securities Authorized For Issuance Under Equity Compensation Plans

For information regarding securities authorized for issuance under equity compensation plans, see Part III "Item 12—Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters."

Stock Performance Graph

The graph below compares the cumulative total stockholder return on $100 invested at the close of the market on December 31, 2016, with dividends being reinvested on the date paid through and including the market close on December 31, 2021 with the cumulative total return of the same time period on the same amount invested in the Standard & Poor's 500 Index (S&P 500) and the S&P Health Care Services Select Industry Index (SPSIHP). The chart below the graph sets forth the actual numbers depicted on the graph.



	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021
Select Medical Holdings Corporation (SEM)	$ 100.00	$ 133.21	$ 115.85	$ 176.15	$ 208.75	$ 224.37
S&P Health Care Services Select Industry Index (SPSIHP)	$ 100.00	$ 116.89	$ 119.64	$ 141.66	$ 188.41	$ 206.20
S&P 500	$ 100.00	$ 119.42	$ 111.97	$ 144.31	$ 167.77	$ 212.89

Purchases of Equity Securities by the Issuer

Holdings' board of directors previously authorized a common stock repurchase program to repurchase up to $500.0 million worth of shares of its common stock. On November 2, 2021, the board of directors increased the capacity of the program from $500.0 million to $1.0 billion worth of shares and the program has been extended until December 31, 2023. The common stock repurchase program will remain in effect until then, unless further extended or earlier terminated by the board of directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate.

The following table provides information regarding repurchases of our common stock during the three months ended December 31, 2021.

	Total Number of Shares Purchased [1]	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under Plans or Programs[2]
October 1 – October 31, 2021	—	$ —	—	$ 595,889,186
November 1 – November 30, 2021	68,911	33.89	—	595,889,186
December 1 – December 31, 2021	387,212	28.65	387,212	584,796,612
Total	456,123	29.44	387,212	$ 584,796,612

(1) The shares purchased during November 2021 represent common stock surrendered to us to satisfy tax withholding obligations associated with the vesting of restricted shares issued to employees, pursuant to the provisions of our equity incentive plans.

(2) The approximate dollar value of shares that may be purchased under the common stock repurchase program is based on the increased capacity of $1.0 billion.

Item 6. [Reserved]

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

You should read this discussion together with the consolidated financial statements and accompanying notes included elsewhere herein.

This section of this 10-K generally discusses 2021 and 2020 items and year-to-year comparisons between 2021 and 2020. Discussions of 2019 items and year-to-year comparisons between 2020 and 2019 that are not included in this Form 10-K can be found in "*Management's Discussion and Analysis of Financial Condition and Results of Operations*" in Part II, Item 7 of the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020.

Overview

We began operations in 1997 and, based on number of facilities, are one of the largest operators of critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, and occupational health centers in the United States. As of December 31, 2021, we had operations in 46 states and the District of Columbia. We operated 104 critical illness recovery hospitals in 28 states, 30 rehabilitation hospitals in 12 states, and 1,881 outpatient rehabilitation clinics in 38 states and the District of Columbia. Concentra operated 518 occupational health centers in 41 states as of December 31, 2021. Concentra also provides contract services at employer worksites.

Our reportable segments include the critical illness recovery hospital segment, the rehabilitation hospital segment, the outpatient rehabilitation segment, and the Concentra segment. We had revenue of $6,204.5 million for the year ended December 31, 2021. Of this total, we earned approximately 36% of our revenue from our critical illness recovery hospital segment, approximately 14% from our rehabilitation hospital segment, approximately 17% from our outpatient rehabilitation segment, and approximately 28% from our Concentra segment. Our critical illness recovery hospital segment consists of hospitals designed to serve the needs of patients recovering from critical illnesses, often with complex medical needs, and our rehabilitation hospital segment consists of hospitals designed to serve patients that require intensive physical rehabilitation care. Patients are typically admitted to our critical illness recovery hospitals and rehabilitation hospitals from general acute care hospitals. Our outpatient rehabilitation segment consists of clinics that provide physical, occupational, and speech rehabilitation services. Our Concentra segment consists of occupational health centers that provide workers' compensation injury care, physical therapy, and consumer health services as well as onsite clinics located at employer worksites that deliver occupational medicine services.

Non-GAAP Measure

We believe that the presentation of Adjusted EBITDA, as defined below, is important to investors because Adjusted EBITDA is commonly used as an analytical indicator of performance by investors within the healthcare industry. Adjusted EBITDA is used by management to evaluate financial performance and determine resource allocation for each of our segments. Adjusted EBITDA is not a measure of financial performance under accounting principles generally accepted in the United States of America ("GAAP"). Items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation, or as an alternative to, or substitute for, net income, income from operations, cash flows generated by operations, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is thus susceptible to varying definitions, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies.

We define Adjusted EBITDA as earnings excluding interest, income taxes, depreciation and amortization, gain (loss) on early retirement of debt, stock compensation expense, gain (loss) on sale of businesses, and equity in earnings (losses) of unconsolidated subsidiaries. We will refer to Adjusted EBITDA throughout the remainder of Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following table reconciles net income and income from operations to Adjusted EBITDA and should be referenced when we discuss Adjusted EBITDA.

	For the Year Ended December 31,		
	2019	2020	2021
	(in thousands)		
Net income	$ 201,031	$ 344,606	$ 499,949
Income tax expense	63,718	111,867	129,773
Interest expense	200,570	153,011	135,985
Interest income	—	—	(5,350)
Gain on sale of businesses	(6,532)	(12,387)	(2,155)
Equity in earnings of unconsolidated subsidiaries	(24,989)	(29,440)	(44,428)
Loss on early retirement of debt	38,083	—	—
Income from operations	471,881	567,657	713,774
Stock compensation expense:			
Included in general and administrative	20,334	22,053	24,598
Included in cost of services	6,117	5,197	6,342
Depreciation and amortization	212,576	205,659	202,645
Adjusted EBITDA	$ 710,908	$ 800,566	$ 947,359

Effects of the COVID-19 Pandemic on our Results of Operations

Beginning in March 2020, state governments placed significant restrictions on businesses and mandated closures of non-essential or non-life sustaining businesses, causing many employers to furlough their workforce and temporarily cease or significantly reduce their operations. State governments also implemented restrictions on travel and individual activities outside of the home, closed schools, and mandated other social distancing measures. At the same time, hospitals and other facilities began suspending elective surgeries. In an effort to ensure hospitals and health systems had the capacity to absorb and effectively manage surges of COVID-19 patients, a number of waivers and modifications of certain requirements under the Medicare, Medicaid and CHIP programs were authorized in March 2020, including certain regulations under the Medicare program which govern admissions into our critical illness recovery hospitals and rehabilitation hospitals. Specifically, our critical illness recovery hospitals which are certified as LTCHs became exempt from the greater-than-25-day average length of stay requirement for all cost reporting periods that include the COVID-19 public health emergency period. Our rehabilitation hospitals which are certified as IRFs could exclude patients admitted solely to respond to the emergency from the calculation of the "60 percent rule" thresholds to receive payment as an IRF. The COVID-19 public health emergency period has been extended and is currently in effect through April 16, 2022.

The adverse effects of the COVID-19 pandemic, along with the actions of governmental authorities and those in the private sector to limit the spread of COVID-19, caused disruptions in each of our segments; these disruptions were most significant within our outpatient rehabilitation and Concentra segments. By mid-March 2020, our outpatient rehabilitation clinics began experiencing significantly less patient visit volume due to declines in patient referrals from physicians, a reduction in workers' compensation injury visits resulting from the temporary closure of businesses, and the suspension of elective surgeries that normally increase the demand for outpatient rehabilitation services. Our Concentra centers experienced similar declines in patient visit volume due to businesses furloughing their workforce and temporarily ceasing or significantly reducing their operations. Since March 2021, our outpatient rehabilitation clinics and Concentra centers have experienced patient visit volumes which approximate or exceed the levels experienced in the months prior to the widespread emergence of COVID-19 in the United States. Although it had experienced temporary disruptions in its core businesses as a result of the COVID-19 pandemic, our Concentra segment was able to expand its services to provide COVID-19 screening and testing.

Our critical illness recovery hospitals have played a critical role in caring for patients during the COVID-19 pandemic. The relaxation of certain admission restrictions contributed to volume increases in certain of our hospitals during the year ended December 31, 2020. The revenue of our critical illness recovery hospitals and rehabilitation hospitals has also benefited from the temporary suspension of the 2.0% cut to Medicare payments due to sequestration, which began May 1, 2020 following the enactment of the CARES Act, and was extended through March 31, 2022. From April 1, 2022 through June 30, 2022, the sequestration cut will be 1.0% and the full 2.0% sequestration cut will resume July 1, 2022. Certain of our rehabilitation hospitals did experience temporary declines in patient volume in areas more significantly impacted by the spread of COVID-19 and as a result of the suspension of elective surgeries at hospitals and other facilities, which consequently reduced the demand for inpatient rehabilitation services. Additionally, some of our rehabilitation hospitals temporarily restricted admissions as a result of the COVID-19 pandemic. The declines in volume occurred principally in April and May 2020.

Beginning at the onset of the COVID-19 pandemic, both our critical illness recovery hospitals and rehabilitation hospitals modified certain of their protocols in order to follow the guidelines and recommendations for patient treatment and for the protection of our patients and staff members. This has resulted in increased labor costs as well as additional costs resulting from the purchase of personal protective equipment. Further, labor shortages have become more pronounced as a result of the COVID-19 pandemic. We have experienced an increase in labor costs in our hospitals as a result of constrained staffing due to a shortage of healthcare workers, an increased dependence on contract clinical workers, the loss of unvaccinated employees in jurisdictions requiring vaccination, and federal unemployment subsidies, including unemployment benefits offered in response to the COVID-19 pandemic. Increased turnover rates within our employee base have also lead to increased overtime to meet demand and increased wage rates to attract and retain employees.

The unpredictable effects of the COVID-19 pandemic, including the duration and extent of disruption on our operations, creates uncertainties about our future operating results and financial condition. This is discussed further in our risk factors contained in Item 1A. "*Risk Factors.*" We have provided revenue and certain operating statistics below for each of our segments for each of the periods presented. Please refer to "*Summary Financial Results*" and "*Results of Operations*" for further discussion of our segment performance measures and to "*Operating Statistics*" for a discussion regarding the uses and calculations of the metrics provided below.

Critical Illness Recovery Hospital

	Revenue			Patient Days			Occupancy Rate			Number of Hospitals Owned[1]		
	2019	2020	2021	2019	2020	2021	2019	2020	2021	2019	2020	2021
	(in thousands)											
January	$ 149,799	$ 163,238	$ 199,611	86,238	90,783	100,933	69%	69%	75%	96	100	99
February	145,586	165,375	190,703	80,806	87,844	92,036	71%	72%	75%	96	100	99
March	162,149	171,908	204,558	91,085	91,831	100,149	73%	70%	74%	96	100	99
Three Months Ended March 31	$ 457,534	$ 500,521	$ 594,872	258,129	270,458	293,118	71%	70%	75%	96	100	99
April	$ 156,231	$ 171,445	$ 185,934	88,357	90,710	91,506	70%	71%	70%	99	100	99
May	156,422	178,223	183,471	89,350	95,191	93,708	69%	72%	70%	99	100	99
June	148,490	169,958	174,654	85,153	90,988	87,767	68%	71%	68%	99	100	99
Three Months Ended June 30	$ 461,143	$ 519,626	$ 544,059	262,860	276,889	272,981	69%	72%	69%	99	100	99
Six Months Ended June 30	$ 918,677	$1,020,147	$1,138,931	520,989	547,347	566,099	70%	71%	72%	99	100	99
July	$ 151,416	$ 175,253	$ 171,483	87,143	94,144	88,119	67%	71%	65%	99	99	100
August	155,485	173,967	178,240	86,553	93,964	91,756	66%	71%	68%	99	99	100
September	155,991	170,234	180,923	84,393	90,955	92,579	67%	71%	71%	99	99	100
Three Months Ended September 30	$ 462,892	$ 519,454	$ 530,646	258,089	279,063	272,454	67%	71%	68%	99	99	100
Nine Months Ended September 30	$1,381,569	$1,539,601	$1,669,577	779,078	826,410	838,553	69%	71%	70%	99	99	100
October	$ 152,791	$ 181,251	$ 195,444	87,188	95,616	99,935	66%	71%	71%	100	100	104
November	150,399	174,133	191,134	84,540	92,651	96,102	67%	71%	71%	100	99	104
December	151,759	182,514	190,617	87,555	97,079	98,449	67%	72%	70%	100	99	104
Three Months Ended December 31	$ 454,949	$ 537,898	$ 577,195	259,283	285,346	294,486	67%	71%	71%	100	99	104
Twelve Months Ended December 31	$1,836,518	$2,077,499	$2,246,772	1,038,361	1,111,756	1,133,039	68%	71%	71%	100	99	104

Rehabilitation Hospital

	Revenue			Patient Days			Occupancy Rate			Number of Hospitals Owned[1]		
	2019	2020	2021	2019	2020	2021	2019	2020	2021	2019	2020	2021
	(in thousands)											
January	$ 50,615	$ 61,673	$ 68,297	27,434	32,111	34,404	74%	79%	82%	17	19	20
February	48,080	60,690	64,202	25,442	31,813	32,178	76%	84%	84%	17	19	20
March	55,863	59,656	75,305	29,940	30,644	35,857	78%	76%	85%	18	19	20
Three Months Ended March 31	$ 154,558	$ 182,019	$ 207,804	82,816	94,568	102,439	76%	79%	84%	18	19	20
April	$ 51,991	$ 45,878	$ 70,295	28,266	23,553	34,861	76%	61%	85%	18	19	20
May	56,019	57,815	71,190	29,730	29,787	35,604	75%	73%	84%	19	19	20
June	52,364	64,974	71,181	28,529	30,741	34,483	73%	78%	84%	19	19	20
Three Months Ended June 30	$ 160,374	$ 168,667	$ 212,666	86,525	84,081	104,948	75%	71%	85%	19	19	20
Six Months Ended June 30	$ 314,932	$ 350,686	$ 420,470	169,341	178,649	207,387	76%	75%	84%	19	19	20
July	$ 57,077	$ 62,312	$ 70,467	30,054	31,986	34,894	75%	81%	83%	19	18	20
August	58,072	63,673	71,682	30,228	32,518	34,835	75%	83%	83%	19	18	20
September	58,220	62,090	70,285	29,172	31,176	33,224	75%	82%	81%	19	18	20
Three Months Ended September 30	$ 173,369	$ 188,075	$ 212,434	89,454	95,680	102,953	75%	82%	82%	19	18	20
Nine Months Ended September 30	$ 488,301	$ 538,761	$ 632,904	258,795	274,329	310,340	75%	77%	84%	19	18	20
October	$ 61,975	$ 66,591	$ 72,509	31,767	33,378	35,908	78%	82%	85%	19	19	20
November	60,353	64,610	71,865	31,022	31,581	34,491	79%	80%	84%	19	19	20
December	60,342	64,711	72,062	31,447	31,545	33,962	78%	78%	80%	19	19	20
Three Months Ended December 31	$ 182,670	$ 195,912	$ 216,436	94,236	96,504	104,361	78%	80%	83%	19	19	20
Twelve Months Ended December 31	$ 670,971	$ 734,673	$ 849,340	353,031	370,833	414,701	76%	78%	83%	19	19	20

	Outpatient Rehabilitation								
	Revenue			Visits			Working Days[2]		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
	(in thousands)								
January	$ 83,185	$ 90,924	$ 76,763	687,007	757,171	625,964	22	22	20
February	78,573	88,239	77,063	658,610	739,061	641,942	20	20	20
March	85,147	76,086	98,135	708,866	626,433	832,248	21	22	23
Three Months Ended March 31	$ 246,905	$ 255,249	$ 251,961	2,054,483	2,122,665	2,100,154	63	64	63
April	$ 90,230	$ 49,084	$ 95,251	762,914	386,108	810,314	22	22	22
May	90,272	51,186	89,030	759,829	409,703	758,773	22	20	20
June	81,389	66,868	96,128	680,762	546,456	835,774	20	22	22
Three Months Ended June 30	$ 261,891	$ 167,138	$ 280,409	2,203,505	1,342,267	2,404,861	64	64	64
Six Months Ended June 30	$ 508,796	$ 422,387	$ 532,370	4,257,988	3,464,932	4,505,015	127	128	127
July	$ 89,267	$ 77,793	$ 90,352	754,102	636,826	780,118	22	22	21
August	90,687	79,034	93,056	743,813	651,738	798,459	22	21	22
September	85,376	83,215	91,132	706,413	694,808	768,493	20	21	21
Three Months Ended September 30	$ 265,330	$ 240,042	$ 274,540	2,204,328	1,983,372	2,347,070	64	64	64
Nine Months Ended September 30	$ 774,126	$ 662,429	$ 806,910	6,462,316	5,448,304	6,852,085	191	192	191
October	$ 96,868	$ 88,274	$ 91,705	808,649	745,562	772,068	23	22	21
November	87,072	82,102	93,345	722,607	685,885	797,756	20	20	21
December	87,945	87,108	92,401	725,710	713,593	771,715	21	22	21
Three Months Ended December 31	$ 271,885	$ 257,484	$ 277,451	2,256,966	2,145,040	2,341,539	64	64	63
Twelve Months Ended December 31	$ 1,046,011	$ 919,913	$ 1,084,361	8,719,282	7,593,344	9,193,624	255	256	254

	Concentra								
	Revenue			Visits			Working Days[2]		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
	(in thousands)								
January	$ 133,507	$ 141,236	$ 127,103	985,598	1,032,069	867,793	22	22	20
February	126,309	133,690	132,349	919,065	965,741	869,910	20	20	20
March	136,505	123,609	163,388	1,006,944	879,585	1,057,871	21	22	23
Three Months Ended March 31	$ 396,321	$ 398,535	$ 422,840	2,911,607	2,877,395	2,795,574	63	64	63
April	$ 140,050	$ 91,178	$ 152,143	1,040,543	610,555	999,622	22	22	22
May	143,183	99,228	142,228	1,073,763	674,629	956,250	22	20	20
June	130,218	121,932	162,001	988,783	865,896	1,074,206	20	22	22
Three Months Ended June 30	$ 413,451	$ 312,338	$ 456,372	3,103,089	2,151,080	3,030,078	64	64	64
Six Months Ended June 30	$ 809,772	$ 710,873	$ 879,212	6,014,696	5,028,475	5,825,652	127	128	127
July	$ 142,385	$ 132,465	$ 146,509	1,057,809	930,427	1,033,266	22	22	21
August	144,452	130,291	150,333	1,087,165	933,555	1,106,356	22	21	22
September	135,063	129,103	145,348	1,005,929	963,065	1,084,009	20	21	21
Three Months Ended September 30	$ 421,900	$ 391,859	$ 442,190	3,150,903	2,827,047	3,223,631	64	64	64
Nine Months Ended September 30	$ 1,231,672	$ 1,102,732	$ 1,321,402	9,165,599	7,855,522	9,049,283	191	192	191
October	$ 149,260	$ 139,365	$ 143,609	1,113,408	1,011,816	1,072,531	23	22	21
November	123,152	126,431	135,417	908,159	867,918	991,937	19	19	21
December	124,733	132,906	131,613	881,699	892,648	938,973	21	22	21
Three Months Ended December 31	$ 397,145	$ 398,702	$ 410,639	2,903,266	2,772,382	3,003,441	63	63	63
Twelve Months Ended December 31	$ 1,628,817	$ 1,501,434	$ 1,732,041	12,068,865	10,627,904	12,052,724	254	255	254

(1) Represents the number of hospitals owned at the end of each period presented.
(2) Represents the number of days in which normal business operations were conducted during the periods presented.

Summary Financial Results

The following tables reconcile our segment performance measures to our consolidated operating results for the years ended December 31, 2021, 2020, and 2019:

	For the Year Ended December 31, 2021					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Revenue	$ 2,246,772	$ 849,340	$ 1,084,361	$ 1,732,041	$ 292,001	$ 6,204,515
Operating expenses	(1,998,660)	(664,636)	(946,086)	(1,379,566)	(443,176)	(5,432,124)
Depreciation and amortization	(53,094)	(27,677)	(29,592)	(82,210)	(10,072)	(202,645)
Other operating income	19,881	—	—	34,999	89,148	144,028
Income (loss) from operations	214,899	157,027	108,683	305,264	(72,099)	713,774
Depreciation and amortization	53,094	27,677	29,592	82,210	10,072	202,645
Stock compensation expense	—	—	—	2,142	28,798	30,940
Adjusted EBITDA	$ 267,993	$ 184,704	$ 138,275	$ 389,616	$ (33,229)	$ 947,359
Adjusted EBITDA margin	11.9 %	21.7 %	12.8 %	22.5 %	N/M	15.3 %

	For the Year Ended December 31, 2020					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Revenue	$ 2,077,499	$ 734,673	$ 919,913	$ 1,501,434	$ 298,194	$ 5,531,713
Operating expenses	(1,735,072)	(581,470)	(840,749)	(1,252,200)	(438,918)	(4,848,409)
Depreciation and amortization	(51,531)	(27,727)	(29,009)	(87,865)	(9,527)	(205,659)
Other operating income	—	—	—	1,146	88,866	90,012
Income (loss) from operations	290,896	125,476	50,155	162,515	(61,385)	567,657
Depreciation and amortization	51,531	27,727	29,009	87,865	9,527	205,659
Stock compensation expense	—	—	—	2,512	24,738	27,250
Adjusted EBITDA	$ 342,427	$ 153,203	$ 79,164	$ 252,892	$ (27,120)	$ 800,566
Adjusted EBITDA margin	16.5 %	20.9 %	8.6 %	16.8 %	N/M	14.5 %

	For the Year Ended December 31, 2019					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Revenue	$ 1,836,518	$ 670,971	$ 1,046,011	$ 1,628,817	$ 271,605	$ 5,453,922
Operating expenses	(1,581,650)	(535,114)	(894,180)	(1,355,404)	(403,117)	(4,769,465)
Depreciation and amortization	(50,763)	(27,322)	(28,301)	(96,807)	(9,383)	(212,576)
Income (loss) from operations	204,105	108,535	123,530	176,606	(140,895)	471,881
Depreciation and amortization	50,763	27,322	28,301	96,807	9,383	212,576
Stock compensation expense	—	—	—	3,069	23,382	26,451
Adjusted EBITDA	$ 254,868	$ 135,857	$ 151,831	$ 276,482	$ (108,130)	$ 710,908
Adjusted EBITDA margin	13.9 %	20.2 %	14.5 %	17.0 %	N/M	13.0 %

Net income was $499.9 million, $344.6 million, and $201.0 million for the years ended December 31, 2021, 2020, and 2019, respectively. Net income included pre-tax gains on sales of businesses of $2.2 million and $12.4 million for the years ended December 31, 2021 and 2020, respectively. Net income included pre-tax losses on early retirement of debt of $38.1 million and a pre-tax gain on sale of businesses of $6.5 million for the year ended December 31, 2019.

The following tables summarize the changes in our segment performance measures for the year-to-date periods specified below. Due to the significant impact of the COVID-19 pandemic on our operations during the year ended December 31, 2020, which is discussed further under "*Effects of the COVID-19 Pandemic on our Results of Operations,*" we also provided a comparison of the changes in our segment performance measures for the year ended December 31, 2021, as compared to the year ended December 31, 2019.

	2021 Compared to 2020					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
Change in revenue	8.1 %	15.6 %	17.9 %	15.4 %	(2.1)%	12.2 %
Change in income (loss) from operations	(26.1)%	25.1 %	116.7 %	87.8 %	N/M	25.7 %
Change in Adjusted EBITDA	(21.7)%	20.6 %	74.7 %	54.1 %	N/M	18.3 %

	2021 Compared to 2019					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
Change in revenue	22.3 %	26.6 %	3.7 %	6.3 %	7.5 %	13.8 %
Change in income (loss) from operations	5.3 %	44.7 %	(12.0)%	72.9 %	N/M	51.3 %
Change in Adjusted EBITDA	5.1 %	36.0 %	(8.9)%	40.9 %	N/M	33.3 %

	2020 Compared to 2019					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
Change in revenue	13.1 %	9.5 %	(12.1)%	(7.8)%	9.8 %	1.4 %
Change in income (loss) from operations	42.5 %	15.6 %	(59.4)%	(8.0)%	N/M	20.3 %
Change in Adjusted EBITDA	34.4 %	12.8 %	(47.9)%	(8.5)%	N/M	12.6 %

N/M — Not meaningful.

Significant Events

Dividend Payments

On May 5, 2021, August 4, 2021, and November 2, 2021, our board of directors declared cash dividends, each in the amount of $0.125 per share. Cash dividends totaling $50.6 million were paid during the year ended December 31, 2021.

Financing Transactions

On June 2, 2021, Select entered into Amendment No. 5 to its credit agreement which, among other things, increased the aggregate commitments available under the revolving facility from $450.0 million to $650.0 million, including a $125.0 million sublimit for the issuance of standby letters of credit.

On June 2, 2021, Concentra Inc. terminated its obligations under the agreement governing its revolving facility (the "Concentra-JPM first lien credit agreement"). The Concentra-JPM first lien credit agreement provided for commitments of $100.0 million under Concentra Inc.'s revolving facility, which was set to mature on March 1, 2022.

Purchases of Concentra Interest

On December 24, 2021, Select, WCAS, DHHC, and other members of Concentra Group Holdings Parent entered into agreements pursuant to which Select acquired additional outstanding membership interests of Concentra Group Holdings Parent. The purchase was in lieu of, and collectively deemed to constitute, the exercise of WCAS' and DHHC's third put right. Select acquired substantially all of the outstanding membership interests of Concentra Group Holdings Parent that it did not already own from WCAS, DHHC and the other equity holders of Concentra Group Holdings Parent, in exchange for an aggregate payment of approximately $660.7 million. Upon consummation of the Concentra Interest Purchases, Select owns in the aggregate approximately 99.3% of the outstanding membership interests of Concentra Group Holdings Parent on a fully diluted basis and 100.0% of the outstanding voting membership interests of Concentra Group Holdings Parent.

Regulatory Changes

The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and CMS. Revenue generated directly from the Medicare program represented approximately 26%, 25%, and 23% of the Company's revenue for the years ended December 31, 2019, 2020, and 2021, respectively.

The Medicare program reimburses various types of providers using different payment methodologies. Those payment methodologies are complex and are described elsewhere in this report under "Business—Government Regulations." The following is a discussion of some of the more significant healthcare regulatory changes that have affected our financial performance in the periods covered by this report or are likely to affect our financial performance and financial condition in the future.

Federal Health Care Program Changes in Response to the COVID-19 Pandemic

On January 31, 2020, HHS declared a public health emergency under section 319 of the Public Health Service Act, 42 U.S.C. § 247d, in response to the COVID-19 outbreak in the United States. The HHS Secretary renewed the public health emergency determination for 90-day periods effective on April 26, 2020, July 25, 2020, October 23, 2020, January 21, 2021, April 21, 2021, July 20, 2021, October 18, 2021, and January 16, 2022. On March 13, 2020, President Trump declared a national emergency due to the COVID-19 pandemic and the HHS Secretary authorized the waiver or modification of certain requirements under the Medicare, Medicaid and CHIP programs pursuant to section 1135 of the Social Security Act. Under this authority, CMS issued a number of blanket waivers that excuse health care providers or suppliers from specific program requirements. The following blanket waivers, while in effect, may impact our results of operations:

i. IRFs, IRF units, and hospitals and units applying to be classified as IRFs, can exclude patients admitted solely to respond to the emergency from the calculation of the "60 percent rule" thresholds to receive payment as an IRF.

ii. LTCHs are exempt from the greater-than-25-day average length of stay requirement for all cost reporting periods that include the COVID-19 public health emergency period. Hospitals seeking LTCH classification can exclude patient stays from the greater-than-25-day average length of stay requirement where the patient was admitted or discharged to meet the demands of the COVID-19 public health emergency.

iii. Medicare expanded the types of health care professionals who can furnish telehealth services to include all those who are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

iv. Medicare will not require out-of-state physician and non-physician practitioners to be licensed in the state where they are providing services when they are licensed in another state, subject to certain conditions and state or local licensure requirements.

v. Many requirements under the hospital conditions of participation ("CoPs") are waived during the emergency period to give hospitals more flexibility in treating COVID-19 patients.

vi. Hospitals can operate temporary expansion locations without meeting the provider-based entity requirements or certain requirements in the physical environment CoP for hospitals during the emergency. This waiver also allows hospitals to change the status of their current provider-based department locations to meet patient needs as part of the state or local pandemic plan.

vii. IRFs, LTCHs and certain other providers did not need to submit quality data to Medicare for October 1, 2019 through June 30, 2020 to comply with the quality reporting programs.

viii. The HHS Secretary waived sanctions under the physician self-referral law (i.e., Stark law) for certain types of remuneration and referral arrangements that are related to a COVID-19 purpose. The OIG will also exercise enforcement discretion to not impose administrative sanctions under the federal anti-kickback statute for many payments covered by the Stark law waivers.

CMS also approved section 1135 waivers and/or temporary changes to Medicaid and/or CHIP state plan amendments for every state Medicaid program (including the District of Columbia, Puerto Rico, and other territories). In addition, CMS approved traditional changes to some states' Medicaid state plan amendments and section 1115 waivers in certain states for Medicaid demonstration projects addressing the COVID-19 public health emergency. CMS will consider specific waiver requests from providers and suppliers. We have submitted one or more specific waiver requests to make it easier for our operators or referral partners to treat COVID-19 patients, and we may submit others in the future.

Pursuant to the Coronavirus Preparedness and Response Supplemental Appropriations Act, Public Law 116-123, CMS has waived Medicare telehealth payment requirements during the emergency so that beneficiaries in all areas of the country (not just rural areas) can receive telehealth services, including in their homes, beginning on March 6, 2020. CMS issued additional waivers to permit more than 160 additional services to be furnished by telehealth, allow physicians to monitor patient services remotely, and fulfill face-to-face requirements in IRFs.

In addition to these agency actions, the CARES Act was enacted on March 27, 2020. It provides additional waivers, reimbursement, grants and other funds to assist health care providers during the COVID-19 public health emergency. Some of the CARES Act provisions that may impact our operations include:

i. $100 billion in appropriations for the Public Health and Social Services Emergency Fund to be used for preventing, preparing, and responding to COVID-19, and for reimbursing "eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus." The Paycheck Protection Program and Health Care Enhancement Act, Public Law 116-139, added $75 billion to this fund. The Consolidated Appropriations Act, 2021, added another $3 billion to this fund. HHS has allocated four general distributions from the fund for payments to Medicare providers. The Phase 1 General Distribution included $30 billion for health care providers that received Medicare fee-for-service payments in 2019. Another $20 billion was allocated to Medicare providers in a manner that was intended to make the entire $50 billion Phase 1 General Distribution proportional to each provider's share of 2018 net patient revenue. Payments from the additional $20 billion allocation were determined based on the lesser of a provider's 2018 (or most recent complete tax year) gross receipts or the sum of incurred losses for March and April of 2020. HHS distributed a total of $46.02 billion from the Phase 1 allocations. The Phase 2 General Distribution allocated $18 billion for providers in state Medicaid/CHIP programs, Medicaid managed care plans, dentists, and certain Medicare providers who did not receive a Phase 1 General Distribution payment. HHS distributed $5.98 billion from the $18 billion Phase 2 allocation. The Phase 3 General Distribution was projected to include $20 billion for providers to apply for if they suffered financial losses or changes in operating expenses caused by COVID-19 or if they were previously ineligible for a general distribution. HHS made $24.5 billion in payments as part of the Phase 3 General Distribution. HHS recently announced a Phase 4 General Distribution allocation of $17 billion. Providers could apply for a Phase 4 General Distribution payment if they had lost revenues and eligible expenses from July 1, 2020 to March 31, 2021. HHS said it intends to make the Phase 4 payments more equitable than earlier distributions and will reimburse smaller providers at a higher rate than large providers. The application for a Phase 4 General Distribution payment also allowed applicants to seek a payment from an $8.5 billion American Rescue Plan fund for providers that serve rural Medicaid, CHIP, or Medicare patients. The remainder of the COVID-19 related appropriations to the Public Health and Social Services Emergency Fund is for targeted allocations to providers in high impact COVID-19 areas ($20.75 billion), rural providers (approximately $11.09 billion), skilled nursing facilities (approximately $5 billion), nursing home infection control (approximately $2.75 billion), safety net hospitals (approximately $13.07 billion), Indian Health Service and urban health centers ($520 million), children's hospitals ($1.06 billion), and unspecified allocations for providers treating uninsured COVID-19 patients. HHS also established a $2.25 billion incentive payment structure for skilled nursing facilities and nursing homes for keeping new COVID-19 infection and mortality rates among residents lower than the communities they serve.

Starting on July 1, 2021, recipients of these payments must begin reporting data to HHS on the use of the funds via an online portal. By September 30, 2021, recipients were required to report to HHS on the use of funds received from April 10, 2020 to June 30, 2020. HHS announced a 60-day grace period for this September 30, 2021 deadline because providers were facing challenges from recent natural disasters and the COVID-19 Delta variant. HHS would not initiate collection activities or enforcement actions against providers during this grace period. The deadline to apply payments received from April 10, 2020 to June 30, 2020 towards eligible expenses and lost revenue attributable to COVID-19 was June 30, 2021. For payments received from July 1, 2020 to December 31, 2020, recipients must use the funds by December 31, 2021 and will report to HHS regarding the use of the funds during the period of January 1, 2022 to March 31, 2022. Next, any payments received from January 1, 2021 to June 30, 2021 must be used by June 30, 2022 and recipients must report to HHS regarding such payments from July 1, 2022 to September 30, 2022. Finally, if any provider receives payments during the period of July 1, 2021 to December 31, 2021, the provider must use the funds by December 31, 2022 and report to HHS on the use of these funds during the period of January 1, 2023 to March 31, 2023. Any funds that a provider does not apply towards expenses or lost revenue attributable to COVID-19 must be returned to HHS within 30 calendar days after the end of the applicable reporting period. All recipients of funds are subject to audit by HHS, the HHS OIG, or the Pandemic Response Accountability Committee. Audits may include examination of the accuracy of the data providers submitted to HHS in their applications for payments.

ii. Expansion of the Accelerated and Advance Payment Program to advance three months of payments to Medicare providers. CMS has the ability to recoup the advanced payments through future Medicare claims. Section 2501 of the Continuing Appropriations Act, 2021 and Other Extensions Act, Public Law 116-159, modified the terms of repayment so that a provider can request no recoupment for one year after the advanced payment was issued, followed by a 25% offset the next 11 months, and a 50% offset the last 6 months. Any amounts that remain unpaid after 29 months will be subject to a 4% interest rate (instead of 10.25%). CMS began recouping advance payments on March 30, 2021, but the actual date for each provider is based on the first anniversary of when the provider received the first payment. CMS publishes repayment data every six months, beginning June 28, 2021.

iii. Temporary suspension of the 2% cut to Medicare payments due to sequestration so that, for the period of May 1, 2020 to December 31, 2020, the Medicare program will be exempt from any sequestration order. The Consolidated Appropriations Act, 2021, extended this temporary suspension of the 2% sequestration cut through March 31, 2021. The Medicare sequester relief bill, which became Public Law 117-7, extended the temporary suspension of the sequestration cut again, through December 31, 2021. To pay for the continued suspension of the sequestration cuts through December 31, 2021, Congress increased the sequestration cut that will apply in fiscal year 2030. The Protecting Medicare and American Farmers from Sequester Cuts Act, signed into law by President Biden on December 10, 2021, further extends the suspension of the sequestration cut through March 31, 2022, and reduces the sequestration cut to 1% from April 1, 2022 through June 30, 2022. The full 2% sequestration cut will resume July 1, 2022. To pay for this relief, Congress increased the sequestration cut to Medicare payments to 2.25% for the first sixth months of fiscal year 2030 and to 3% for the final sixth months of fiscal year 2030. The same legislation defers an across-the-board 4% payment cut due to the American Rescue Plan from the FY 2022 Statutory Pay-As-You-Go ("PAYGO") scorecard to the FY 2023 PAYGO scorecard.

iv. Two waivers of Medicare statutory requirements regarding site neutral payment to LTCHs. The first waives the LTCH discharge payment percentage requirement (i.e., 50% rule) for the cost reporting period(s) that include the emergency period. The second waives application of the site neutral payment rate so that all LTCH cases admitted during the emergency period will be paid the LTCH-PPS standard federal rate.

v. Waiver of the IRF 3-hour rule so that IRF services provided during the public health emergency period do not need to meet the coverage requirement that patients receive at least 3 hours of therapy a day or 15 hours of therapy per week.

vi. Broader waiver authority for HHS under section 1135 of the Social Security Act to issue additional telehealth waivers.

The CARES Act also provides for a 20% increase in the payment weight for Medicare payments to hospitals paid under the IPPS for treating COVID-19 patients. We are monitoring developments related to this provision, in case CMS provides a similar payment add-on for LTCHs and IRFs.

Medicare Reimbursement of LTCH Services

The following is a summary of significant regulatory changes to the Medicare prospective payment system for our critical illness recovery hospitals, which are certified by Medicare as LTCHs, which have affected our results of operations, as well as the policies and payment rates that may affect our future results of operations. Medicare payments to our critical illness recovery hospitals are made in accordance with LTCH-PPS.

Fiscal Year 2020. On August 16, 2019, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2020 (affecting discharges and cost reporting periods beginning on or after October 1, 2019 through September 30, 2020). Certain errors in the final rule were corrected in a document published October 8, 2019. The standard federal rate was set at $42,678, an increase from the standard federal rate applicable during fiscal year 2019 of $41,559. The update to the standard federal rate for fiscal year 2020 included a market basket increase of 2.9%, less a productivity adjustment of 0.4%. The standard federal rate also included an area wage budget neutrality factor of 1.0020203. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $26,778, a decrease from the fixed-loss amount in the 2019 fiscal year of $27,121. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $26,552, an increase from the fixed-loss amount in the 2019 fiscal year of $25,743. For LTCH discharges occurring in cost reporting periods beginning in fiscal year 2020, site neutral payment rate cases began to be paid fully on the site neutral payment rate, rather than the transitional blended rate. However, the CARES Act waived the site neutral payment rate for patients admitted during the COVID-19 emergency period and in response to the public health emergency, as discussed above.

Fiscal Year 2021. On September 18, 2020, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2021 (affecting discharges and cost reporting periods beginning on or after October 1, 2020 through September 30, 2021). Certain errors in the final rule were corrected in a document published December 7, 2020. The standard federal rate was set at $43,755, an increase from the standard federal rate applicable during fiscal year 2020 of $42,678. The update to the standard federal rate for fiscal year 2021 included a market basket increase of 2.3% with no productivity adjustment. The standard federal rate also included an area wage budget neutrality factor of 1.0016837. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $27,195, an increase from the fixed-loss amount in the 2020 fiscal year of $26,778. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $29,064, an increase from the fixed-loss amount in the 2020 fiscal year of $26,552.

Fiscal Year 2022. On August 13, 2021, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2022 (affecting discharges and cost reporting periods beginning on or after October 1, 2021 through September 30, 2022). The standard federal rate was set at $44,714, an increase from the standard federal rate applicable during fiscal year 2021 of $43,755. The update to the standard federal rate for fiscal year 2022 included a market basket increase of 2.6%, less a productivity adjustment of 0.7%. The standard federal rate also included an area wage budget neutrality factor of 1.002848. As a result of the CARES Act, all LTCH cases are paid at the standard federal rate during the public health emergency. If the public health emergency ends during fiscal year 2022, then CMS will return to using the site-neutral payment rate for reimbursement of cases that do not meet the LTCH patient criteria. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $33,015, a significant increase from the fixed-loss amount in the 2021 fiscal year of $27,195. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $30,988, an increase from the fixed-loss amount in the 2021 fiscal year of $29,064.

Medicare Reimbursement of IRF Services

The following is a summary of significant regulatory changes to the Medicare prospective payment system for our rehabilitation hospitals, which are certified by Medicare as IRFs, which have affected our results of operations, as well as the policies and payment rates that may affect our future results of operations. Medicare payments to our rehabilitation hospitals are made in accordance with IRF-PPS.

Fiscal Year 2020. On August 8, 2019, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2020 (affecting discharges and cost reporting periods beginning on or after October 1, 2019 through September 30, 2020). The standard payment conversion factor for discharges for fiscal year 2020 was set at $16,489, an increase from the standard payment conversion factor applicable during fiscal year 2019 of $16,021. The update to the standard payment conversion factor for fiscal year 2020 included a market basket increase of 2.9%, less a productivity adjustment of 0.4%. CMS decreased the outlier threshold amount for fiscal year 2020 to $9,300 from $9,402 established in the final rule for fiscal year 2019.

Fiscal Year 2021. On August 10, 2020, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2021 (affecting discharges and cost reporting periods beginning on or after October 1, 2020 through September 30, 2021). The standard payment conversion factor for discharges for fiscal year 2021 was set at $16,856, an increase from the standard payment conversion factor applicable during fiscal year 2020 of $16,489. The update to the standard payment conversion factor for fiscal year 2021 included a market basket increase of 2.4% with no productivity adjustment. CMS decreased the outlier threshold amount for fiscal year 2021 to $7,906 from $9,300 established in the final rule for fiscal year 2020.

Fiscal Year 2022. On August 4, 2021, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2022 (affecting discharges and cost reporting periods beginning on or after October 1, 2021 through September 30, 2022). The standard payment conversion factor for discharges for fiscal year 2022 was set at $17,240, an increase from the standard payment conversion factor applicable during fiscal year 2021 of $16,856. The update to the standard payment conversion factor for fiscal year 2022 included a market basket increase of 2.6%, less a productivity adjustment of 0.7%. CMS increased the outlier threshold amount for fiscal year 2022 to $9,491 from $7,906 established in the final rule for fiscal year 2021.

Medicare Reimbursement of Outpatient Rehabilitation Clinic Services

Outpatient rehabilitation providers enroll in Medicare as a rehabilitation agency, a clinic, or a public health agency. The Medicare program reimburses outpatient rehabilitation providers based on the Medicare physician fee schedule. For services provided in 2017 through 2019, a 0.5% update was applied each year to the fee schedule payment rates, subject to an adjustment beginning in 2019 under the MIPS. In 2019, CMS added physical and occupational therapists to the list of MIPS eligible clinicians. For these therapists in private practice, payments under the fee schedule are subject to adjustment in a later year based on their performance in MIPS according to established performance standards. Calendar year 2021 is the first year that payments are adjusted, based upon the therapist's performance under MIPS in 2019. Providers in facility-based outpatient therapy settings are excluded from MIPS eligibility and therefore not subject to this payment adjustment. For services provided in 2020 through 2025, a 0.0% percent update will be applied each year to the fee schedule payment rates, subject to adjustments under MIPS and the APMs. In 2026 and subsequent years, eligible professionals participating in APMs who meet certain criteria would receive annual updates of 0.75%, while all other professionals would receive annual updates of 0.25%.

Each year from 2019 through 2024 eligible clinicians who receive a significant share of their revenues through an advanced APM (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus. The bonus payment for APM participation is intended to encourage participation and testing of new APMs and to promote the alignment of incentives across payors.

In the 2020 Medicare physician fee schedule final rule, CMS revised coding, documentation guidelines, and increased the valuation for E/M office visit codes, beginning in 2021. Because the Medicare physician fee schedule is budget-neutral, any revaluation of E/M services that will increase spending by more than $20 million will require a budget neutrality adjustment. To increase values for the E/M codes while maintaining budget neutrality under the fee schedule, CMS cut the values of other codes to make up the difference, beginning in 2021.

In the 2021 Medicare physician fee schedule final rule, CMS increased the values for the E/M office visit codes and cuts to other specialty codes to maintain budget neutrality. As a result, therapy services provided in our outpatient rehabilitation clinics received an estimated 3.6% decrease in payment from Medicare in calendar year 2021. The Consolidated Appropriations Act, 2021, provided relief in the form of a one-time 3.75% increase in payments in calendar year 2021 for therapy services and other services paid under the physician fee schedule.

In the calendar year 2022 physician fee schedule final rule, CMS announced that Medicare payments for the therapy specialty are expected to decrease 1% in 2022. After CMS issued the final rule, Congress passed the Protecting Medicare and American Farmers from Sequester Cuts Act, which provided in Section 3 a one-time 3% increase in payments in calendar year 2022 to offset most of the 3.75% cut to payments for therapy services and other services paid under the physician fee schedule. In the final rule, CMS also adopted its plan to transition the MIPS program to MVPs. CMS will begin the transition to MVPs in 2023 with an initial set of MVPs in which reporting is voluntary. Beginning in 2026, multispecialty groups must form subgroups to report MVPs. CMS plans to develop more MVPs from 2024 to 2027 and is considering that MVP reporting would become mandatory in 2028. Each MVP would include population health claims-based measures and require clinicians to report on the Promoting Interoperability performance category measures. In addition, MVP participants would select certain quality measures and improvement activities and then report data for such measures and activities.

Modifiers to Identify Services of Physical Therapy Assistants or Occupational Therapy Assistants

In the Medicare Physician Fee Schedule final rule for calendar year 2019, CMS established two new modifiers (CQ and CO) to identify services furnished in whole or in part by PTAs or OTAs. These modifiers were mandated by the Bipartisan Budget Act of 2018, which requires that claims for outpatient therapy services furnished in whole or part by therapy assistants on or after January 1, 2020 include the appropriate modifier. In the final 2020 Medicare physician fee schedule rule, CMS clarified that when the physical therapist is involved for the entire duration of the service and the PTA provides skilled therapy alongside the physical therapist**,** the CQ modifier is not required. Also, when the same service (code) is furnished separately by the physical therapist and PTA, CMS will apply the *de minimis* standard to each 15-minute unit of codes, not on the total physical therapist and PTA time of the service, allowing the separate reporting, on two different claim lines, of the number of units to which the new modifiers apply and the number of units to which the modifiers do not apply. In the calendar year 2022 physician fee schedule final rule, CMS implemented the final part of the requirements in the Bipartisan Budget Act of 2018 regarding PTA and OTA services. For dates of service on and after January 1, 2022, CMS will pay for physical therapy and occupational therapy services provided by PTAs and OTAs at 85% of the otherwise applicable Part B payment amount. CMS also modified the *de minimis* standard for calendar year 2022. Specifically, CMS will allow a timed service to be billed without the CQ or CO modifier when a PTA or OTA participates in providing care, but the physical therapist or occupational therapist meets the Medicare billing requirements without including the PTA's or OTA's minutes. This occurs when the physical therapist or occupational therapist provides more minutes than the 15-minute midpoint.

Critical Accounting Estimates

Revenue Recognition and Accounts Receivable

Our principal revenue source comes from providing healthcare services to patients. Patient service revenues are recognized at an amount equal to the consideration we expect to be entitled to in exchange for providing healthcare services to our patients. Revenue earned from these services is variable in nature, as we are required to make judgments that impact the transaction price.

We determine the transaction price for services provided to patients who are Medicare beneficiaries using Medicare's prospective payment systems and other payment methods. The expected payment is determined by the level of clinical services provided and is sensitive to the patient's length of stay. Additionally, we are paid by various other non-Medicare payor sources including, but not limited to, insurance companies (including Medicare Advantage plans), state Medicaid programs, workers' compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as patients themselves. The transaction price for services provided to non-Medicare patients include amounts prescribed by state and federal fee schedules, negotiated contracted amounts, or usual and customary amounts associated with the specific payor or based on the service provided. We apply a portfolio approach in determining revenues for certain homogeneous non-Medicare patient populations.

There is variability in the transaction price for services provided to our patients, as the transaction price is impacted by several factors, such as the patient's condition and length of stay, which in turn impact the payment we expect to receive for providing such services. Variable consideration included in the transaction price is inclusive of our estimates of implicit discounts and other adjustments related to timely filing and documentation denials, out of network adjustments, and medical necessity denials, which are estimated using our historical experience. We are also subject to regular post-payment inquiries, investigations, and audits of the claims we submit for services provided. Some claims can take several years for resolution and may result in adjustments to the transaction price. Management includes in its estimates of the transaction price its expectations for these types of adjustments such that the amount of cumulative revenue recognized will not be subject to significant reversal in future periods. Historically, adjustments arising from a change in the transaction price have not been significant.

Our accounts receivable is reported at an amount equal to the amount we expect to collect for providing healthcare services to our patients. Because our accounts receivable is typically paid for by highly-solvent, creditworthy payors, such as Medicare, other governmental programs, and highly-regulated commercial insurers on behalf of the patient, our credit losses are infrequent and insignificant in nature; as such, we generally do not recognize allowances for expected credit losses.

Insurance Risk Programs

Under a number of our insurance programs, which include our employee health insurance, workers' compensation, and professional malpractice liability insurance programs, we are liable for a portion of our losses before we can attempt to recover from the applicable insurance carrier. We accrue for losses under an occurrence-based approach, whereby we estimate the losses that will be incurred in a respective accounting period. The estimate of losses includes actuarial loss projections of both known claims and incurred but not reported claims. These estimates are based on specific claim facts, claim frequency and severity, payment patterns for historical claims, and estimates of fees for outside counsel. In addition to the actuarial loss projections, insurance premiums and out-of-pocket expenses for the administration and analysis of claims are included in the estimate of losses accrued in a respective accounting period.

We monitor these programs quarterly and revise our estimates as necessary to take into account additional information. We recorded a liability of $173.6 million and $173.5 million for our estimated losses under these insurance programs at December 31, 2020 and 2021, respectively. We also recorded insurance proceeds receivable of $13.0 million and $14.5 million at December 31, 2020 and 2021, respectively, for liabilities which exceed our deductibles and self-insured retention limits and are recoverable through our insurance policies.

Goodwill

We operate four reporting units which include the critical illness recovery hospital reporting unit, the rehabilitation hospital reporting unit, the outpatient rehabilitation reporting unit, and the Concentra reporting unit. We assign goodwill to our reporting units based upon the specific nature of the business acquired or, when a business combination contains business components related to more than one reporting unit, goodwill is assigned to each reporting unit based upon an allocation determined by the relative fair values of the business acquired. When we dispose of a business, we allocate a portion of the reporting unit's goodwill to that business based on the relative fair values of the portion of the reporting unit being disposed of and the portion of the reporting unit remaining. We evaluate our reporting units on an annual basis and, if our reporting units are reorganized, we reassign goodwill based on the relative fair values of the new reporting units.

We perform an annual goodwill impairment assessment for each of our reporting units as of October 1 or when events or conditions occur that might suggest a possible impairment. Events or conditions which might suggest impairment could include a significant change in the business environment, the regulatory environment, or legal factors; a current period operating or cash flow loss combined with a history of such losses or a projection of continuing losses; or a sale or disposition of a significant portion of a reporting unit.

We first assess qualitative factors for each of our reporting units when performing our annual impairment assessment. In performing the qualitative assessment, we apply judgment in determining the events and circumstances that most affect the fair value of the reporting unit and in evaluating the significance of those identified events and circumstances in order to determine whether it is more likely than not that the fair value of the reporting unit is less than its carrying amount. As part of our assessments, we considered (i) the relationship between the reporting unit's excess fair value over its carrying amount from the most recent quantitative impairment test, (ii) industry and market conditions, including the impacts of the COVID-19 pandemic, (iii) our historical financial performance, including our revenue, earnings, and operating cash flow growth trends, (iv) our forecasts of revenue, earnings, and operating cash flows, (v) cost factors, including the effects of inflation and rising prices, (vi) the regulatory environment, including reimbursement and compliance requirements such as those that exist under the Medicare program, (vii) other factors specific to each reporting unit, such as a change in strategy, a change in management, or acquisitions and divestitures affecting the composition of the reporting unit and its future operating results, and (viii) consideration of changes in our market capitalization. Historically, each reporting unit's fair value has significantly exceeded its carrying value.

We have recorded total goodwill of $3.4 billion at December 31, 2021, of which $1.1 billion related to our critical illness recovery hospital reporting unit, $442.2 million related to our rehabilitation hospital reporting unit, $654.1 million related to our outpatient rehabilitation reporting unit, and $1.2 billion related to the Concentra reporting unit.

Our annual assessment, performed as of October 1, 2021, did not indicate that goodwill impairment was likely for any of our reporting units. We did not identify any goodwill impairment events as of December 31, 2021.

Operating Statistics

The following table sets forth operating statistics for each of our segments for the periods presented. The operating statistics reflect data for the period of time we managed these operations. Our operating statistics include metrics we believe provide relevant insight about the number of facilities we operate, volume of services we provide to our patients, and average payment rates for services we provide. These metrics are utilized by management to monitor trends and performance in our businesses and therefore may be important to investors because management may assess our performance based in part on such metrics. Other healthcare providers may present similar statistics, and these statistics are susceptible to varying definitions. Our statistics as presented may not be comparable to other similarly titled statistics of other companies.

	For the Year Ended December 31,		
	2019	**2020**	**2021**
Critical illness recovery hospital data:			
Number of hospitals owned—start of period	96	100	99
Number of hospitals acquired	4	1	6
Number of hospital start-ups	—	—	—
Number of hospitals closed/sold	—	(2)	(1)
Number of hospitals owned—end of period	100	99	104
Number of hospitals managed—end of period	1	—	—
Total number of hospitals (all)—end of period	101	99	104
Available licensed beds[1]	4,265	4,362	4,518
Admissions[1][2]	36,774	37,456	37,921
Patient days[1][3]	1,038,361	1,111,756	1,133,039
Average length of stay (days)[1][4]	28	30	30
Revenue per patient day[1][5]	$ 1,753	$ 1,858	$ 1,972
Occupancy rate[1][6]	68 %	71 %	71 %
Percent patient days—Medicare[1][7]	51 %	45 %	38 %
Rehabilitation hospital data:			
Number of hospitals owned—start of period	17	19	19
Number of hospitals acquired	—	1	1
Number of hospital start-ups	2	—	—
Number of hospitals closed/sold	—	(1)	—
Number of hospitals owned—end of period	19	19	20
Number of hospitals managed—end of period	10	11	10
Total number of hospitals (all)—end of period	29	30	30
Available licensed beds[1]	1,309	1,311	1,361
Admissions[1][2]	24,889	25,081	28,868
Patient days[1][3]	353,031	370,833	414,701
Average length of stay (days)[1][4]	14	15	14
Revenue per patient day[1][5]	$ 1,685	$ 1,793	$ 1,868
Occupancy rate[1][6]	76 %	78 %	83 %
Percent patient days—Medicare[1][7]	52 %	48 %	49 %
Outpatient rehabilitation data:			
Number of clinics owned—start of period	1,423	1,461	1,503
Number of clinics acquired	31	17	33
Number of clinic start-ups	57	55	53
Number of clinics closed/sold	(50)	(30)	(17)
Number of clinics owned—end of period	1,461	1,503	1,572
Number of clinics managed—end of period	279	285	309
Total number of clinics (all)—end of period	1,740	1,788	1,881
Number of visits[1][8]	8,719,282	7,593,344	9,193,624
Revenue per visit[1][9]	$ 103	$ 104	$ 102

	For the Year Ended December 31,		
	2019	2020	2021
Concentra data:			
Number of centers owned—start of period	524	521	517
Number of centers acquired	6	6	6
Number of center start-ups	—	1	2
Number of centers closed/sold	(9)	(11)	(7)
Number of centers owned—end of period	521	517	518
Number of onsite clinics operated—end of period	131	134	134
Number of CBOCs owned—end of period	32	—	—
Number of visits[(1)(8)]	12,068,865	10,627,904	12,052,724
Revenue per visit[(1)(9)]	$ 122	$ 123	$ 125

(1) Data excludes locations managed by the Company. For purposes of our Concentra segment, onsite clinics and community-based outpatient clinics ("CBOCs") are excluded.

(2) Represents the number of patients admitted to our hospitals during the periods presented.

(3) Each patient day represents one patient occupying one bed for one day during the periods presented.

(4) Represents the average number of days in which patients were admitted to our hospitals. Average length of stay is calculated by dividing the number of patient days, as presented above, by the number of patients discharged from our hospitals during the periods presented.

(5) Represents the average amount of revenue recognized for each patient day. Revenue per patient day is calculated by dividing patient service revenues, excluding revenues from certain other ancillary and outpatient services provided at our hospitals, by the total number of patient days.

(6) Represents the portion of our hospitals being utilized for patient care during the periods presented. Occupancy rate is calculated using the number of patient days, as presented above, divided by the total number of bed days available during the period. Bed days available is derived by adding the daily number of available licensed beds for each of the periods presented.

(7) Represents the portion of our patient days which are paid by Medicare. The Medicare patient day percentage is calculated by dividing the total number of patient days which are paid by Medicare by the total number of patient days, as presented above.

(8) Represents the number of visits in which patients were treated at our outpatient rehabilitation clinics and Concentra centers during the periods presented.

(9) Represents the average amount of revenue recognized for each patient visit. Revenue per visit is calculated by dividing patient service revenue, excluding revenues from certain other ancillary services, by the total number of visits. For purposes of this computation for our Concentra segment, patient service revenue does not include onsite clinics and CBOCs.

Results of Operations

The following table outlines selected operating data as a percentage of revenue for the periods indicated:

	For the Year Ended December 31,		
	2019	**2020**	**2021**
Revenue	100.0 %	100.0 %	100.0 %
Costs and expenses:			
Cost of services, exclusive of depreciation and amortization[(1)]	85.1	85.2	85.2
General and administrative	2.4	2.5	2.4
Depreciation and amortization	3.8	3.6	3.2
Total costs and expenses	91.3	91.3	90.8
Other operating income	—	1.6	2.3
Income from operations	8.7	10.3	11.5
Loss on early retirement of debt	(0.7)	—	—
Equity in earnings of unconsolidated subsidiaries	0.5	0.5	0.7
Gain on sale of businesses	0.1	0.2	—
Interest income	—	—	0.1
Interest expense	(3.7)	(2.7)	(2.2)
Income before income taxes	4.9	8.3	10.1
Income tax expense	1.2	2.1	2.0
Net income	3.7	6.2	8.1
Net income attributable to non-controlling interests	1.0	1.5	1.6
Net income attributable to Select Medical Holdings Corporation	2.7 %	4.7 %	6.5 %

(1) Cost of services includes salaries, wages and benefits, operating supplies, lease and rent expense, and other operating costs.

The following table summarizes selected financial data by segment for the periods indicated:

	Year Ended December 31,				
	2019	2020	2021	% Change 2019 – 2020	% Change 2020 – 2021
	(in thousands, except percentages)				
Revenue:					
Critical illness recovery hospital	$ 1,836,518	$ 2,077,499	$ 2,246,772	13.1 %	8.1 %
Rehabilitation hospital	670,971	734,673	849,340	9.5	15.6
Outpatient rehabilitation	1,046,011	919,913	1,084,361	(12.1)	17.9
Concentra	1,628,817	1,501,434	1,732,041	(7.8)	15.4
Other[1]	271,605	298,194	292,001	9.8	(2.1)
Total Company	$ 5,453,922	$ 5,531,713	$ 6,204,515	1.4 %	12.2 %
Income (loss) from operations:					
Critical illness recovery hospital[2]	$ 204,105	$ 290,896	$ 214,899	42.5 %	(26.1)%
Rehabilitation hospital	108,535	125,476	157,027	15.6	25.1
Outpatient rehabilitation	123,530	50,155	108,683	(59.4)	116.7
Concentra[2]	176,606	162,515	305,264	(8.0)	87.8
Other[1][2]	(140,895)	(61,385)	(72,099)	N/M	N/M
Total Company	$ 471,881	$ 567,657	$ 713,774	20.3 %	25.7 %
Adjusted EBITDA:					
Critical illness recovery hospital[2]	$ 254,868	$ 342,427	$ 267,993	34.4 %	(21.7)%
Rehabilitation hospital	135,857	153,203	184,704	12.8	20.6
Outpatient rehabilitation	151,831	79,164	138,275	(47.9)	74.7
Concentra[2]	276,482	252,892	389,616	(8.5)	54.1
Other[1][2]	(108,130)	(27,120)	(33,229)	N/M	N/M
Total Company	$ 710,908	$ 800,566	$ 947,359	12.6 %	18.3 %
Adjusted EBITDA margins:					
Critical illness recovery hospital[2]	13.9 %	16.5 %	11.9 %		
Rehabilitation hospital	20.2	20.9	21.7		
Outpatient rehabilitation	14.5	8.6	12.8		
Concentra[2]	17.0	16.8	22.5		
Other[1][2]	N/M	N/M	N/M		
Total Company	13.0 %	14.5 %	15.3 %		
Total assets:					
Critical illness recovery hospital	$ 2,099,833	$ 2,213,892	$ 2,304,116		
Rehabilitation hospital	1,127,028	1,148,617	1,194,136		
Outpatient rehabilitation	1,289,190	1,302,110	1,348,316		
Concentra	2,372,187	2,400,646	2,275,345		
Other[1]	452,050	590,134	238,258		
Total Company	$ 7,340,288	$ 7,655,399	$ 7,360,171		
Purchases of property and equipment:					
Critical illness recovery hospital	$ 45,573	$ 49,726	$ 65,690		
Rehabilitation hospital	27,216	7,571	13,003		
Outpatient rehabilitation	33,628	28,876	36,301		
Concentra	44,101	50,114	46,787		
Other[1]	6,608	10,153	18,756		
Total Company	$ 157,126	$ 146,440	$ 180,537		

(1) Other includes our corporate administration and shared services, as well as employee leasing services with our non-consolidating subsidiaries. Total assets include certain non-consolidating joint ventures and minority investments in other healthcare related businesses.

(2) For the years ended December 31, 2021 and 2020, we recognized other operating income of $144.0 million and $90.0 million, respectively. We did not recognize other operating income during the year ended December 31, 2019. The impact of this income on the operating results of our segments and other activities is outlined within the tables presented under "*Summary Financial Results.*"

N/M — Not meaningful.

Year Ended December 31, 2021 Compared to Year Ended December 31, 2020

In the following, we discuss our results of operations related to revenue, operating expenses, other operating income, Adjusted EBITDA, depreciation and amortization, income from operations, equity in earnings of unconsolidated subsidiaries, gain on sale of businesses, interest, income taxes, and net income attributable to non-controlling interests.

Please refer to "*Effects of the COVID-19 Pandemic on our Results of Operations*" above for further discussion.

Revenue

Our revenue increased 12.2% to $6,204.5 million for the year ended December 31, 2021, compared to $5,531.7 million for the year ended December 31, 2020.

Critical Illness Recovery Hospital Segment. Revenue increased 8.1% to $2,246.8 million for the year ended December 31, 2021, compared to $2,077.5 million for the year ended December 31, 2020. The increase in revenue was principally due to an increase in revenue per patient day during the year ended December 31, 2021, as compared to the year ended December 31, 2020. Revenue per patient day increased 6.1% to $1,972 for the year ended December 31, 2021, compared to $1,858 for the year ended December 31, 2020. We experienced increases in both our non-Medicare and Medicare revenue per patient day during the year ended December 31, 2021, compared to the year ended December 31, 2020. Occupancy in our critical illness recovery hospitals was 71% for both the years ended December 31, 2021 and 2020. Our patient days increased 1.9% to 1,133,039 patient days for the year ended December 31, 2021, compared to 1,111,756 patient days for the year ended December 31, 2020. Our patient days for the year ended December 31, 2021 were positively impacted by the acquisition of seven hospitals during 2020 and 2021, as well as the reopening of our Panama City hospital in July 2020. These hospitals contributed 48,239 patient days during the year ended December 31, 2021, as compared to 9,670 patient days during the year ended December 31, 2020.

Rehabilitation Hospital Segment. Revenue increased 15.6% to $849.3 million for the year ended December 31, 2021, compared to $734.7 million for the year ended December 31, 2020. The increase in revenue resulted from increases in both patient volume and revenue per patient day during the year ended December 31, 2021, as compared to the year ended December 31, 2020. Occupancy in our rehabilitation hospitals increased to 83% for the year ended December 31, 2021, compared to 78% for the year ended December 31, 2020. Our patient days increased 11.8% to 414,701 days for the year ended December 31, 2021, compared to 370,833 days for the year ended December 31, 2020. Our patient volume during the year ended December 31, 2020 was adversely affected within our rehabilitation hospitals in New Jersey and South Florida that temporarily restricted their admissions as a result of the COVID-19 pandemic. Certain of our rehabilitation hospitals also experienced lower patient volume due to the suspension of elective surgeries at hospitals and other facilities, which consequently reduced the demand for inpatient rehabilitation services during the year ended December 31, 2020. Our revenue per patient day increased 4.2% to $1,868 for the year ended December 31, 2021, compared to $1,793 for the year ended December 31, 2020. We experienced increases in both our Medicare and non-Medicare revenue per patient day during the year ended December 31, 2021, compared to the year ended December 31, 2020.

Outpatient Rehabilitation Segment. Revenue increased 17.9% to $1,084.4 million for the year ended December 31, 2021, compared to $919.9 million for the year ended December 31, 2020. The increase in revenue was attributable to an increase in visits, which increased 21.1% to 9,193,624 for the year ended December 31, 2021, compared to 7,593,344 visits for the year ended December 31, 2020. During the year ended December 31, 2020, our outpatient rehabilitation clinics experienced significant declines in patient visit volume due to fewer patient referrals from physicians, a reduction in workers' compensation injury visits due to the closure of businesses, the suspension of elective surgeries at hospitals and other facilities which resulted in less demand for outpatient rehabilitation services, and social distancing practices resulting from the COVID-19 pandemic. Our revenue per visit was $102 for the year ended December 31, 2021, compared to $104 for the year ended December 31, 2020. During the year ended December 31, 2020, we experienced changes in our payor mix as our patient volume declined from the effects of the COVID-19 pandemic. These changes caused our revenue per visit to increase. As our patient volume increased during the year ended December 31, 2021, as compared to the year ended December 31, 2020, our payor mix began to normalize and is now more closely aligned with the mix experienced during the months prior to the widespread emergence of COVID-19 in the United States.

Concentra Segment. Revenue increased 15.4% to $1,732.0 million for the year ended December 31, 2021, compared to $1,501.4 million for the year ended December 31, 2020. Our patient visits, which increased 13.4% to 12,052,724 for the year ended December 31, 2021, compared to 10,627,904 visits for the year ended December 31, 2020, contributed to the increase in revenue. During the year ended December 31, 2020, our centers experienced significant declines in patient visit volume due to employers furloughing their workforce and temporarily ceasing or significantly reducing their operations. Although we experienced temporary disruptions in our core businesses as a result of the COVID-19 pandemic, we were able to expand our services to provide COVID-19 screening and testing services. These services contributed $137.6 million of revenue during the year ended December 31, 2021, compared to $62.0 million during the year ended December 31, 2020. During the year ended December 31, 2021, our revenue per visit increased to $125, compared to $123 for the year ended December 31, 2020. We experienced a higher revenue per visit due to increases in the reimbursement rates payable pursuant to certain state fee schedules for workers' compensation visits, as well as increases in our employer services rates, during the year ended December 31, 2021. The increase in revenue per visit was offset partially by a greater percentage of employer services visits, which yield lower per visit rates. Additionally, the sale of Concentra's Department of Veterans Affairs community-based outpatient clinic business on September 1, 2020 contributed to the change in revenue. The Concentra segment recognized $58.3 million of revenue related to this business during the year ended December 31, 2020.

Operating Expenses

Our operating expenses consist principally of cost of services and general and administrative expenses. Our operating expenses were $5,432.1 million, or 87.6% of revenue, for the year ended December 31, 2021, compared to $4,848.4 million, or 87.7% of revenue, for the year ended December 31, 2020. Our cost of services, a major component of which is labor expense, was $5,285.1 million, or 85.2% of revenue, for the year ended December 31, 2021, compared to $4,710.4 million, or 85.2% of revenue, for the year ended December 31, 2020. General and administrative expenses were $147.0 million, or 2.4% of revenue, for the year ended December 31, 2021, compared to $138.0 million, or 2.5% of revenue, for the year ended December 31, 2020.

Other Operating Income

Other operating income was $144.0 million for the year ended December 31, 2021, compared to $90.0 million for the year ended December 31, 2020.

For the year ended December 31, 2021, $123.8 million of other operating income is related to the recognition of payments received under the Provider Relief Fund for health care related expenses and lost revenues attributable to COVID-19. $89.1 million and $34.7 million of this other operating income is included within the operating results of our other activities and Concentra segment, respectively. For the year ended December 31, 2021, $19.9 million of other operating income is related to the outcome of litigation with CMS and is included in the operating results of our critical illness recovery hospital segment.

For the year ended December 31, 2020, the other operating income of $90.0 million is related to the recognition of payments received under the Provider Relief Fund for health care related expenses and lost revenues attributable to COVID-19. $88.9 million and $1.1 million of other operating income is included within the operating results of our other activities and Concentra segment, respectively.

Adjusted EBITDA

Critical Illness Recovery Hospital Segment. Adjusted EBITDA was $268.0 million for the year ended December 31, 2021, compared to $342.4 million for the year ended December 31, 2020. Our Adjusted EBITDA margin for the critical illness recovery hospital segment was 11.9% for the year ended December 31, 2021, compared to 16.5% for the year ended December 31, 2020. Our Adjusted EBITDA and Adjusted EBITDA margin for the year ended December 31, 2021 were adversely affected by the incurrence of additional operating expenses, particularly labor costs, as a result of the effects of the COVID-19 pandemic. Constrained staffing due to a shortage of healthcare workers, increased dependence on contract clinical workers, the loss of unvaccinated employees in jurisdictions requiring vaccination, and other factors described further under "*Effects of the COVID-19 Pandemic on our Results of Operations*" have contributed to the increased labor costs. The decrease in Adjusted EBITDA for our critical illness recovery hospital segment was offset in part by the recognition of $19.9 million of other operating income related to the outcome of litigation with CMS during the year ended December 31, 2021, as described further above under "*Other Operating Income*."

Rehabilitation Hospital Segment. Adjusted EBITDA increased 20.6% to $184.7 million for the year ended December 31, 2021, compared to $153.2 million for the year ended December 31, 2020. Our Adjusted EBITDA margin for the rehabilitation hospital segment was 21.7% for the year ended December 31, 2021, compared to 20.9% for the year ended December 31, 2020. The increase in Adjusted EBITDA was driven by increases in both patient volume and revenue per patient day, as discussed further under "*Revenue,"* with the most significant increases occurring in our rehabilitation hospitals in New Jersey and South Florida that temporarily restricted their admissions as a result of the COVID-19 pandemic during the year ended December 31, 2020. Our Adjusted EBITDA and Adjusted EBITDA margin for our rehabilitation hospital segment have been affected by the incurrence of additional operating expenses which are due in part to the effects of the COVID-19 pandemic. Our rehabilitation hospitals have experienced increased usage of contract clinical labor during the year ended December 31, 2021 and the cost of this labor has risen significantly due to the demand for healthcare professionals.

Outpatient Rehabilitation Segment. Adjusted EBITDA increased 74.7% to $138.3 million for the year ended December 31, 2021, compared to $79.2 million for the year ended December 31, 2020. Our Adjusted EBITDA margin for the outpatient rehabilitation segment was 12.8% for the year ended December 31, 2021, compared to 8.6% for the year ended December 31, 2020. The increases in Adjusted EBITDA and Adjusted EBITDA margin were driven by increases in patient visit volume. During the year ended December 31, 2020, our outpatient rehabilitation clinics experienced significant declines in patient visit volume as a result of the effects of the COVID-19 pandemic, as described further above.

Concentra Segment. Adjusted EBITDA increased 54.1% to $389.6 million for the year ended December 31, 2021, compared to $252.9 million for the year ended December 31, 2020. Our Adjusted EBITDA margin for the Concentra segment was 22.5% for the year ended December 31, 2021, compared to 16.8% for the year ended December 31, 2020. The increase in patient visit volume contributed to the increases in Adjusted EBITDA and Adjusted EBITDA margin. As described further above, our Concentra segment experienced significant declines in patient visit volume as a result of the effects of the COVID-19 pandemic during the year ended December 31, 2020. The increases in Adjusted EBITDA and Adjusted EBITDA margin were also due in part to the COVID-19 screening and testing services provided at our centers and various onsite clinics located at employer worksites, as discussed further under "*Revenue.*" We incur lower operating expenses associated with these services as compared to our core services. Our Concentra segment also recognized $35.0 million of other operating income during the year ended December 31, 2021, as described further above under "*Other Operating Income*," compared to $1.1 million for the year ended December 31, 2020.

Depreciation and Amortization

Depreciation and amortization expense was $202.6 million for the year ended December 31, 2021, compared to $205.7 million for the year ended December 31, 2020.

Income from Operations

For the year ended December 31, 2021, we had income from operations of $713.8 million, compared to $567.7 million for the year ended December 31, 2020. The improved operating performance of our Concentra, outpatient rehabilitation, and rehabilitation hospital segments contributed to the increase in income from operations. We also recognized other operating income of $144.0 million during the year ended December 31, 2021, as described further under "*Other Operating Income*," compared to $90.0 million for the year ended December 31, 2020.

Equity in Earnings of Unconsolidated Subsidiaries

For the year ended December 31, 2021, we had equity in earnings of unconsolidated subsidiaries of $44.4 million, compared to $29.4 million for the year ended December 31, 2020. The increase in equity in earnings is principally due to the improved operating performance of our rehabilitation businesses in which we are a minority owner.

Gain on Sale of Businesses

We recognized a gain of $2.2 million during the year ended December 31, 2021. The gain resulted from the sale of a Concentra business.

We recognized gains of $12.4 million during the year ended December 31, 2020. During the year ended December 31, 2020, we sold an outpatient rehabilitation business, a rehabilitation hospital business, and Concentra's Department of Veterans Affairs community-based outpatient clinic business. These sales resulted in gains of approximately $21.4 million. We also incurred a loss of $9.0 million related to an indemnity claim associated with a previously sold business.

Interest

Interest expense was $136.0 million for the year ended December 31, 2021, compared to $153.0 million for the year ended December 31, 2020. The decrease in interest expense was principally due to a decline in variable interest rates.

For the year ended December 31, 2021, we recognized interest income of $5.4 million. The interest income is related to the outcome of litigation with CMS.

Income Taxes

We recorded income tax expense of $129.8 million for the year ended December 31, 2021, which represented an effective tax rate of 20.6%. We recorded income tax expense of $111.9 million for the year ended December 31, 2020, which represented an effective tax rate of 24.5%. The decrease in the effective tax rate resulted from lower state and local effective tax rates and tax credits.

Refer to Note 19 – Income Taxes of the notes to our consolidated financial statements included herein for the reconciliations of the statutory federal income tax rate to our effective income rate for the years ended December 31, 2021 and 2020.

Net Income Attributable to Non-Controlling Interests

Net income attributable to non-controlling interests was $97.7 million for the year ended December 31, 2021, compared to $85.6 million for the year ended December 31, 2020. The increase in net income attributable to non-controlling interests was principally due to an increase in the net income of our Concentra segment during the year ended December 31, 2021. This increase resulted primarily from its improved operating performance and the recognition of $35.0 million of other operating income, as described further above, during the year ended December 31, 2021, as compared to $1.1 million for the year ended December 31, 2020.

Liquidity and Capital Resources

Cash Flows for the Years Ended December 31, 2019, 2020, and 2021

In the following, we discuss cash flows from operating activities, investing activities, and financing activities.

	For the Year Ended December 31,		
	2019	2020	2021
Cash flows provided by operating activities	$ 445,182	$ 1,028,073	$ 401,228
Cash flows used in investing activities	(316,729)	(115,353)	(256,594)
Cash flows provided by (used in) financing activities	32,251	(671,541)	(647,385)
Net increase (decrease) in cash and cash equivalents	160,704	241,179	(502,751)
Cash and cash equivalents at beginning of period	175,178	335,882	577,061
Cash and cash equivalents at end of period	$ 335,882	$ 577,061	$ 74,310

Operating activities provided $401.2 million, $1,028.1 million, and $445.2 million of cash flows for the years ended December 31, 2021, 2020, and 2019, respectively. During the year ended December 31, 2020, we experienced an increase in cash flows provided by operating activities as a result of receiving approximately $318.1 million of advance payments under the Accelerated and Advance Payment Program, as well as approximately $172.6 million of payments under the Provider Relief Fund. During the year ended December 31, 2021, we received an additional $43.1 million of payments under the Provider Relief Fund. Our repayment of the advance payments received under the Accelerated and Advance Payment Program began in April 2021. We experienced strong operating cash flows for the year ended December 31, 2021 despite CMS recouping $241.2 million of Medicare payments during this period. Refer to Note 22 – CARES Act of the notes to our consolidated financial statements included herein for further information regarding the CARES Act, including the recoupment provisions associated with the Accelerated and Advance Payment Program.

Our days sales outstanding was 52 days at December 31, 2021, 56 days at December 31, 2020, and 51 days at December 31, 2019. Our days sales outstanding will fluctuate based upon variability in our collection cycles and patient volumes.

Investing activities used $256.6 million, $115.4 million and $316.7 million of cash flows for the years ended December 31, 2021, 2020, and 2019, respectively. For the year ended December 31, 2021, the principal uses of cash were $180.5 million for purchases of property and equipment and $102.9 million for investments in and acquisitions of businesses. The cash outflows were offset in part by proceeds received from the sale of assets and businesses of $26.8 million. For the year ended December 31, 2020, the principal uses of cash were $146.4 million for purchases of property and equipment and $52.2 million for investments in and acquisitions of businesses. We also received proceeds from the sale of assets and business of $83.3 million. For the year ended December 31, 2019, the principal uses of cash were $157.1 million for purchases of property and equipment and $159.8 million for investments in and acquisitions of businesses.

Financing activities used $647.4 million of cash flows for the year ended December 31, 2021. The principal use of cash was $660.7 million for the purchase of additional membership interests of Concentra Group Holdings Parent, as discussed above under "*Other Significant Events*." Other uses of cash included $79.5 million for repurchases of common stock, $73.1 million for distributions to and purchases of non-controlling interests, and $50.6 million of dividend payments to common stockholders. We had borrowings of $160.0 million under our revolving facility.

Financing activities used $671.5 million of cash flows for the year ended December 31, 2020. The principal use of cash was $576.4 million for the purchase of additional membership interests of Concentra Group Holdings Parent during the year ended December 31, 2020. We also used $39.8 million of cash for the mandatory prepayment of term loans under our credit facilities.

Financing activities provided $32.3 million of cash flows for the year ended December 31, 2019. The principal sources of cash were from the issuance of $1,225.0 million aggregate principal amount of 6.250% senior notes, $1,115.0 million of incremental term loan borrowings under our credit facilities, and $100.0 million of incremental term loan borrowings under the Concentra-JPM first lien credit agreement. These borrowings provided net financing cash inflows of $2,453.1 million. A portion of the net proceeds of the 6.250% senior notes, together with a portion of the proceeds from the incremental term loan borrowings under our credit facilities, were used by Select to redeem in full its $710.0 million 6.375% senior notes and to make a term loan in an aggregate principal amount of approximately $1,240.3 million to Concentra Inc. Concentra Inc. then repaid its $1,240.3 million term loan outstanding under the Concentra-JPM first lien credit agreement. The proceeds from the incremental term loans under the Concentra-JPM first lien credit agreement were used, in part, to repay the $240.0 million of term loans outstanding under the Concentra-JPM second lien credit agreement. We also used $98.8 million and $33.9 million of cash for mandatory prepayments of term loans outstanding under our credit facilities and the Concentra-JPM first and second lien credit agreements, respectively. During the year ended December 31, 2019, we had net repayments of $20.0 million under our and Concentra Inc.'s revolving facility.

Capital Resources

Working capital. We had net working capital deficit of $133.6 million at December 31, 2021, compared to net working capital of $155.6 million at December 31, 2020. The decrease in our working capital was primarily caused by a reduction in cash resulting from the purchase of additional membership interests of Concentra Group Holdings Parent for $660.7 million on December 24, 2021. Refer to the "*Liquidity*" section below for additional discussion regarding our ability to finance our operations in the short term.

A significant component of our net working capital is our accounts receivable. Collection of these accounts receivable is our primary source of cash and is critical to our liquidity and capital resources. Most of our patients are subject to healthcare coverage through third party payor arrangements, including Medicare and Medicaid. It is our general policy to verify healthcare coverage prior to providing services. We have credit risk associated with our accounts receivable; however, we believe there is a remote possibility of default with these payors.

Credit facilities. On June 2, 2021, Select entered into Amendment No. 5 to its credit agreement which, among other things, increased the aggregate commitments available under our revolving facility from $450.0 million to $650.0 million, including a $125.0 million sublimit for the issuance of standby letters of credit.

At December 31, 2021, Select had outstanding borrowings under its credit facilities consisting of a $2,103.4 million term loan (excluding unamortized original issue discounts and debt issuance costs of $13.3 million). At December 31, 2021, Select had $434.7 million of availability under its revolving facility after giving effect to $160.0 million of outstanding borrowings and $55.3 million of outstanding letters of credit.

On the last day of each calendar quarter, Select is required to pay each lender a commitment fee in respect of any unused commitments under the revolving facility, which is currently 0.375% per annum and subject to adjustment based on Select's leverage ratio, as specified in the credit agreement.

As of December 31, 2021, Select's leverage ratio (its ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters), which is required to be maintained at less than 7.00 to 1.00 under the terms of the revolving facility, was 3.77 to 1.00.

Our credit facilities also contain a number of other affirmative and restrictive covenants, including limitations on mergers, consolidations and dissolutions; sales of assets; investments and acquisitions; indebtedness; liens; affiliate transactions; and dividends and restricted payments. Our credit facilities contain events of default for non-payment of principal and interest when due (subject, as to interest, to a grace period), cross-default and cross-acceleration provisions and an event of default that would be triggered by a change of control.

6.250% senior notes. At December 31, 2021, Select had $1,225.0 million of 6.250% senior notes outstanding (excluding the unamortized premium and debt issuance costs of $13.7 million).

The terms of the senior notes contains covenants that, among other things, limit Select's ability and the ability of certain of Select's subsidiaries to (i) grant liens on its assets, (ii) make dividend payments, other distributions or other restricted payments, (iii) incur restrictions on the ability of Select's restricted subsidiaries to pay dividends or make other payments, (iv) enter into sale and leaseback transactions, (v) merge, consolidate, transfer or dispose of substantially all of their assets, (vi) incur additional indebtedness, (vii) make investments, (viii) sell assets, including capital stock of subsidiaries, (ix) use the proceeds from sales of assets, including capital stock of restricted subsidiaries, and (x) enter into transactions with affiliates. These covenants are subject to a number of exceptions, limitations and qualifications.

Concentra-JPM First Lien Credit Agreement. On June 2, 2021, Concentra Inc. terminated its obligations under the Concentra-JPM first lien credit agreement. The Concentra-JPM first lien credit agreement provided for commitments of $100.0 million under Concentra Inc.'s revolving facility, which was set to mature on March 1, 2022.

Stock Repurchase Program. Holdings' board of directors previously authorized a common stock repurchase program to repurchase up to $500.0 million worth of shares of its common stock. On November 2, 2021, the board of directors increased the capacity of the program from $500.0 million to $1.0 billion worth of shares and the program has been extended until December 31, 2023. The common stock repurchase program will remain in effect until then, unless further extended or earlier terminated by the board of directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate. Holdings funds this program with cash on hand and borrowings under its revolving facility. During the year ended December 31, 2021, Holdings repurchased 1,770,720 shares at a cost of approximately $58.6 million, or $33.09 per share, which includes transaction costs. Since the inception of the program through December 31, 2021, Holdings has repurchased 40,351,628 shares at a cost of approximately $415.2 million, or $10.29 per share, which includes transaction costs.

Use of Capital Resources. We may from time to time pursue opportunities to develop new joint venture relationships with large, regional health systems and other healthcare providers. We also intend to open new outpatient rehabilitation clinics and occupational health centers in local areas that we currently serve where we can benefit from existing referral relationships and brand awareness to produce incremental growth. In addition to our development activities, we may grow through opportunistic acquisitions.

Liquidity

The duration and extent of the impact from the COVID-19 pandemic on our operations and liquidity depends on future developments that cannot be accurately predicted at this time; however, we believe our internally generated cash flows and borrowing capacity under our revolving facility will allow us to finance our operations in both the short and long term. As of December 31, 2021, we had cash and cash equivalents of $74.3 million and $434.7 million of availability under our revolving facility, after giving effect to $160.0 million of outstanding borrowings and $55.3 million of outstanding letters of credit.

Our material cash requirements from known contractual and other obligations include:

i. *Debt payments, including finance lease payments* – Our expected principal payments total $3,573.8 million, with $17.6 million payable within the next twelve months. We intend to refinance our long-term indebtedness before it matures. Refer to Note 11 – Long-Term Debt and Notes Payable of the notes to our consolidated financial statements included herein for additional information.

ii. *Interest payments* – Our expected interest payments on the 6.250% senior notes, term loan, and revolving facility total $526.8 million, with $132.4 million payable within the next twelve months. Interest payments for the 6.250% senior notes were calculated using the stated interest rate. Interest payments for the term loan and revolving facility were estimated using the average interest rates for the year ended December 31, 2021, which were 2.5% and 2.6%, respectively.

    Our interest rate is indexed against 1-month LIBOR, which was less than 1.0% at December 31, 2021. Our interest rate cap limits our 1-month LIBOR rate to 1.0% on $2.0 billion of principal outstanding under the term loan and applies to interest payments from and including April 30, 2021 through September 30, 2024. We will receive payments from the counterparty when 1-month LIBOR rises above 1.0%. We pay an annual premium equal to 0.0916% on the notional amount to the counterparty.

iii. *Operating lease payments* – Our expected operating lease payments total $1,490.1 million, with $284.4 million payable within the next twelve months. Refer to Note 6 – Leases of the notes to our consolidated financial statements included herein for additional information.

iv. *Purchase and construction commitments* – Our expected payments related to purchase and construction obligations total $207.7 million, with $101.9 million payable within the next twelve months. Our purchase obligations primarily relate to software licensing and support agreements which specify all significant contractual terms and are legally binding and enforceable. Our construction commitments are described further in Note 21 – Commitments and Contingencies.

v. *Insurance liabilities* – Our expected payments related to our insurance liabilities, including those for workers' compensation and professional malpractice liabilities, total $173.5 million, with $69.1 million payable within the next twelve months. The amounts payable within the next twelve months are recorded in accrued other in the consolidated balance sheet as of December 31, 2021. The remaining amounts are recorded in other non-current liabilities.

vi. Other current liabilities recorded in the consolidated balance sheet as of December 31, 2021, such as accounts payable, accrued expenses, and government advances received under the Accelerated and Advance Payment Program, which are not specifically identified above.

We may from time to time seek to retire or purchase our outstanding debt through cash purchases and/or exchanges for equity securities, in open market purchases, privately negotiated transactions, tender offers or otherwise. Such repurchases or exchanges, if any, may be funded from operating cash flows or other sources and will depend on prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. The amounts involved may be material.

Recent Accounting Pronouncements

Refer to Note 1 – Organization and Significant Accounting Policies of the notes to our consolidated financial statements included herein for information regarding recent accounting pronouncements.

Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk.***

We are subject to interest rate risk in connection with our variable rate long-term indebtedness. Our principal interest rate exposure relates to the loans outstanding under our credit facilities, which bear interest rates that are indexed against LIBOR.

As of December 31, 2021, Select had outstanding borrowings under its credit facilities consisting of a $2,103.4 million term loan (excluding unamortized original issue discount and debt issuance costs of $13.3 million) and $160.0 million of borrowings under its revolving facility.

In order to mitigate our exposure to rising interest rates, we entered into an interest rate cap transaction to limit our 1-month LIBOR rate to 1.0% on $2.0 billion of principal outstanding under our term loan. The agreement applies to interest payments from and including April 30, 2021 through September 30, 2024. As of December 31, 2021, the 1-month LIBOR rate was 0.10%.

As of December 31, 2021, a 0.25% change in market interest rates would impact the interest expense on our variable rate debt by $5.7 million until 1-month LIBOR exceeds 1.0%, at which time the impact of increases in 1-month LIBOR on our interest expense will be mitigated in part by the interest rate cap, as described further in Note 12 – Interest Rate Cap of the notes to our consolidated financial statements included herein.

Item 8. ***Financial Statements and Supplementary Data.***

See Consolidated Financial Statements and Notes thereto commencing at Page F-1.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.***

None.

Item 9A. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation, under the supervision and with the participation of our principal executive officer and principal financial officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rule 13a-15(e) of the Securities Exchange Act of 1934) as of the end of the period covered in this report. Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures, including the accumulation and communication of disclosure to our principal executive officer and principal financial officer as appropriate to allow timely decisions regarding disclosure, are effective as of December 31, 2021 to provide reasonable assurance that material information required to be included in our periodic SEC reports is recorded, processed, summarized, and reported within the time periods specified in the relevant SEC rules and forms.

Changes in Internal Control over Financial Reporting

There was no change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Securities Exchange Act of 1934) identified in connection with the evaluation required by Rule 13a-15(d) of the Securities Exchange Act of 1934 that occurred during the fourth quarter of the year ended December 31, 2021 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

It should be noted that any system of controls, however well designed and operated, can provide only reasonable, and not absolute, assurance that the objectives of the system will be met. In addition, the design of any control system is based in part upon certain assumptions about the likelihood of future events. Because of these and other inherent limitations of control systems, there is only reasonable assurance that our controls will succeed in achieving their goals under all potential future conditions.

Management's Report on Internal Control over Financial Reporting

Management is responsible for establishing and maintaining an adequate system of internal control over our financial reporting. In order to evaluate the effectiveness of internal control over financial reporting, as required by Section 404 of the Sarbanes-Oxley Act, management has conducted an assessment, including testing, using the criteria of "Internal Control—Integrated Framework (2013)" issued by the Committee of Sponsoring Organizations of the Treadway Commission, or "COSO," as of December 31, 2021. Our system of internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation and fair presentation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness of internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2021. This assessment was based on criteria for effective internal control over financial reporting described in "Internal Control —Integrated Framework (2013)" issued by COSO. Based on this assessment, management concludes that, as of December 31, 2021, internal control over financial reporting was effective to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements in accordance with U.S. generally accepted accounting principles. The effectiveness of the Company's internal control over financial reporting as of December 31, 2021 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm as stated in their report which appears herein.

Item 9B. ***Other Information.***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance.***

The information regarding directors and nominees for directors of the Company, including identification of the audit committee and audit committee financial expert, and Compliance with Section 16(a) of the Exchange Act is presented under the headings "Corporate Governance—Committees of the Board of Directors" and "Election of Directors—Directors and Nominees" in the Company's definitive proxy statement for use in connection with the 2022 Annual Meeting of Stockholders (the "Proxy Statement") to be filed within 120 days after the end of the Company's fiscal year ended December 31, 2021. The information contained under these headings is incorporated herein by reference. Information regarding the executive officers of the Company is included in this annual report on Form 10-K under Item 1 of Part I as permitted by the Instruction to Item 401 of Regulation S-K.

We have adopted a written code of business conduct and ethics, known as our Code of Conduct, which applies to all of our directors, officers, and employees, as well as a Code of Ethics applicable to our senior financial officers, including our Chief Executive Officer, our Chief Financial Officer and our Chief Accounting Officer. Our Code of Conduct and Code of Ethics for senior financial officers are available on our website, www.selectmedicalholdings.com. Our Code of Conduct and Code of Ethics for senior financial officers may also be obtained by contacting investor relations at (717) 972-1100. Any amendments to our Code of Conduct or Code of Ethics for senior financial officers or waivers from the provisions of the codes for our Chief Executive Officer, our Chief Financial Officer and our Chief Accounting Officer will be disclosed on our website promptly following the date of such amendment or waiver.

Item 11. ***Executive Compensation.***

Information concerning executive compensation is presented under the headings "Executive Compensation Discussion and Analysis" and "Compensation Committee Report" in the Proxy Statement. The information contained under these headings is incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.***

Information with respect to security ownership of certain beneficial owners and management is set forth under the heading "Security Ownership of Certain Beneficial Owners and Directors and Officers" in the Proxy Statement. The information contained under this heading is incorporated herein by reference.

Equity Compensation Plan Information

Set forth in the table below is a list of all of our equity compensation plans and the number of securities to be issued on exercise of equity rights, average exercise price, and number of securities that would remain available under each plan if outstanding equity rights were exercised as of December 31, 2021.

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))(c)
Equity compensation plans approved by security holders:			
Select Medical Holdings Corporation 2020 Equity Incentive Plan	—	—	4,660,593
Equity compensation plans not approved by security holders	—	—	—

Item 13. ***Certain Relationships, Related Transactions and Director Independence.***

Information concerning related transactions is presented under the heading "Certain Relationships, Related Transactions and Director Independence" in the Proxy Statement. The information contained under this heading is incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services.***

Information concerning principal accountant fees and services is presented under the heading "Ratification of Appointment of Independent Registered Public Accounting Firm" in the Proxy Statement. The information contained under this heading is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules.***

a. The following documents are filed as part of this report:

i. Financial Statements: See Index to Financial Statements appearing on page F-1 of this report.

ii. Financial Statement Schedule: See Schedule II—Valuation and Qualifying Accounts appearing on page F-40 of this report.

iii. The following exhibits are filed as part of, or incorporated by reference into, this report:

Number	Description
2.1	Equity Purchase and Contribution Agreement, by and among Dignity Health Holding Corporation, U.S. HealthWorks, Inc., Concentra Group Holdings, LLC, Concentra Inc. and Concentra Group Holdings Parent, LLC, dated October 22, 2017, incorporated herein by reference to Exhibit 2.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed on October 23, 2017 (Reg. Nos. 001-34465 and 001-31441).
3.1	Amended and Restated Certificate of Incorporation of Select Medical Corporation, incorporated by reference to Exhibit 3.1 of Select Medical Corporation's Form S-4 filed June 15, 2005 (Reg. No. 001-31441).
3.2	Form of Restated Certificate of Incorporation of Select Medical Holdings Corporation, incorporated by reference to Exhibit 3.3 of Select Medical Holdings Corporation's Form S-1/A filed September 21, 2009 (Reg. No. 333-152514).
3.3	Amended and Restated Bylaws of Select Medical Corporation, incorporated herein by reference to Exhibit 3.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed on October 30, 2014 (Reg. Nos. 001-34465 and 001-31441).
3.4	Amended and Restated Bylaws of Select Medical Holdings Corporation, as amended, incorporated herein by reference to Exhibit 3.4 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2016 (Reg. Nos. 001-34465 and 001-31441).
4.1	Indenture, dated as of August 1, 2019, by and among Select Medical Corporation, the guarantors named therein and U.S. Bank National Association, as trustee, incorporated herein by reference to Exhibit 4.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation on August 1, 2019 (Reg. No. 001-34465).
4.2	Forms of 6.250% Senior Notes due 2026, incorporated herein by reference to Exhibit 4.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation on August 1, 2019 (Reg. No. 001-34465).
4.3	Description of Registrant's Securities, incorporated herein by reference to Exhibit 4.3 of Select Medical Holdings Corporation's Annual Report on Form 10-K for the fiscal year December 31, 2019, filed on February 20, 2020 (Reg. No. 001-34465).
10.1	Employment Agreement, dated as of March 1, 2000, between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.16 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.2	Amendment No. 1 to Employment Agreement, dated as of August 8, 2000, between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.17 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.3	Amendment No. 2 to Employment Agreement, dated as of February 23, 2001, between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.47 of Select Medical Corporation's Registration Statement on Form S-1 March 30, 2001 (Reg. No. 333-48856).
10.4	Amendment No. 3 to Employment Agreement, dated as of April 24, 2001, between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.50 of Select Medical Corporation's Registration Statement on Form S-4 filed June 26, 2001 (Reg. No. 333-63828).
10.5	Amendment No. 4 to Employment Agreement, dated as of September 17, 2001, between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.52 of Select Medical Corporation's Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (Reg. No. 000-32499).
10.6	Amendment No. 5 to Employment Agreement, dated as of February 24, 2005, between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.10 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846).
10.7	Employment Agreement, dated as of March 1, 2000, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.14 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.8	Amendment No. 1 to Employment Agreement, dated as of August 8, 2000, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.15 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.9	Amendment No. 2 to Employment Agreement, dated as of February 23, 2001, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.48 of Select Medical Corporation's Registration Statement on Form S-1 filed March 30, 2001 (Reg. No. 333-48856).

Number	Description
10.10	Amendment No. 3 to Employment Agreement, dated as of September 17, 2001, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.53 of Select Medical Corporation's Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (Reg. No. 000-32499).
10.11	Amendment No. 4 to Employment Agreement, dated as of December 10, 2004, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 99.3 of Select Medical Corporation's Current Report on Form 8-K filed December 16, 2004 (Reg. No. 001-31441).
10.12	Amendment No. 5 to Employment Agreement, dated as of February 24, 2005, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.16 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846).
10.13	Change of Control Agreement, dated as of March 1, 2000, between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.11 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.14	Amendment to Change of Control Agreement, dated as of February 23, 2001, between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.52 of Select Medical Corporation's Registration Statement on Form S-1 filed March 30, 2001 (Reg. No. 333-48856).
10.15	Second Amendment to Change of Control Agreement, dated as of February 24, 2005, between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.24 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846).
10.16	Change of Control Agreement, dated as of March 1, 2000, between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.22 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.17	Amendment to Change of Control Agreement, dated as of February 23, 2001, between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.54 of Select Medical Corporation's Registration Statement on Form S-1 filed March 30, 2001 (Reg. No. 333-48856).
10.18	Second Amendment to Change of Control Agreement, dated as of February 24, 2005, between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.39 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846).
10.19	Change of Control Agreement, dated as of March 1, 2000, between Select Medical Corporation and Scott A. Romberger, incorporated by reference to Exhibit 10.56 of Select Medical Corporation's Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (Reg. No. 000-32499).
10.20	Amendment to Change of Control Agreement, dated as of February 23, 2001, between Select Medical Corporation and Scott A. Romberger, incorporated by reference to Exhibit 10.57 of Select Medical Corporation's Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (Reg. No. 000-32499).
10.21	Second Amendment to Change of Control Agreement, dated as of February 24, 2005, between Select Medical Corporation and Scott A. Romberger, incorporated by reference to Exhibit 10.42 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846).
10.22	Office Lease Agreement, dated as of June 17, 1999, between Select Medical Corporation and Old Gettysburg Associates III, incorporated by reference to Exhibit 10.27 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856).
10.23	First Addendum to Lease Agreement, dated as of April 25, 2008, between Old Gettysburg Associates III and Select Medical Corporation, incorporated by reference to Exhibit 10.65 of Select Medical Holdings Corporation's Form S-1 filed July 24, 2008 (Reg. No. 333-152514).
10.24	Second Addendum to Lease Agreement, dated as of November 1, 2012, between Old Gettysburg Associates III LP and Select Medical Corporation, incorporated by reference to Exhibit 10.37 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441).
10.25	Office Lease Agreement, dated August 25, 2006, between Old Gettysburg Associates IV, L.P. and Select Medical Corporation, incorporated by reference to Exhibit 10.1 of Select Medical Corporation's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006 (Reg. No. 001-31441).
10.26	First Addendum to Lease Agreement, dated as of November 1, 2012, between Old Gettysburg Associates IV LP and Select Medical Corporation, incorporated by reference to Exhibit 10.39 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441).
10.27	Office Lease Agreement, dated November 1, 2012, by and between Select Medical Corporation and Old Gettysburg Associates, incorporated by reference to Exhibit 10.40 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441).
10.28	Office Lease Agreement, dated November 1, 2012, by and between Select Medical Corporation and Old Gettysburg Associates II, LP, incorporated by reference to Exhibit 10.41 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441).

Number	Description
10.29	Amendment No. 6 to Employment Agreement between Select Medical Corporation and Rocco A. Ortenzio, incorporated by reference to Exhibit 10.95 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514).
10.30	Amendment No. 6 to Employment Agreement between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.96 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514).
10.31	Third Amendment to Change of Control Agreement between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.100 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514).
10.32	Third Amendment to Change of Control Agreement between Select Medical Corporation and Scott A. Romberger, incorporated by reference to Exhibit 10.102 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514).
10.33	Third Amendment to Change of Control Agreement between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.103 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514).
10.34	Employment Agreement, dated September 13, 2010, by and between Select Medical Corporation and David S. Chernow, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed on September 15, 2010. (Reg. Nos. 001-34465 and 001-31441).
10.35	Amendment No. 1 to Employment Agreement, dated March 21, 2011, between Select Medical Corporation and David S. Chernow, incorporated herein by reference to Exhibit 10.8 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed on May 5, 2011. (Reg. Nos. 001-34465 and 001-31441).
10.36	Amendment No. 7 to Employment Agreement, dated November 10, 2010, by and between Select Medical Corporation and Rocco A. Ortenzio, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select filed on November 15, 2010. (Reg. Nos. 001-34465 and 001-31441).
10.37	Amendment No. 7 to Employment Agreement, dated November 10, 2010, by and between Select Medical Corporation and Robert A. Ortenzio, incorporated herein by reference to Exhibit 10.2 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select filed on November 15, 2010. (Reg. Nos. 001-34465 and 001-31441).
10.38	Fourth Amendment to Change of Control Agreement, dated March 8, 2011, between Select Medical Corporation and Martin F. Jackson, incorporated herein by reference to Exhibit 10.111 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441).
10.39	Amendment No. 8 to Employment Agreement, dated March 8, 2011, between Select Medical Corporation and Robert A. Ortenzio, incorporated herein by reference to Exhibit 10.112 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441).
10.40	Amendment No. 8 to Employment Agreement, dated March 8, 2011, between Select Medical Corporation and Rocco A. Ortenzio, incorporated herein by reference to Exhibit 10.113 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441).
10.41	Fourth Amendment to Change of Control Agreement, dated March 8, 2011, between Select Medical Corporation and Scott A. Romberger, incorporated herein by reference to Exhibit 10.115 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441).
10.42	Fourth Amendment to Change of Control Agreement, dated March 8, 2011, between Select Medical Corporation and Michael E. Tarvin, incorporated herein by reference to Exhibit 10.117 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441).
10.43	Office Lease Agreement, dated October 30, 2014, between Century Park Investments, L.P. and Select Medical Corporation, incorporated herein by reference to Exhibit 10.80 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 25, 2015 (Reg. Nos. 001-34465 and 001-31441).
10.44	First Lien Credit Agreement, dated June 1, 2015, by and among, Concentra Holdings, Inc., Concentra, Inc., JPMorgan Chase Bank, N.A. as administrative agent, collateral agent and lender and the additional lenders names therein, incorporated herein by reference to Exhibit 10.3 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed on August 6, 2015 (Reg. Nos. 001-34465 and 001-31441).

Number	Description
10.45	First Amendment to Lease Agreement, dated February 24, 2016, between Old Gettysburg II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.82 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 26, 2016 (Reg. Nos. 001-34465 and 001-31441).
10.46	Second Amendment to the Lease Agreement, dated June 1, 2016, between Old Gettysburg II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed August 4, 2016 (Reg. Nos. 001-34465 and 001-31441).
10.47	Third Amendment to the Lease Agreement, dated September 19, 2016, between Old Gettysburg II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed November 3, 2016 (Reg. Nos. 001-34465 and 001-31441).
10.48	Amendment No. 1, dated September 26, 2016, among Concentra Inc., Concentra Holdings, Inc., JP Morgan Chase Bank, N.A, as the administrative agent, collateral agent and lender, and the additional lenders named therein, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed on September 28, 2016 (Reg. Nos. 001-34465 and 001-31441).
10.49	Office Lease Agreement, dated October 28, 2016, between Select Medical Corporation and Old Gettysburg Associates V, L.P., incorporated herein by reference to Exhibit 10.3 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed November 3, 2016 (Reg. Nos. 001-34465 and 001-31441).
10.50	First Amendment to the Lease Agreement, dated November 15, 2016, between Old Gettysburg Associates and Select Medical Corporation, incorporated herein by reference to Exhibit 10.75 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 23, 2017 (Reg. Nos. 001-34465 and 001-31441).
10.51	Select Medical Holdings Corporation 2016 Equity Incentive Plan, incorporated herein by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A of Select Medical Holdings Corporation filed March 3, 2016 (Reg. No. 001-34465).
10.52	Form of Restricted Stock Award Agreement under the Select Medical Holdings Corporation 2016 Equity Incentive Plan, incorporated herein by reference to Exhibit 10.77 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 23, 2017 (Reg. Nos. 001-34465 and 001-31441).
10.53	Credit Agreement, dated as of March 6, 2017, among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative and Collateral Agent, Wells Fargo Securities, LLC and Deutsche Bank Securities Inc., as CoSyndication Agents and RBC Capital Markets, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Goldman Sachs Bank USA, PNC Bank, National Association and Morgan Stanley Senior Funding, Inc., as Co-Documentation Agents and the other lenders and issuing banks party thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 7, 2017 (Reg. Nos. 001- 34465 and 001-31441).
10.54	Change of Control Agreement, dated February 16, 2017, between Select Medical Corporation and John A. Saich, incorporated herein by reference to Exhibit 10.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed May 4, 2017 (Reg. Nos. 001- 34465 and 001-31441).
10.55	Second Amendment to Lease Agreement, dated as of May 30, 2017, between Old Gettysburg Associates and Select Medical Corporation, incorporated by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed August 3, 2017 (Reg. Nos. 001-34465 and 001-31441).
10.56	Amended and Restated Limited Liability Company Agreement of Concentra Group Holdings Parent, LLC, dated February 1, 2018, by and among Concentra Group Holdings Parent, LLC, Select Medical Corporation, Welsh, Carson, Anderson & Stowe XII, L.P., Dignity Health Holding Corporation, Cressey & Company IV LP, and the other members named therein, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 2, 2018 (Reg. Nos. 001-34465 and 001-31441).
10.57	Amendment No. 3, dated February 1, 2018, to the First Lien Credit Agreement, dated as of June 1, 2015, among Concentra Inc., MJ Acquisition Corporation, Concentra Holdings, Inc., the Lenders party thereto and JPMorgan Chase Bank, N.A., as amended by Amendment No. 1, dated as of September 26, 2016, Amendment No. 2, dated as of March 20, 2017, incorporated herein by reference to Exhibit 10.2 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 2, 2018 (Reg. Nos. 001-34465 and 001-31441).
10.58	Amendment No. 1, dated March 22, 2018, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed March 23, 2018 (Reg. Nos. 001-34465 and 001-31441).

Number	Description
10.59	Amendment No. 1, dated June 28, 2018, to the Amended and Restated Limited Liability Company Agreement of Concentra Group Holdings Parent, LLC, dated February 1, 2018, by and among Concentra Group Holdings Parent, LLC, Select Medical Corporation, Welsh, Carson, Anderson & Stowe XII, L.P., Dignity Health Holding Corporation, Cressey & Company IV LP, and the other members named therein, incorporated herein by reference to Exhibit 10.68 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 21, 2019 (Reg. Nos. 001-34465 and 001-31441).
10.60	Amendment No. 2, dated October 26, 2018, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, incorporated herein by reference to Exhibit 10.1 of Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed October 31, 2018 (Reg. Nos. 001-34465 and 001-31441).
10.61	Amendment No. 4, dated October 26, 2018, to the First Lien Credit Agreement, dated as of June 1, 2015, among Concentra Holdings Inc., MJ Acquisition Corporation, Concentra Inc., the lenders party thereto and JPMorgan Chase Bank, N.A., as Administrative and Collateral Agent, as amended by Amendment No. 1, dated as of September 26, 2016, Amendment No. 2, dated as of March 20, 2017 and Amendment No. 3, dated February 1, 2018, incorporated herein by reference to Exhibit 10.2 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed October 31, 2018 (Reg. Nos. 001-34465 and 001-31441).
10.62	Office Lease Agreement, dated as of October 24, 2018, between 207 Associates and Independence Avenue Investments, LLC and Select Medical Corporation, incorporated herein by reference to Exhibit 10.71 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 21, 2019 (Reg. Nos. 001-34465 and 001-31441).
10.63	Amendment No. 5, dated April 8, 2019, to the First Lien Credit Agreement, dated as of June 1, 2015, among Concentra Holdings Inc., MJ Acquisition Corporation, Concentra Inc., the lenders party thereto and JPMorgan Chase Bank, N.A., as Administrative and Collateral Agent, as amended by Amendment No. 1, dated as of September 26, 2016, Amendment No. 2, dated as of March 20, 2017, Amendment No. 3, dated as of February 1, 2018, and Amendment No. 4, dated as of October 26, 2018, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed April 11, 2019 (Reg. Nos. 001-34465 and 001-31441).
10.64	Amendment No. 3, dated August 1, 2019, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, and Amendment No. 2, dated as of October 26, 2018, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation filed August 1, 2019 (Reg. No. 001-34465).
10.65	Amendment No. 6, dated September 20, 2019, to the First Lien Credit Agreement, dated as of June 1, 2015, among Concentra Holdings Inc., MJ Acquisition Corporation, Concentra Inc., the lenders party thereto and JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, as amended by Amendment No. 1, dated as of September 26, 2016, Amendment No. 2, dated as of March 20, 2017, Amendment No. 3, dated as of February 1, 2018, Amendment No. 4, dated as of October 26, 2018, and Amendment No. 5, dated as of April 8, 2019, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation filed September 24, 2019 (Reg. No. 001-34465).
10.66	Amendment No. 4, dated December 10, 2019, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2, dated as of October 26, 2018 and Amendment No. 3, dated as of August 1, 2019, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation filed December 11, 2019 (Reg. No. 001-34465).
10.67	First Lien Term Loan Credit Agreement, dated December 10, 2019, by and among Select Medical Corporation, Concentra Inc. and Concentra Holdings, Inc., incorporated herein by reference to Exhibit 10.2 of the Current Report on Form 8-K of Select Medical Holdings Corporation filed December 11, 2019 (Reg. No. 001-34465).
10.68	Interest Purchase Agreement, dated January 1, 2020, by and among Concentra Group Holdings Parent, LLC, Select Medical Corporation, Welsh, Carson, Anderson & Stowe XII, L.P., Dignity Health Holding Corporation and the other signatories thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on January 2, 2020 (Reg. No. 001-34465).
10.69	Interest Purchase Agreement, dated February 1, 2020, by and among Concentra Group Holdings Parent, LLC, Select Medical Corporation, Welsh, Carson, Anderson & Stowe XII, L.P., Dignity Health Holding Corporation and the other signatories thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on February 3, 2020 (Reg. No. 001-34465).
10.70	Select Medical Holdings Corporation 2020 Equity Incentive Plan, incorporated herein by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A of Select Medical Holdings Corporation filed March 4, 2020 (Reg. No. 001-34465).

Number	Description
10.71	Form of Restricted Stock Award Agreement under the Select Medical Holdings Corporation 2020 Equity Incentive Plan, incorporated herein by reference to Exhibit 10.71 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 25, 2021 (Reg. No. 001-34465).
10.72	First Amendment to Lease Agreement, dated as of April 24, 2020, between 225 Grandview Investors, LLC and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on July 30, 2020 (Reg. No. 001-34465).
10.73	Third Addendum to Lease Agreement, dated as of May 5, 2020, between Old Gettysburg Associates III, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on July 30, 2020 (Reg. No. 001-34465).
10.74	Interest Purchase Agreement, dated December 31, 2020, by and among Concentra Group Holdings Parent, LLC, Select Medical Corporation, Welsh, Carson, Anderson & Stowe XII, L.P., Dignity Health Holding Corporation and the other signatories thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on January 4, 2021 (Reg. No. 001-34465).
10.75	Change of Control Agreement, dated February 18, 2021, between Select Medical Corporation and Thomas P. Mullin, incorporated herein by reference to Exhibit 10.75 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 25, 2021 (Reg. No. 001-34465).
10.76	Amendment No. 5, dated June 2, 2021, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2, dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019 and Amendment No. 4, dated as of December 10, 2019, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on June 4, 2021 (Reg. No. 001-34465).
10.77	First Addendum to Lease Agreement, dated as of July 21, 2021, between Old Gettysburg Associates V, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on November 4, 2021 (Reg. No. 001-34465).
10.78	Letter Agreement, dated August 6, 2021, between Robert A. Ortenzio and Select Medical Corporation, incorporated herein by reference to Exhibit 10.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on November 4, 2021 (Reg. No. 001-34465).
10.79	First Amendment to Lease Agreement, dated as of August 9, 2021, between Century Park Investments, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.3 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on November 4, 2021 (Reg. No. 001-34465).
10.80	Interest Purchase Agreement, dated December 24, 2021, by and among Concentra Group Holdings Parent, LLC, Select Medical Corporation, Welsh, Carson, Anderson & Stowe XII, L.P., Dignity Health Holding Corporation and the other signatories thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on December 28, 2021 (Reg. No. 001-34465).
10.81	Fourth Amendment to Lease Agreement, dated as of December 28, 2021, between Old Gettysburg Associates II, LP and Select Medical Corporation.
21.1	Subsidiaries of Select Medical Holdings Corporation.
23	Consent of PricewaterhouseCoopers LLP.
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer, and Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350 as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.

The representations, warranties, and covenants contained in the agreements set forth in this Exhibit Index were made only as of specified dates for the purposes of the applicable agreement, were made solely for the benefit of the parties to such agreement, and may be subject to qualifications and limitations agreed upon by the parties. In particular, the representations, warranties, and covenants contained in such agreement were negotiated with the principal purpose of allocating risk between the parties, rather than establishing matters as facts, and may have been qualified by confidential disclosures. Such representations, warranties, and covenants may also be subject to a contractual standard of materiality different from those generally applicable to stockholders and to reports and documents filed with the SEC. Accordingly, investors should not rely on such representations, warranties, and covenants as characterizations of the actual state of facts or circumstances described therein. Information concerning the subject matter of such representations, warranties, and covenants may change after the date of such agreement, which subsequent information may or may not be fully reflected in the parties' public disclosures.

Item 16. ***Form 10-K Summary.***

None.

Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

SELECT MEDICAL HOLDINGS CORPORATION

By: /s/ MICHAEL E. TARVIN
Michael E. Tarvin
(Executive Vice President, General Counsel and Secretary)

Date: February 24, 2022

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated as of February 24, 2022.

/s/ ROCCO A. ORTENZIO
Rocco A. Ortenzio
Director, Vice Chairman and Co-Founder

/s/ ROBERT A. ORTENZIO
Robert A. Ortenzio
Director, Executive Chairman and Co-Founder

/s/ DAVID S. CHERNOW
David S. Chernow
President and Chief Executive Officer
(principal executive officer)

/s/ MARTIN F. JACKSON
Martin F. Jackson
Executive Vice President and Chief Financial Officer
(principal financial officer)

/s/ SCOTT A. ROMBERGER
Scott A. Romberger
Senior Vice President and Chief Accounting Officer
(principal accounting officer)

/s/ RUSSELL L. CARSON
Russell L. Carson
Director

/s/ BRYAN C. CRESSEY
Bryan C. Cressey
Director

/s/ WILLIAM H. FRIST, M.D.
William H. Frist, M.D.
Director

/s/ JAMES S. ELY III
James S. Ely III
Director

/s/ DANIEL J. THOMAS
Daniel J. Thomas
Director

/s/ THOMAS A. SCULLY
Thomas A. Scully
Director

/s/ KATHERINE R. DAVISSON
Katherine R. Davisson
Director

/s/ MARILYN B. TAVENNER
Marilyn B. Tavenner
Director

/s/ PARVINDERJIT S. KHANUJA
Parvinderjit S. Khanuja
Director

SELECT MEDICAL HOLDINGS CORPORATION

INDEX TO FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Select Medical Holdings Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheet of Select Medical Holdings Corporation and its subsidiaries (the "Company") as of December 31, 2021 and 2020, and the related consolidated statements of operations, of comprehensive income, of equity and income and of cash flows for each of the three years in the period ended December 31, 2021, including the related notes and financial statement schedule listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matter communicated below is a matter arising from the current period audit of the consolidated financial statements that was communicated or required to be communicated to the audit committee and that (i) relates to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Valuation of patient accounts receivable

As described in Note 1 to the consolidated financial statements, substantially all of the Company's accounts receivable is related to providing healthcare services to patients. These services are paid for primarily by federal and state governmental authorities, managed care health plans, commercial insurance companies, and workers' compensation and employer-directed programs. As of December 31, 2021, accounts receivable of the Company totaled approximately $889.3 million. As disclosed by management, accounts receivable is reported at an amount equal to the amount it expects to collect for providing healthcare services to its patients. This amount is inclusive of management's estimate of factors such as implicit discounts and other adjustments, which are estimated using historical experience.

The principal considerations for our determination that performing procedures relating to the valuation of patient accounts receivable is a critical audit matter are the significant judgment by management in estimating accounts receivable at an amount equal to the amount management expects to receive, which in turn led to a high degree of auditor judgment, subjectivity and audit effort in performing procedures and evaluating the audit evidence obtained in relation to the valuation of patient accounts receivable.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of patient accounts receivable, including controls over management's valuation approach, assumptions and data used to estimate patient accounts receivable. These procedures included, among others: (i) testing management's process for developing its estimate of patient accounts receivable; (ii) testing the completeness, accuracy, and relevance of the underlying data used to estimate patient accounts receivable, including historical billing and reimbursement data; (iii) evaluating the historical accuracy of management's process for developing the estimate of the amount which management expects to collect by comparing actual cash receipts related to patient accounts receivable balances which existed as of the prior period balance sheet date; and (iv) for the Outpatient Rehabilitation segment, developing an independent expectation of the net accounts receivable balance. Developing an independent expectation involved calculating the percentage of cash collections as compared to the corresponding revenue transactions either throughout the year or as of the end of the prior year, applying those calculated percentages to the recorded accounts receivable balance as of December 31, 2021, and comparing the calculated balance to management's estimate of the Outpatient Rehabilitation net accounts receivable balance.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 24, 2022

We have served as the Company's auditor since 2005.

PART I FINANCIAL INFORMATION

ITEM 1. CONSOLIDATED FINANCIAL STATEMENTS

Select Medical Holdings Corporation
Consolidated Balance Sheets
(in thousands, except share and per share amounts)

	December 31, 2020	December 31, 2021
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 577,061	$ 74,310
Accounts receivable	896,763	889,303
Prepaid income taxes	5,686	55,620
Other current assets	114,490	120,206
Total Current Assets	1,594,000	1,139,439
Operating lease right-of-use assets	1,032,217	1,078,754
Property and equipment, net	943,420	961,467
Goodwill	3,379,014	3,448,912
Identifiable intangible assets, net	387,541	374,879
Other assets	319,207	356,720
Total Assets	$ 7,655,399	$ 7,360,171
LIABILITIES AND EQUITY		
Current Liabilities:		
Overdrafts	$ —	$ 42,353
Current operating lease liabilities	220,413	229,334
Current portion of long-term debt and notes payable	12,621	17,572
Accounts payable	177,087	233,844
Accrued payroll	224,876	247,292
Accrued vacation	132,811	144,048
Accrued interest	29,240	29,002
Accrued other	228,948	244,312
Government advances (Note 22)	321,807	83,790
Unearned government assistance (Note 22)	82,607	93
Income taxes payable	7,956	1,437
Total Current Liabilities	1,438,366	1,273,077
Non-current operating lease liabilities	875,367	916,540
Long-term debt, net of current portion	3,389,398	3,556,385
Non-current deferred tax liability	132,421	142,792
Other non-current liabilities	168,703	106,442
Total Liabilities	6,004,255	5,995,236
Commitments and contingencies (Note 21)		
Redeemable non-controlling interests	398,171	39,033
Stockholders' Equity:		
Common stock, $0.001 par value, 700,000,000 shares authorized, 134,850,735 and 133,884,817 shares issued and outstanding at 2020 and 2021, respectively	135	134
Capital in excess of par	509,128	504,314
Retained earnings	553,244	593,251
Accumulated other comprehensive income (loss)	(2,027)	12,282
Total Stockholders' Equity	1,060,480	1,109,981
Non-controlling interests	192,493	215,921
Total Equity	1,252,973	1,325,902
Total Liabilities and Equity	$ 7,655,399	$ 7,360,171

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Holdings Corporation
Consolidated Statements of Operations
(in thousands, except per share amounts)

	For the Year Ended December 31,		
	2019	**2020**	**2021**
Revenue	$ 5,453,922	$ 5,531,713	$ 6,204,515
Costs and expenses:			
Cost of services, exclusive of depreciation and amortization	4,641,002	4,710,372	5,285,149
General and administrative	128,463	138,037	146,975
Depreciation and amortization	212,576	205,659	202,645
Total costs and expenses	4,982,041	5,054,068	5,634,769
Other operating income	—	90,012	144,028
Income from operations	471,881	567,657	713,774
Other income and expense:			
Loss on early retirement of debt	(38,083)	—	—
Equity in earnings of unconsolidated subsidiaries	24,989	29,440	44,428
Gain on sale of businesses	6,532	12,387	2,155
Interest income	—	—	5,350
Interest expense	(200,570)	(153,011)	(135,985)
Income before income taxes	264,749	456,473	629,722
Income tax expense	63,718	111,867	129,773
Net income	201,031	344,606	499,949
Less: Net income attributable to non-controlling interests	52,582	85,611	97,724
Net income attributable to Select Medical Holdings Corporation	$ 148,449	$ 258,995	$ 402,225
Earnings per common share (Note 20):			
Basic	$ 1.10	$ 1.93	$ 2.98
Diluted	$ 1.10	$ 1.93	$ 2.98

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Holdings Corporation
Consolidated Statements of Comprehensive Income
(in thousands)

	For the Year Ended December 31,		
	2019	**2020**	**2021**
Net income	$ 201,031	$ 344,606	$ 499,949
Other comprehensive income (loss), net of tax:			
Gain (loss) on interest rate cap cash flow hedge	—	(2,027)	14,270
Reclassification adjustment for (gains) losses included in net income	—	—	39
Net change, net of tax benefit (expense) of $—, $705 and $(4,799)	—	(2,027)	14,309
Comprehensive income	201,031	342,579	514,258
Less: Comprehensive income attributable to non-controlling interests	52,582	85,611	97,724
Comprehensive income attributable to Select Medical Holdings Corporation	$ 148,449	$ 256,968	$ 416,534

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Holdings Corporation
Consolidated Statements of Changes in Equity and Income
(in thousands)

		Total Stockholders' Equity						
	Common Stock Issued	Common Stock Par Value	Capital in Excess of Par	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity	Non-controlling Interests	Total Equity
Balance at December 31, 2018	135,266	$ 135	$ 482,556	$ 320,351	$ —	$ 803,042	$ 113,198	$ 916,240
Net income attributable to Select Medical Holdings Corporation				148,449		148,449		148,449
Net income attributable to non-controlling interests						—	26,626	26,626
Issuance of restricted stock	1,500	2	(2)			—		—
Forfeitures of unvested restricted stock	(43)	0	0			—		—
Vesting of restricted stock			23,382			23,382		23,382
Repurchase of common shares	(2,500)	(3)	(22,565)	(15,963)		(38,531)		(38,531)
Exercise of stock options	105	0	964			964		964
Issuance of non-controlling interests			6,499			6,499	31,622	38,121
Distributions to and purchases of non-controlling interests			204			204	(15,065)	(14,861)
Redemption value adjustment on non-controlling interests				(172,915)		(172,915)		(172,915)
Other				(122)		(122)	1,682	1,560
Balance at December 31, 2019	134,328	$ 134	$ 491,038	$ 279,800	$ —	$ 770,972	$ 158,063	$ 929,035
Net income attributable to Select Medical Holdings Corporation				258,995		258,995		258,995
Net income attributable to non-controlling interests						—	47,850	47,850
Issuance of restricted stock	1,478	1	(1)			—		—
Forfeitures of unvested restricted stock	(84)	0	0			—		—
Vesting of restricted stock			24,738			24,738		24,738
Repurchase of common shares	(872)	0	(8,996)	(7,038)		(16,034)		(16,034)
Issuance of non-controlling interests			3,042			3,042	5,020	8,062
Distributions to and purchases of non-controlling interests			102	(5,935)		(5,833)	(20,787)	(26,620)
Redemption value adjustment on non-controlling interests				27,470		27,470		27,470
Other comprehensive loss					(2,027)	(2,027)		(2,027)
Other			(795)	(48)		(843)	2,347	1,504
Balance at December 31, 2020	134,850	$ 135	$ 509,128	$ 553,244	$ (2,027)	$ 1,060,480	$ 192,493	$ 1,252,973
Net income attributable to Select Medical Holdings Corporation				402,225		402,225		402,225
Net income attributable to non-controlling interests						—	47,571	47,571
Cash dividends declared for common stockholders ($0.375 per share)				(50,600)		(50,600)		(50,600)
Issuance of restricted stock	1,363	1	(1)			—		—
Forfeitures of unvested restricted stock	(18)	0	0			—		—
Vesting of restricted stock			28,798			28,798		28,798
Repurchase of common shares	(2,311)	(2)	(33,322)	(46,152)		(79,476)		(79,476)
Issuance of non-controlling interests			3,646			3,646	17,540	21,186
Non-controlling interests acquired in business combination						—	11,153	11,153
Distributions to and purchases of non-controlling interests			(3,757)	(15,440)		(19,197)	(52,961)	(72,158)
Redemption value adjustment on non-controlling interests				(250,083)		(250,083)		(250,083)
Other comprehensive income					14,309	14,309		14,309
Other			(178)	57		(121)	125	4
Balance at December 31, 2021	133,884	$ 134	$ 504,314	$ 593,251	$ 12,282	$ 1,109,981	$ 215,921	$ 1,325,902

The accompanying notes are an integral part of these consolidated financial statements.

Select Medical Holdings Corporation
Consolidated Statements of Cash Flows
(in thousands)

	For the Year Ended December 31,		
	2019	**2020**	**2021**
Operating activities			
Net income	$ 201,031	$ 344,606	$ 499,949
Adjustments to reconcile net income to net cash provided by operating activities:			
Distributions from unconsolidated subsidiaries	20,222	35,390	37,002
Depreciation and amortization	212,576	205,659	202,645
Provision for expected credit losses	3,038	604	236
Equity in earnings of unconsolidated subsidiaries	(24,989)	(29,440)	(44,428)
Loss on extinguishment of debt	22,130	—	—
Gain on sale of assets and businesses	(6,321)	(22,563)	(2,409)
Stock compensation expense	26,451	27,250	30,940
Amortization of debt discount, premium and issuance costs	11,566	2,184	2,217
Deferred income taxes	(7,435)	(14,715)	5,055
Changes in operating assets and liabilities, net of effects of business combinations:			
Accounts receivable	(57,991)	(116,601)	23,101
Other current assets	(4,259)	(18,775)	(2,418)
Other assets	6,122	17,587	(7,196)
Accounts payable	5,743	27,325	53,392
Accrued expenses	37,298	168,839	(73,159)
Government advances	—	318,116	(241,185)
Unearned government assistance	—	82,607	(82,514)
Net cash provided by operating activities	445,182	1,028,073	401,228
Investing activities			
Business combinations, net of cash acquired	(93,705)	(20,808)	(81,911)
Purchases of property and equipment	(157,126)	(146,440)	(180,537)
Investment in businesses	(66,090)	(31,425)	(20,967)
Proceeds from sale of assets and businesses	192	83,320	26,821
Net cash used in investing activities	(316,729)	(115,353)	(256,594)
Financing activities			
Borrowings on revolving facilities	700,000	470,000	160,000
Payments on revolving facilities	(720,000)	(470,000)	—
Proceeds from term loans	1,208,106	—	—
Payments on term loans	(1,618,170)	(39,843)	—
Proceeds from 6.250% senior notes	1,244,987	—	—
Payment on 6.375% senior notes	(710,000)	—	—
Revolving facility debt issuance costs	(310)	—	—
Borrowings of other debt	24,225	40,108	33,013
Principal payments on other debt	(30,604)	(48,381)	(39,668)
Dividends paid to common stockholders	—	—	(50,600)
Repurchase of common stock	(38,531)	(16,034)	(79,476)
Proceeds from exercise of stock options	964	—	—
Increase (decrease) in overdrafts	(25,083)	—	42,353
Proceeds from issuance of non-controlling interests	18,447	7,564	20,732
Distributions to and purchases of non-controlling interests	(21,780)	(38,589)	(73,081)
Purchase of membership interests of Concentra Group Holdings Parent (Note 2)	—	(576,366)	(660,658)
Net cash provided by (used in) financing activities	32,251	(671,541)	(647,385)
Net increase (decrease) in cash and cash equivalents	160,704	241,179	(502,751)
Cash and cash equivalents at beginning of period	175,178	335,882	577,061
Cash and cash equivalents at end of period	$ 335,882	$ 577,061	$ 74,310
Supplemental information:			
Cash paid for interest	$ 182,992	$ 155,236	$ 132,203
Cash paid for taxes	70,592	108,890	181,184
Non-cash investing and financing activities:			
Liabilities for purchases of property and equipment	$ 28,760	$ 24,480	$ 23,441

The accompanying notes are an integral part of these consolidated financial statements.

SELECT MEDICAL HOLDINGS CORPORATION
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Significant Accounting Policies

Business Description

The consolidated financial statements of Select Medical Holdings Corporation ("Holdings") include the accounts of its wholly owned subsidiary, Select Medical Corporation ("Select"). Holdings conducts substantially all of its business through Select and its subsidiaries. Holdings and Select and its subsidiaries are collectively referred to as the "Company."

The Company is, based on number of facilities, one of the largest operators of critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, and occupational health centers in the United States. As of December 31, 2021, the Company had operations in 46 states and the District of Columbia. As of December 31, 2021, the Company operated 104 critical illness recovery hospitals, 30 rehabilitation hospitals, and 1,881 outpatient rehabilitation clinics. As of December 31, 2021, Concentra operated 518 occupational health centers and 134 onsite clinics at employer worksites.

The Company operates through four business segments: the critical illness recovery hospital segment, the rehabilitation hospital segment, the outpatient rehabilitation segment, and the Concentra segment. The Company's critical illness recovery hospital segment consists of hospitals designed to serve the needs of patients recovering from critical illnesses, often with complex medical needs, and the rehabilitation hospital segment consists of hospitals designed to serve patients that require intensive physical rehabilitation care. Patients are typically admitted to the Company's critical illness recovery hospitals and rehabilitation hospitals from general acute care hospitals. The Company's outpatient rehabilitation segment consists of clinics that provide physical, occupational, and speech rehabilitation services. The Company's Concentra segment consists of occupational health centers that provide workers' compensation injury care, physical therapy, and consumer health services and onsite clinics located at employer worksites that deliver occupational medicine services.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues, and expenses. Estimates and assumptions are used for, but not limited to: revenue recognition, allowances for expected credit losses, estimated useful lives of assets, the fair value of goodwill and intangible assets, amounts payable for self-insured losses, and the computation of income taxes. Future events and their effects cannot be predicted with certainty; accordingly, the Company's accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as the Company's operating environment changes. The Company's management evaluates and updates assumptions and estimates on an ongoing basis. Actual results could differ from those estimates.

Principles of Consolidation

The consolidated financial statements include the accounts of Holdings, Select, and the subsidiaries, limited liability companies, limited partnerships, and variable interest entities in which the Company has a controlling financial interest. All intercompany balances and transactions are eliminated in consolidation.

Variable Interest Entities

Certain states prohibit the "corporate practice of medicine," which restricts the Company from owning medical practices which directly employ physicians and from exercising control over medical decisions by physicians. In these states, the Company enters into long-term management agreements with medical practices that are owned by licensed physicians which, in turn, employ or contract with physicians who provide professional medical services in certain of its occupational health centers and clinics. The agreements provide for the Company to direct the transfer of ownership of the medical practices to new licensed physicians at any time. Based on the provisions of the management agreements, the medical practices are variable interest entities for which the Company is the primary beneficiary.

1. Organization and Significant Accounting Policies (Continued)

Non-Controlling Interests

The ownership interests held by outside parties in subsidiaries, which include limited liability companies and limited partnerships, controlled by the Company are classified as non-controlling interests. Net income or loss is attributed to the Company's non-controlling interests. Some of the Company's non-controlling ownership interests consist of outside parties that have certain redemption rights that, if exercised, require the Company to purchase the parties' ownership interests. These interests are classified and reported as redeemable non-controlling interests and have been adjusted to their approximate redemption values, after the attribution of net income or loss.

Earnings per Share

The Company's capital structure includes common stock and unvested restricted stock awards. To compute earnings per share ("EPS"), the Company applies the two-class method because the Company's unvested restricted stock awards are participating securities which are entitled to participate equally with the Company's common stock in undistributed earnings. Application of the Company's two-class method is as follows:

(i) Net income attributable to the Company is reduced by the amount of dividends declared and by the contractual amount of dividends that must be paid for the current period for each class of stock, if any.

(ii) The remaining undistributed net income of the Company is then equally allocated to its common stock and unvested restricted stock awards, as if all of the earnings for the period had been distributed. The total net income allocated to each security is determined by adding both distributed and undistributed net income for the period.

(iii) The net income allocated to each security is then divided by the weighted average number of outstanding shares for the period to determine the EPS for each security considered in the two-class method.

Cash and Cash Equivalents

The Company considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents. Cash equivalents are stated at cost which approximates fair value.

Accounts Receivable

Substantially all of the Company's accounts receivable is related to providing healthcare services to patients. These services are paid for primarily by federal and state governmental authorities, managed care health plans, commercial insurance companies, workers' compensation programs, and employer-directed programs. The Company's general policy is to verify insurance coverage prior to the date of admission for patients admitted to its critical illness recovery hospitals and rehabilitation hospitals. Within the Company's outpatient rehabilitation clinics, insurance coverage is verified prior to the patient's visit. Within the Company's Concentra centers, insurance coverage is verified or an authorization is received from the patient's employer prior to the patient's visit.

The Company performs periodic assessments to determine if an allowance for expected credit losses is necessary. The Company considers its incurred loss experience and adjusts for known and expected events and other circumstances. In estimating its expected credit losses, the Company may consider changes in the length of time its receivables have been outstanding, changes in credit ratings for its payors, requests from payors to alter payment terms due to financial difficulty, and notices of payor bankruptcies or payors entering receivership. Because the Company's accounts receivable is typically paid for by highly-solvent, creditworthy payors, such as Medicare, other governmental programs, and highly-regulated commercial insurers on behalf of the patient, the Company's credit losses have been infrequent and insignificant in nature. Amounts recognized for allowances for expected credit losses are immaterial to the consolidated financial statements.

1. Organization and Significant Accounting Policies (Continued)

Leases

The Company evaluates whether a contract is or contains a lease at the inception of the contract. Upon lease commencement, the date on which a lessor makes the underlying asset available to the Company for use, the Company classifies the lease as either an operating or finance lease. Most of the Company's facility leases are classified as operating leases.

A right-of-use asset represents the Company's right to use an underlying asset for the lease term while the lease liability represents an obligation to make lease payments arising from a lease. Right-of-use assets and lease liabilities are measured at the present value of the remaining fixed lease payments at lease commencement. As most of the Company's leases do not specify an implicit rate, the Company uses its incremental borrowing rate, which coincides with the lease term at the commencement of a lease, in determining the present value of its remaining lease payments. The Company's leases may also specify extension or termination clauses; these options are factored into the measurement of the lease liability when it is reasonably certain that the Company will exercise the option. Right-of-use assets also include any prepaid lease payments and initial direct costs, less any lease incentive received, at the lease commencement date.

The Company has elected to account for lease and non-lease components, such as common area maintenance, as a single lease component for its facility leases. As a result, the fixed payments that would otherwise be allocated to the non-lease components are accounted for as lease payments and are included in the measurement of the Company's right-of-use asset and lease liability.

For the Company's operating leases, lease expense, a component of cost of services and general and administrative expense in the consolidated statements of operations, is recognized on a straight-line basis over the lease term. For the Company's finance leases, interest expense on the lease liability is recognized using the effective interest method and amortization expense related to the right-of-use asset is recognized on a straight-line basis over the shorter of the estimated useful life of the asset or the lease term. The Company also makes variable lease payments which are expensed as incurred. These payments relate to changes in indexes or rates after the lease commencement date, as well as property taxes, insurance, and common area maintenance which were not fixed at lease commencement. This expense is a component of cost of services and general and administrative expense in the consolidated statements of operations.

The Company may enter into arrangements to sublease portions of its facilities and the Company typically retains the obligation to the lessor under these arrangements. The Company's subleases are classified as operating leases; accordingly, the Company continues to account for the original leases as it did prior to commencement of the subleases. Sublease income, a component of cost of services in the consolidated statements of operations, is recognized on a straight-line basis, as a reduction to lease expense, over the term of the sublease.

The Company elected the short-term lease exemption for equipment leases; accordingly, equipment leases with terms of 12 months or less are not recorded in the consolidated balance sheets. For these leases, the Company recognizes lease payments on a straight-line basis over the lease term and variable lease payments are expensed as incurred. These expenses are included as components of cost of services in the consolidated statements of operations.

1. Organization and Significant Accounting Policies (Continued)

Property and Equipment

Property and equipment are stated at cost, net of accumulated depreciation. Maintenance and repairs of property and equipment are expensed as incurred. Improvements that increase the estimated useful life of an asset are capitalized. Direct internal and external costs of developing software for internal use, including programming and enhancements, are capitalized and depreciated over the estimated useful lives once the software is placed in service. Capitalized software costs are included within furniture and equipment. Software training costs, maintenance, and repairs are expensed as incurred. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets or the term of the lease, as appropriate. The general range of useful lives is as follows:

Land improvements	5 – 25 years
Leasehold improvements	1 – 20 years
Buildings	40 years
Building improvements	5 – 40 years
Furniture and equipment	1 – 20 years

The Company's long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of those assets or asset groups may not be recoverable. If the expected undiscounted future cash flows are less than the carrying amount of such assets or asset groups, the Company recognizes an impairment loss to the extent the carrying amount exceeds its estimated fair value.

Intangible Assets

Goodwill and indefinite-lived identifiable intangible assets

Goodwill and other indefinite-lived intangible assets are recognized primarily as the result of business combinations. Goodwill is assigned to reporting units based upon the specific nature of the business acquired or, when a business combination contains business components related to more than one reporting unit, goodwill is assigned to each reporting unit based upon an allocation determined by the relative fair values of the business acquired. When the Company disposes of a business, the Company allocates a portion of the reporting unit's goodwill to that business based on the relative fair values of the portion of the reporting unit being disposed of and the portion of the reporting unit remaining. The Company evaluates its reporting units on an annual basis and, if its reporting units are reorganized, the Company reassigns goodwill based on the relative fair values of the new reporting units.

Goodwill and other indefinite-lived intangible assets are not amortized, but instead are subject to periodic impairment evaluations. The Company performs its impairment tests annually as of October 1 or when events or conditions occur that might suggest a possible impairment. Events or conditions which might suggest impairment could include a significant change in the business environment, the regulatory environment, or legal factors; a current period operating or cash flow loss combined with a history of such losses or a projection of continuing losses; or a sale or disposition of a significant portion of a reporting unit.

The Company may first assess qualitatively whether goodwill is more likely than not impaired by considering relevant events or circumstances that affect the fair value or carrying amount of a reporting unit. If goodwill is more likely than not impaired, the Company is then required to complete a quantitative analysis. The Company considers both the income and market approach in determining the fair values of its reporting units when performing a quantitative analysis. If the carrying value of a reporting unit exceeds its fair value, an impairment charge is recognized equal to the difference between the carrying amount of the reporting unit and its fair value, not to exceed the carrying value of goodwill of the reporting unit.

At December 31, 2021, the Company's other indefinite-lived intangible assets consist of trademarks, certificates of need, and accreditations. To determine the fair values of its trademarks, the Company uses a relief from royalty income approach. For the Company's certificates of need and accreditations, the Company performs qualitative assessments. As part of these assessments, the Company evaluates the current business environment, regulatory environment, legal and other company-specific factors. If it is more likely than not that the fair values are less than the carrying values, the Company performs a quantitative impairment test.

1. Organization and Significant Accounting Policies (Continued)

The Company's most recent impairment assessments were completed during the fourth quarter of 2021 utilizing information as of October 1, 2021. The Company did not identify any instances of impairment with respect to goodwill or other indefinite-lived intangible assets as of October 1, 2021.

Finite-lived identifiable intangible assets

Finite-lived intangible assets are amortized based on the pattern in which the economic benefits are consumed or otherwise depleted. If such a pattern cannot be reliably determined, finite-lived intangible assets are amortized on a straight-line basis over their estimated lives. Management believes that the below estimated useful lives are reasonable based on the economic factors applicable to each class of finite-lived intangible asset. The general range of useful lives is as follows:

Customer relationships	5 – 15 years
Non-compete agreements	1 – 15 years

The Company's finite-lived intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of those assets or asset groups may not be recoverable. If the expected undiscounted future cash flows are less than the carrying amount of such assets or asset groups, the Company recognizes an impairment loss to the extent the carrying amount exceeds its estimated fair value.

Equity Method Investments

The Company applies the equity method of accounting for investments in which the Company has the ability to exercise significant influence over the operating and financial policies of the investee, but does not possess a controlling financial interest in the investee. Investments of this nature are recorded at their original cost and adjusted periodically to recognize the Company's share of its investees' net income or losses after the date of investment. When net losses from an investment accounted for under the equity method exceed the carrying amount, the investment balance is reduced to zero. The Company resumes accounting for the investment under the equity method if the investee subsequently reports net income and the Company's share of that net income exceeds the share of the net losses not recognized during the period the equity method was suspended. Investments are written down only when there is clear evidence that a decline in value that is other than temporary has occurred. The Company evaluates its equity method investments for impairment when there is evidence or indicators that a loss in value may be other than temporary.

Income Taxes

The Company recognizes deferred tax assets and liabilities for the expected future tax consequences of events that have been recognized in the Company's financial statements. Deferred tax assets and liabilities are determined on the basis of the differences between the book and tax bases of assets and liabilities by using enacted tax rates in effect for the year in which the differences are expected to reverse. The Company also recognizes the future tax benefits from net operating loss carryforwards as deferred tax assets. The effect of a change in tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date.

The Company evaluates the realizability of deferred tax assets and reduces those assets using a valuation allowance if it is more likely than not that some portion or all of the deferred tax asset will not be realized. Among the factors used to assess the likelihood of realization are projections of future taxable income streams, the expected timing of the reversals of existing temporary differences, and the impact of tax planning strategies that could be implemented to avoid the potential loss of future tax benefits.

Reserves for uncertain tax positions are established for exposure items related to various federal and state tax matters. Income tax reserves are recorded when an exposure is identified and when, in the opinion of management, it is more likely than not that a tax position will not be sustained and the amount of the liability can be estimated.

1. Organization and Significant Accounting Policies (Continued)

Insurance Risk Programs

Under a number of the Company's insurance programs, which include the Company's employee health insurance, workers' compensation, and professional malpractice liability insurance programs, the Company is liable for a portion of its losses before it can attempt to recover from the applicable insurance carrier. The Company accrues for losses under an occurrence-based approach whereby the Company estimates the losses that will be incurred in a respective accounting period and accrues that estimated liability using actuarial methods. These programs are monitored quarterly and estimates are revised as necessary to take into account additional information. The Company also records insurance proceeds receivable for liabilities which exceed the Company's deductibles and self-insured retention limits and are recoverable through its insurance policies.

Revenue Recognition

Patient Service Revenues

Patient service revenues are recognized at an amount equal to the consideration the Company expects to be entitled to in exchange for providing healthcare services to its patients. Amounts owed for services provided are the obligations of the Company's patients and can be paid for by third-party payors, including health insurers, government programs, and other payors on the patient's behalf. Most of the Company's patients are subject to healthcare coverage through a third-party payor arrangement. Given the nature and extent of third-party payor arrangements, the Company disaggregates its revenue by the following payor categories:

Medicare: Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end stage renal disease. The Company determines the transaction price for services provided to patients who are Medicare beneficiaries using Medicare's prospective payment systems and other payment methods. The expected payment is determined by the level of clinical services provided and is sensitive to the patient's length of stay.

Non-Medicare: Non-Medicare payor sources include, but are not limited to, insurance companies (including Medicare Advantage plans), state Medicaid programs, workers' compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as patients themselves. The transaction price for services provided to non-Medicare patients include amounts prescribed by state and federal fee schedules, negotiated contract amounts, or usual and customary amounts associated with the specific payor or based on the service provided. The Company applies the portfolio approach in determining revenues for certain homogeneous non-Medicare patient populations.

The Company's principal revenue source comes from providing healthcare services to patients. For patients treated within the Company's outpatient rehabilitation clinics and Concentra centers, performance obligations are generally satisfied upon completion of the patient's visit. For patients treated within the Company's critical illness recovery and rehabilitation hospitals, the Company's performance obligation is satisfied over the duration of the patient's stay. As such, the Company recognizes revenue over the patient's stay in amounts which are commensurate with the level of services provided to the patient. Any differences between the Company's estimates of the transaction price, which may be impacted by various factors as described further below, and the payment received upon a patient's discharge would be recognized as revenue in the period in which this change becomes known; such adjustments are not significant. The Company has an obligation to continue delivering treatment to patients admitted in the Company's critical illness recovery and rehabilitation hospitals at the end of each reporting period. These performance obligations are typically satisfied in the subsequent month following the reporting period. The Company has elected the optional exemption which allows for the exclusion of disclosures regarding the transaction price allocated to unsatisfied performance obligations of contracts with a duration of less than one year.

1. Organization and Significant Accounting Policies (Continued)

Revenue earned from providing services to patients is variable in nature, as the Company is required to make judgments which impact the transaction price, such as a patient's condition and length of stay. These factors, among others, impact the payment the Company expects to receive for providing services. Variable consideration included in the transaction price is inclusive of the Company's estimates of implicit discounts and other adjustments related to timely filing and documentation denials, out of network adjustments, and medical necessity denials, which are estimated using the Company's historical experience. The Company is also subject to regular post-payment inquiries, investigations, and audits of the claims it submits for services provided. Some claims can take several years for resolution and may result in adjustments to the transaction price. Management includes in its estimates of the transaction price its expectations for these types of adjustments such that the amount of cumulative revenue recognized will not be subject to significant reversal in future periods. Historically, adjustments arising from a change in the transaction price have not been significant.

Other Revenues

The Company recognizes revenue for other services which principally consist of management and employee leasing services under contractual arrangements with related parties affiliated with the Company and non-affiliated healthcare institutions. The Company accounts for management and employee leasing services as single performance obligations satisfied over time. The transaction price is variable in nature and the Company recognizes revenue in amounts which are commensurate with the level of services provided during the period. The Company's transaction price is determined such that the amount of cumulative revenue recognized will not be subject to significant reversal in future periods.

Recently Adopted Accounting Guidance

Reference Rate Reform

In March 2020, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2020-04, *Reference Rate Reform (Topic 848), Facilitation of the Effects of Reference Rate Reform on Financial Reporting* and in January 2021, the FASB issued 2021-01, *Reference Rate Reform (Topic 848), Scope,* which further clarified the scope of the reference rate reform optional practical expedients and exceptions outlined in Topic 848. Topic 848 provides temporary relief from some of the existing rules governing contract modifications when the modification is related to the replacement of the London Interbank Offered Rate ("LIBOR") or other reference rates discontinued as a result of reference rate reform. On March 5, 2021, the Financial Conduct Authority ("FCA") in the U.K. announced that all LIBOR settings will either cease to be provided or no longer be representative (i) immediately after December 31, 2021, in the case of the one-week and two-month USD LIBOR terms and all sterling, euro, Swiss franc and Japanese yen settings, and (ii) immediately after June 30, 2023, in the case of the one-, three-, six-, and 12-month USD LIBOR terms.

For eligible contract modifications, the update generally allows an entity to account for and present modifications as an event that does not require contract remeasurement at the modification date or reassessment of a previous accounting determination. That is, the modified contract is accounted for as a continuation of the existing contract. For cash flow hedging relationships affected by reference rate reform, Topic 848 provides expedients that allow an entity to (i) change the reference rate of either the forecasted transaction or hedging instrument due to reference rate reform without requiring dedesignation of the hedging relationship; (ii) assert that changes to the hedged forecasted transaction due to reference rate reform will not impact whether it remains probable of occurring; and (iii) for the purposes of assessment of hedge effectiveness assume that the reference rate will not be replaced for the remainder of the hedging relationship if both the hedged forecasted transaction and hedging instrument are expected to be impacted by reference rate reform. The standard was effective upon issuance on March 12, 2020, and the optional practical expedients can generally be applied to contract modifications made and hedging relationships entered into on or before December 31, 2022.

Borrowings under the Company's credit agreement bear interest, at the election of Select, based on LIBOR or an alternate base rate. The Company currently elects for its term loan borrowings to bear interest at a rate that is indexed to one-month LIBOR. Provisions within the credit agreement provide the Company with the ability to agree with JPMorgan Chase Bank, N.A., as administrative agent to the lenders, to replace LIBOR with a different reference rate in the event that LIBOR ceases to exist. The Company has not yet agreed upon a different reference rate with JPMorgan Chase Bank, N.A.

1. Organization and Significant Accounting Policies (Continued)

For the Company's cash flow hedge, which mitigates the Company's exposure to increases in the one-month LIBOR rate above 1.0% on $2.0 billion of principal outstanding under the term loan, the Company has elected to assert that the hedged forecasted transaction remains probable of occurring, regardless of a modification or expected modification that may replace one-month LIBOR with a different reference rate. The Company intends to modify the cash flow hedge's contractual terms related to the replacement of the reference rate, as necessary, to align with the reference rate specified for the Company's term loan. For the purpose of the assessment of hedge effectiveness, the Company assumes that the reference rate will not be replaced for the remainder of the hedging relationship, as outlined by Topic 848. The Company's cash flow hedge is described further in Note 12 – Interest Rate Cap.

ASU 2020-04 has not had, and the Company does not expect it to have in future periods, a material impact on the Company's consolidated financial statements.

Government Assistance

In November 2021, the FASB issued ASU 2021-10, *Government Assistance (Topic 832)*, which requires business entities to disclose information about certain government assistance they receive if they account for the transactions by applying a grant or contribution model by analogy (for example, International Financial Reporting Standards ("IFRS") guidance in International Accounting Standard ("IAS") 20 or guidance on contributions for not-for-profit entities in Accounting Standards Codification ("ASC") 958-605). For transactions in the scope of the new standard, business entities will need to provide information about the nature of the transaction and the accounting policy used, the significant terms and conditions associated with the transaction, and the amounts and financial statement line items affected by the transaction. The new guidance is effective for annual reporting periods beginning after December 15, 2021; however, early adoption is permitted. The disclosure requirements can be applied either prospectively or retrospectively.

The Company early adopted ASU 2021-10 as of December 31, 2021. ASU 2021-10 did not have an impact on the Company's consolidated financial statements upon adoption.

Recent Accounting Guidance Not Yet Adopted

Convertible Instruments and Contracts on an Entity's Own Equity

In August 2020, the FASB issued ASU 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity.* The ASU simplifies the accounting for certain financial instruments with characteristics of liabilities and equity, including convertible instruments and contracts on an entity's own equity. As part of this update, convertible instruments are to be included in diluted earnings per share using the if-converted method, rather than the treasury stock method. Further, contracts which can be settled in cash or shares, excluding liability-classified share-based payment awards, are to be included in diluted earnings per share on an if-converted basis if the effect is dilutive, regardless of whether the entity or the counterparty can choose between cash and share settlement. The share-settlement presumption may not be rebutted based on past experience or a stated policy. This pronouncement is effective for fiscal years, and for interim periods within those fiscal years, beginning after December 15, 2021. The use of either the modified retrospective or fully retrospective method of transition is permitted.

Under the terms of the Amended and Restated Limited Liability Company Agreement of Concentra Group Holdings Parent, LLC ("Concentra Group Holdings Parent"), certain members of Concentra Group Holdings Parent had put rights that obligated the Company to purchase such members' equity interests when exercised. The Company could elect to pay the purchase price for those equity interests in cash or in shares of Holdings' common stock. On December 24, 2021, the Company purchased the equity interests which were subject to these provisions.

The Company will adopt this ASU using the modified retrospective method of transition as of January 1, 2022. ASU 2020-06 will not have an impact on the Company's consolidated financial statements upon adoption.

2. Redeemable Non-Controlling Interests

The Company's redeemable non-controlling interests have been comprised primarily of the voting membership interests owned by outside members of Concentra Group Holdings Parent each which have put rights with respect to their interests in Concentra Group Holdings Parent. The redemption value of the voting membership interests was approximately $368.9 million as of December 31, 2020. There were no voting membership interests owned by outside members of Concentra Group Holdings Parent as of December 31, 2021. The remainder of the Company's redeemable non-controlling interest balance primarily relates to put rights held by outside partners in eight less than wholly owned subsidiaries.

During the year ended December 31, 2020, Select, Welsh, Carson, Anderson & Stowe XII, L.P. ("WCAS"), Dignity Health Holding Corporation ("DHHC"), and other members of Concentra Group Holdings Parent entered into agreements pursuant to which Select acquired additional outstanding membership interests of Concentra Group Holdings Parent. The aggregate purchase price for these interests was $576.4 million. Following these purchases, Select owned approximately 78.0% of the outstanding membership interests of Concentra Group Holdings Parent on a fully diluted basis and approximately 79.8% of the outstanding voting membership interests of Concentra Group Holdings Parent.

During the year ended December 31, 2021, Select, WCAS, DHHC, and other members of Concentra Group Holdings Parent entered into agreements pursuant to which Select acquired additional outstanding membership interests of Concentra Group Holdings Parent. The aggregate purchase price for these interests was $660.7 million. Following these purchases, Select owns approximately 99.3% of the outstanding membership interests of Concentra Group Holdings Parent on a fully diluted basis and 100.0% of the outstanding voting membership interests of Concentra Group Holdings Parent.

The changes in redeemable non-controlling interests are as follows:

	For the Year Ended December 31,		
	2019	2020	2021
	(in thousands)		
Balance as of January 1	$ 780,488	$ 974,541	$ 398,171
Net income attributable to redeemable non-controlling interests	25,956	37,761	50,153
Distributions to and purchases of redeemable non-controlling interests	(6,205)	(11,255)	(911)
Redemption value adjustment on redeemable non-controlling interests	172,915	(27,470)	250,083
Purchase of membership interests of Concentra Group Holdings Parent	—	(576,366)	(660,658)
Other	1,387	960	2,195
Balance as of December 31	$ 974,541	$ 398,171	$ 39,033

3. Credit Risk and Payor Concentrations

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash balances and accounts receivable. The Company's excess cash is held with large financial institutions. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements.

Because of the diversity in the Company's non-governmental third-party payor base, as well as their geographic dispersion, accounts receivable due from the Medicare program represent the Company's only significant concentration of credit risk. Approximately 18% and 15% of the Company's accounts receivable is due from Medicare at December 31, 2020 and 2021, respectively.

Revenues from providing services to patients covered under the Medicare program represented approximately 26%, 25%, and 23% of the Company's total revenue for the years ended December 31, 2019, 2020, and 2021, respectively. As a provider of services under the Medicare program, the Company is subject to extensive regulations. The inability of any of the Company's critical illness recovery hospitals, rehabilitation hospitals, or outpatient rehabilitation clinics to comply with Medicare regulations can result in the Company receiving significantly less Medicare payments than the Company currently receives for the services it provides to its patients.

4. Acquisitions

During the year ended December 31, 2019, the Company made acquisitions consisting of critical illness recovery hospital, rehabilitation hospital, outpatient rehabilitation, and Concentra businesses. The consideration given for these acquired businesses consisted principally of $93.7 million of cash and the issuance of $15.1 million of non-controlling interests. The Company allocated the purchase price of these acquired businesses to assets acquired, principally property and equipment, and liabilities assumed based on their estimated fair values. The Company recognized goodwill of $33.6 million, $14.3 million, $13.0 million, and $16.1 million in our critical illness recovery hospital, rehabilitation hospital, outpatient rehabilitation, and Concentra reporting units, respectively.

During the year ended December 31, 2020, the Company made acquisitions consisting of critical illness recovery hospital, rehabilitation hospital, outpatient rehabilitation, and Concentra businesses. The consideration given for these acquired businesses consisted principally of $20.8 million of cash. The Company allocated the purchase price of these acquired businesses to assets acquired, principally accounts receivable and property and equipment, and liabilities assumed based on their estimated fair values. The Company recognized goodwill of $6.0 million, $2.5 million, $2.7 million, and $12.3 million in our critical illness recovery hospital, rehabilitation hospital, outpatient rehabilitation, and Concentra reporting units, respectively.

During the year ended December 31, 2021, the Company made acquisitions consisting of critical illness recovery hospital, rehabilitation hospital, outpatient rehabilitation, and Concentra businesses. The consideration given for these acquired businesses consisted principally of $89.7 million of cash and the issuance of $11.2 million of non-controlling interests. The Company allocated the purchase price of these acquired businesses to assets acquired, principally cash, accounts receivable, property and equipment, and operating lease right-of-use assets, and liabilities assumed based on their estimated fair values. The Company recognized goodwill of $46.7 million, $9.4 million, $7.7 million, and $8.6 million in our critical illness recovery hospital, rehabilitation hospital, outpatient rehabilitation, and Concentra reporting units, respectively.

5. Variable Interest Entities

As of December 31, 2020 and 2021, the total assets of the Company’s variable interest entities were $208.4 million and $225.1 million, respectively, and are principally comprised of accounts receivable. As of December 31, 2020 and 2021, the total liabilities of the Company’s variable interest entities were $55.1 million and $74.8 million, respectively, and are principally comprised of accounts payable and accrued expenses. These variable interest entities have obligations payable for services received under their management agreements with the Company of $151.8 million and $150.3 million as of December 31, 2020 and 2021, respectively. These intercompany balances are eliminated in consolidation.

6. Leases

The Company has operating and finance leases for its facilities. The Company leases its corporate office space from related parties. The Company's critical illness recovery hospitals and rehabilitation hospitals generally have lease terms of 10 years with two, five year renewal options. These renewal options vary for hospitals which operate as a hospital within a hospital, or "HIH." The Company's outpatient rehabilitation clinics generally have lease terms of five years with two, three to five year renewal options. The Company's Concentra centers generally have lease terms of 10 years with two, five year renewal options.

The Company's total lease cost is as follows:

	For the Year Ended December 31,								
	2019			2020			2021		
	Unrelated Parties	Related Parties	Total	Unrelated Parties	Related Parties	Total	Unrelated Parties	Related Parties	Total
	(in thousands)								
Operating lease cost	$ 271,799	$ 5,498	$ 277,297	$ 278,945	$ 7,118	$ 286,063	$ 283,595	$ 7,186	$ 290,781
Finance lease cost:									
Amortization of right-of-use assets	258	—	258	452	—	452	647	—	647
Interest on lease liabilities	812	—	812	1,011	—	1,011	1,142	—	1,142
Short-term lease cost	2,171	—	2,171	—	—	—	269	—	269
Variable lease cost	43,096	553	43,649	49,409	580	49,989	52,666	426	53,092
Sublease income	(9,822)	—	(9,822)	(9,814)	—	(9,814)	(8,955)	—	(8,955)
Total lease cost	$ 308,314	$ 6,051	$ 314,365	$ 320,003	$ 7,698	$ 327,701	$ 329,364	$ 7,612	$ 336,976

Supplemental cash flow information related to leases is as follows:

	For the Year Ended December 31,		
	2019	2020	2021
		(in thousands)	
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows for operating leases	$ 274,095	$ 280,263	$ 294,576
Operating cash flows for finance leases	777	1,011	1,142
Financing cash flows for finance leases	225	140	616
Right-of-use assets obtained in exchange for lease liabilities:			
Operating leases[(1)]	1,275,575	256,697	284,657
Finance leases	9,102	1,220	4,545

(1) Includes the right-of-use assets obtained in exchange for lease liabilities of $1,057.0 million which were recognized upon adoption of ASC Topic 842 during the year ended December 31, 2019.

6. Leases (Continued)

Supplemental balance sheet information related to leases is as follows:

	December 31,					
	2020			2021		
	Unrelated Parties	Related Parties	Total	Unrelated Parties	Related Parties	Total
Operating Leases	(in thousands)					
Operating lease right-of-use assets	$ 1,002,151	$ 30,066	$ 1,032,217	$ 1,052,603	$ 26,151	$ 1,078,754
Current operating lease liabilities	$ 214,377	$ 6,036	$ 220,413	$ 222,865	$ 6,469	$ 229,334
Non-current operating lease liabilities	848,215	27,152	875,367	894,104	22,436	916,540
Total operating lease liabilities	$ 1,062,592	$ 33,188	$ 1,095,780	$ 1,116,969	$ 28,905	$ 1,145,874

	December 31,					
	2020			2021		
	Unrelated Parties	Related Parties	Total	Unrelated Parties	Related Parties	Total
Finance Leases	(in thousands)					
Property and equipment, net	$ 5,644	$ —	$ 5,644	$ 8,505	$ —	$ 8,505
Current portion of long-term debt and notes payable	$ 663	$ —	$ 663	$ 1,404	$ —	$ 1,404
Long-term debt, net of current portion	13,491	—	13,491	16,679	—	16,679
Total finance lease liabilities	$ 14,154	$ —	$ 14,154	$ 18,083	$ —	$ 18,083

The weighted average remaining lease terms and discount rates are as follows:

	December 31,	
	2020	2021
Weighted average remaining lease term (in years):		
Operating leases	7.8	7.8
Finance leases	31.2	24.7
Weighted average discount rate:		
Operating leases	5.6 %	5.6 %
Finance leases	7.2 %	7.4 %

As of December 31, 2021, maturities of lease liabilities are approximately as follows:

	Operating Leases	Finance Leases
	(in thousands)	
2022	$ 284,359	$ 2,724
2023	240,346	2,747
2024	200,347	2,384
2025	162,649	2,101
2026	133,483	2,126
Thereafter	468,921	28,181
Total undiscounted cash flows	1,490,105	40,263
Less: Imputed interest	344,231	22,180
Total discounted lease liabilities	$ 1,145,874	$ 18,083

7. Property and Equipment

The Company's property and equipment consists of the following:

	December 31,	
	2020	2021
	(in thousands)	
Land	$ 93,756	$ 95,912
Leasehold improvements	562,734	620,367
Buildings	552,796	574,916
Furniture and equipment	704,430	728,072
Construction-in-progress	62,748	79,722
Total property and equipment	1,976,464	2,098,989
Accumulated depreciation	(1,033,044)	(1,137,522)
Property and equipment, net	$ 943,420	$ 961,467

Depreciation expense was $182.9 million, $178.0 million, and $173.2 million for the years ended December 31, 2019, 2020, and 2021, respectively.

8. Intangible Assets

Goodwill

The following table shows changes in the carrying amounts of goodwill by reporting unit for the years ended December 31, 2020 and 2021:

	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Total
			(in thousands)		
Balance as of January 1, 2020	$ 1,078,804	$ 430,900	$ 649,763	$ 1,232,488	$ 3,391,955
Acquisition of businesses	5,957	2,481	2,704	12,287	23,429
Measurement period adjustment	—	—	—	(20)	(20)
Sale of businesses	—	(628)	(6,034)	(29,688)	(36,350)
Balance as of December 31, 2020	1,084,761	432,753	646,433	1,215,067	3,379,014
Acquisition of businesses	46,679	9,402	7,692	8,645	72,418
Sale of businesses	—	—	—	(2,520)	(2,520)
Balance as of December 31, 2021	$ 1,131,440	$ 442,155	$ 654,125	$ 1,221,192	$ 3,448,912

8. Intangible Assets (Continued)

Identifiable Intangible Assets

The following table provides the gross carrying amounts, accumulated amortization, and net carrying amounts for the Company's identifiable intangible assets:

	December 31,					
	2020			2021		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
	(in thousands)					
Indefinite-lived intangible assets:						
Trademarks	$ 166,698	$ —	$ 166,698	$ 166,698	$ —	$ 166,698
Certificates of need	18,392	—	18,392	21,478	—	21,478
Accreditations	1,874	—	1,874	1,874	—	1,874
Finite-lived intangible assets:						
Trademarks	5,000	(5,000)	—	5,000	(5,000)	—
Customer relationships	291,923	(113,346)	178,577	304,289	(141,111)	163,178
Non-compete agreements	33,771	(11,771)	22,000	36,746	(15,095)	21,651
Total identifiable intangible assets	$ 517,658	$ (130,117)	$ 387,541	$ 536,085	$ (161,206)	$ 374,879

The Company's accreditations and trademarks have renewal terms and the costs to renew these intangible assets are expensed as incurred. At December 31, 2021, the accreditations and trademarks have a weighted average time until next renewal of 1.5 years and 7.7 years, respectively.

The Company's finite-lived intangible assets amortize over their estimated useful lives. Amortization expense was $29.6 million, $27.6 million, and $29.5 million for the years ended December 31, 2019, 2020, and 2021, respectively.

Estimated amortization expense of the Company's finite-lived intangible assets for each of the five succeeding years is as follows:

	2022	2023	2024	2025	2026
	(in thousands)				
Amortization expense	$ 30,131	$ 29,264	$ 20,674	$ 14,237	$ 13,452

9. Equity Method Investments

The Company's equity method investments consist principally of minority ownership interests in rehabilitation businesses. Equity method investments of $251.1 million and $270.8 million are presented as part of other assets in the consolidated balance sheets as of December 31, 2020 and 2021, respectively. At December 31, 2021, these businesses primarily consist of the following ownership interests:

BIR JV, LLP	49.0 %
OHRH, LLC	49.0 %
GlobalRehab—Scottsdale, LLC	49.0 %
ES Rehabilitation, LLC	49.0 %
BHSM Rehabilitation, LLC	49.0 %

9. Equity Method Investments (Continued)

The Company provides contracted services, principally employee leasing services, and charges management fees to related parties affiliated through its equity method investments. Revenue generated from contracted services provided and management fees charged to related parties affiliated through the Company's equity method investments was $308.2 million, $337.6 million, and $332.0 million for the years ended December 31, 2019, 2020, and 2021, respectively.

The Company had receivables from related parties affiliated through its equity method investments of $13.7 million and $2.5 million, which are included as part of other current assets and other assets in the consolidated balance sheet, respectively, as of December 31, 2020. The Company has receivables from related parties of $23.9 million and $3.5 million, which are included as part of other current assets and other assets in the consolidated balance sheet, respectively, as of December 31, 2021.

The Company had liabilities for the operating cash it holds on behalf of certain rehabilitation businesses in which it has an equity method investment. These liabilities were $30.6 million and $22.0 million as of December 31, 2020 and 2021, respectively, and are included as part of accrued other in the consolidated balance sheets.

Summarized combined financial information of the rehabilitation businesses in which the Company has a minority ownership interest is as follows:

	December 31,	
	2020	2021
	(in thousands)	
Current assets	$ 189,571	$ 181,838
Non-current assets	334,372	356,278
Total assets	$ 523,943	$ 538,116
Current liabilities	$ 96,980	$ 89,953
Non-current liabilities	118,312	103,484
Equity	308,651	344,679
Total liabilities and equity	$ 523,943	$ 538,116

	For the Year Ended December 31,		
	2019	2020	2021
		(in thousands)	
Revenues	$ 536,464	$ 562,031	$ 587,445
Cost of services and other operating expenses	476,182	496,739	503,880
Net income	58,519	72,172	87,528

10. Insurance Risk Programs

Under a number of the Company's insurance programs, which include the Company's employee health insurance, workers' compensation, and professional malpractice liability insurance programs, the Company is liable for a portion of its losses before it can attempt to recover from the applicable insurance carrier. The Company accrues for losses under an occurrence-based approach whereby the Company estimates the losses that will be incurred in a respective accounting period and accrues that estimated liability using actuarial methods. At December 31, 2020 and 2021, provisions for losses for professional liability risks retained by the Company have been discounted at 3%.

The Company recorded a liability of $173.6 million and $173.5 million related to these programs at December 31, 2020 and 2021, respectively. If the Company did not discount the provisions for losses for professional liability risks, the aggregate liability for all of the insurance risk programs would be approximately $178.4 million and $178.5 million at December 31, 2020 and 2021, respectively. At December 31, 2020 and 2021, the Company recorded insurance proceeds receivable of $13.0 million and $14.5 million, respectively, for liabilities which exceeded its deductibles and self-insured retention limits and are recoverable through its insurance policies.

11. Long-Term Debt and Notes Payable

As of December 31, 2021, the Company's long-term debt and notes payable are as follows:

	Principal Outstanding	Unamortized Premium (Discount)	Unamortized Issuance Costs	Carrying Value	Fair Value
			(in thousands)		
6.250% senior notes	$ 1,225,000	$ 27,635	$ (13,951)	$ 1,238,684	$ 1,297,104
Credit facilities:					
Revolving facility	160,000	—	—	160,000	159,400
Term loan	2,103,437	(6,386)	(6,961)	2,090,090	2,087,661
Other debt, including finance leases	85,398	—	(215)	85,183	85,183
Total debt	$ 3,573,835	$ 21,249	$ (21,127)	$ 3,573,957	$ 3,629,348

Principal maturities of the Company's long-term debt and notes payable are approximately as follows:

	2022	2023	2024	2025	2026	Thereafter	Total
				(in thousands)			
6.250% senior notes	$ —	$ —	$ —	$ —	$ 1,225,000	$ —	$ 1,225,000
Credit facilities:							
Revolving facility	—	—	160,000	—	—	—	160,000
Term loan	—	4,757	11,150	2,087,530	—	—	2,103,437
Other debt, including finance leases	17,572	27,072	26,081	1,824	1,286	11,563	85,398
Total debt	$ 17,572	$ 31,829	$ 197,231	$ 2,089,354	$ 1,226,286	$ 11,563	$ 3,573,835

As of December 31, 2020, the Company's long-term debt and notes payable are as follows:

	Principal Outstanding	Unamortized Premium (Discount)	Unamortized Issuance Costs	Carrying Value	Fair Value
			(in thousands)		
6.250% senior notes	$ 1,225,000	$ 33,773	$ (16,953)	$ 1,241,820	$ 1,316,875
Credit facilities:					
Term loan	2,103,437	(8,393)	(9,149)	2,085,895	2,082,403
Other debt, including finance leases	74,606	—	(302)	74,304	74,304
Total debt	$ 3,403,043	$ 25,380	$ (26,404)	$ 3,402,019	$ 3,473,582

Credit Facilities

On March 6, 2017, Select entered into a senior secured credit agreement (the "credit agreement"). The credit agreement provided for $2,265.0 million in term loan borrowings (the "term loan") and a $450.0 million revolving credit facility (the "revolving facility" and, together with the term loan, the "credit facilities"), including a $75.0 million sublimit for the issuance of standby letters of credit. On June 2, 2021, Select entered into Amendment No. 5 to its credit agreement which, among other things, increased the aggregate commitments available under its revolving facility from $450.0 million to $650.0 million, including a $125.0 million sublimit for the issuance of standby letters of credit. At December 31, 2021, Select had $434.7 million of availability under the revolving facility after giving effect to $160.0 million of outstanding borrowings and $55.3 million of outstanding letters of credit. The term loan and the revolving facility are due March 6, 2025 and March 6, 2024, respectively.

11. Long-Term Debt and Notes Payable (Continued)

The interest rates on the term loan and the revolving facility are equal to the Adjusted LIBO Rate (as defined in the credit agreement) plus a percentage ranging from 2.25% to 2.50%, or the Alternate Base Rate (as defined in the credit agreement) plus a percentage ranging from 1.25% to 1.50%, in each case subject to a specified leverage ratio. As of December 31, 2021, the term loan borrowings bear interest at a rate that is indexed to one-month LIBOR plus 2.25%. As of December 31, 2021, the revolving facility borrowings bear interest either at a rate indexed to one-month LIBOR plus 2.25% or the Alternate Base Rate plus 1.25%.

The revolving facility requires Select to maintain a leverage ratio, as specified in the credit agreement, not to exceed 7.00 to 1.00. As of December 31, 2021, Select's leverage ratio was 3.77 to 1.00.

Borrowings under the credit facilities are guaranteed by Holdings and substantially all of Select's current domestic subsidiaries, other than certain non-guarantor subsidiaries including Concentra and its subsidiaries, and will be guaranteed by substantially all of Select's future domestic subsidiaries. Borrowings under the credit facilities are secured by substantially all of Select's existing and future property and assets and by a pledge of Select's capital stock, the capital stock of Select's domestic subsidiaries, other than certain non-guarantor subsidiaries including Concentra and its subsidiaries, and up to 65% of the capital stock of Select's foreign subsidiaries held directly by Select or a domestic subsidiary.

Prepayment of Borrowings

Select will be required to prepay borrowings under the credit facilities with (i) the net cash proceeds received from non-ordinary course asset sales or other dispositions, or as a result of a casualty or condemnation, subject to reinvestment provisions and other customary carveouts and, to the extent required, the payment of certain indebtedness secured by liens having priority over the debt under the credit facilities or subject to a first lien intercreditor agreement, (ii) the net cash proceeds received from the issuance of debt obligations other than certain permitted debt obligations, and (iii) a percentage of excess cash flow (as defined in the credit agreement) based on Select's leverage ratio, as specified in the credit agreement. The Company will not be required to make a prepayment of borrowings as a result of excess cash flow for the year ended December 31, 2021.

6.250% Senior Notes

On August 1, 2019, Select issued and sold $550.0 million aggregate principal amount of 6.250% senior notes due August 15, 2026. On December 10, 2019, Select issued and sold $675.0 million aggregate principal amount of 6.250% senior notes, due August 15, 2026, as additional notes under the indenture pursuant to which it previously issued $550.0 million aggregate principal amount of senior notes. The additional senior notes were issued at 106.00% of the aggregate principal amount. Interest on the senior notes accrues at the rate of 6.250% per annum and is payable semi-annually in arrears on February 15 and August 15 of each year, commencing on February 15, 2020.

The senior notes are Select's senior unsecured obligations which are subordinated to all of Select's existing and future secured indebtedness, including its credit facilities. The senior notes rank equally in right of payment with all of Select's other existing and future senior unsecured indebtedness and senior in right of payment to all of Select's existing and future subordinated indebtedness. The senior notes are unconditionally guaranteed on a joint and several basis by each of Select's direct or indirect existing and future domestic restricted subsidiaries, other than certain non-guarantor subsidiaries, including Concentra and its subsidiaries.

Prior to August 15, 2022, Select may redeem some or all of the senior notes by paying a "make-whole" premium. On or after August 15, 2022, Select may redeem some or all of the senior notes at specified redemption prices. In addition, prior to August 15, 2022, Select may redeem up to 40% of the principal amount of the senior notes with the net proceeds of certain equity offerings at a price of 106.250% plus accrued and unpaid interest, if any. Select is obligated to offer to repurchase the senior notes at a price of 101% of their principal amount plus accrued and unpaid interest, if any, as a result of certain change of control events. These restrictions and prohibitions are subject to certain qualifications and exceptions.

11. Long-Term Debt and Notes Payable (Continued)

Concentra-JPM Revolving Facility

On June 1, 2015, Concentra Inc. entered into a first lien credit agreement (the "Concentra-JPM first lien credit agreement"). The Concentra-JPM first lien credit agreement provided for availability of up to $100.0 million under a revolving credit facility (the "Concentra-JPM revolving facility"), which would mature on March 1, 2022. On June 2, 2021, Concentra Inc. terminated its obligations under the Concentra-JPM first lien credit agreement.

Loss on Early Retirement of Debt

During the year ended December 31, 2019, the Company refinanced its senior notes, credit facilities, and the Concentra-JPM first and second lien credit agreements which resulted in losses on early retirement of debt of $38.1 million. The losses on early retirement of debt consisted of $22.1 million of debt extinguishment losses and $16.0 million of debt modification losses.

12. Interest Rate Cap

The Company is subject to market risk exposure arising from changes in interest rates on its term loan, which bears interest at a rate that is indexed to one-month LIBOR, as discussed further in Note 11 – Long-Term Debt and Notes Payable. The Company's objective in using an interest rate derivative is to mitigate its exposure to increases in interest rates. The interest rate cap limits the Company's exposure to increases in the one-month LIBOR rate to 1.0% on $2.0 billion of principal outstanding under the term loan, as the interest rate cap provides for payments from the counterparty when interest rates rise above 1.0%. The interest rate cap has a $2.0 billion notional amount and became effective March 31, 2021 for the monthly periods from and including April 30, 2021 through September 30, 2024. The Company will pay a monthly premium for the interest rate cap over the term of the agreement. The annual premium is equal to 0.0916% on the notional amount.

The interest rate cap has been designated as a cash flow hedge and is highly effective at offsetting the changes in cash outflows when one-month LIBOR exceeds 1.0%. Changes in the fair value of the interest rate cap, net of tax, are recognized in other comprehensive income and are reclassified out of accumulated other comprehensive income or loss ("AOCI") and into interest expense when the hedged interest obligations affect earnings.

The following table outlines the changes in AOCI, net of tax, during the periods presented:

	For the Year Ended December 31,		
	2019	2020	2021
		(in thousands)	
Beginning balance	$ —	$ —	$ (2,027)
Gain (loss) on interest rate cap cash flow hedge	—	(2,027)	14,270
Amounts reclassified from AOCI	—	—	39
Ending balance	$ —	$ (2,027)	$ 12,282

The Company expects that approximately $1.0 million of estimated pre-tax gains will be reclassified from AOCI into interest expense within the next twelve months.

Refer to Note 13 – Fair Value of Financial Instruments for information on the fair value of the Company's interest rate cap contract and its balance sheet classification. Refer to Note 1 – Organization and Significant Accounting Policies for the Company's considerations regarding reference rate reform and the impact to its interest rate cap contract.

13. Fair Value of Financial Instruments

Financial instruments which are measured at fair value, or for which a fair value is disclosed, are classified in the fair value hierarchy, as outlined below, on the basis of the observability of the inputs used in the fair value measurement:

- Level 1 – inputs are based upon quoted prices for identical instruments in active markets.
- Level 2 – inputs are based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant inputs are observable in the market or can be corroborated by observable market data.
- Level 3 – inputs are generally unobservable and typically reflect management's estimates of assumptions that market participants would use in pricing the instrument.

The Company's interest rate cap contract is recorded at its fair value in the consolidated balance sheets on a recurring basis. The fair value of the interest rate cap contract is based upon a model-derived valuation using observable market inputs, such as interest rates and interest rate volatility, and the strike price.

Financial Instrument	Balance Sheet Classification	Level	December 31, 2020	December 31, 2021
			(in thousands)	
Asset:				
Interest rate cap contract, non-current portion	Other assets	Level 2	$ —	$ 18,055
Liability:				
Interest rate cap contract, current portion	Accrued other	Level 2	$ 1,339	$ 330
Interest rate cap contract, non-current portion	Other non-current liabilities	Level 2	1,392	—

The Company does not measure its indebtedness at fair value in its consolidated balance sheets. The fair value of the credit facilities is based on quoted market prices for this debt in the syndicated loan market. The fair value of the senior notes is based on quoted market prices. The carrying value of the Company's other debt, as disclosed in Note 11 – Long-Term Debt and Notes Payable, approximates fair value.

Financial Instrument	Level	December 31, 2020		December 31, 2021	
		Carrying Value	Fair Value	Carrying Value	Fair Value
		(in thousands)			
6.250% senior notes	Level 2	$ 1,241,820	$ 1,316,875	$ 1,238,684	$ 1,297,104
Credit facilities:					
Revolving facility	Level 2	—	—	160,000	159,400
Term loan	Level 2	2,085,895	2,082,403	2,090,090	2,087,661

The Company's other financial instruments, which primarily consist of cash and cash equivalents, accounts receivable, and accounts payable approximate fair value because of the short-term maturities of these instruments.

14. Stock Repurchase Program

Holdings' board of directors has authorized a common stock repurchase program to repurchase up to $1.0 billion worth of shares of its common stock. The program is in effect until December 31, 2023, unless extended or earlier terminated by the board of directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate. Holdings is funding this program with cash on hand and borrowings under the revolving facility. The common stock repurchase program has available capacity of $584.8 million as of December 31, 2021.

14. Stock Repurchase Program (Continued)

The share repurchases and the cost associated with those repurchases are as follows:

	For the Year Ended December 31,		
	2019	2020	2021
Shares repurchased	2,165,221	491,559	1,770,720
Cost of shares repurchased (in thousands)	$ 33,163	$ 8,692	$ 58,598

15. Segment Information

The Company identifies its segments according to how the chief operating decision maker evaluates financial performance and allocates resources. The Company's reportable segments consist of the critical illness recovery hospital segment, rehabilitation hospital segment, outpatient rehabilitation segment, and Concentra segment. Other activities include the Company's corporate shared services, certain investments, and employee leasing services provided to related parties affiliated through the Company's equity method investments. The accounting policies of the segments are the same as those described in the summary of significant accounting policies. For the years ended December 31, 2020 and 2021, the Company's other activities also include other operating income related to the recognition of payments received under the Provider Relief Fund for health care related expenses and loss of revenue attributable to the coronavirus disease 2019 ("COVID-19"). Refer to Note 22 – CARES Act for further information.

The Company evaluates the performance of its segments based on Adjusted EBITDA. Adjusted EBITDA is defined as earnings excluding interest, income taxes, depreciation and amortization, gain (loss) on early retirement of debt, stock compensation expense, gain (loss) on sale of businesses, and equity in earnings (losses) of unconsolidated subsidiaries. The Company has provided additional information regarding its reportable segments, such as total assets, which contributes to the understanding of the Company and provides useful information to the users of the consolidated financial statements.

The following tables summarize selected financial data for the Company's reportable segments.

	For the Year Ended December 31, 2019					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Revenue	$ 1,836,518	$ 670,971	$ 1,046,011	$ 1,628,817	$ 271,605	$ 5,453,922
Adjusted EBITDA	254,868	135,857	151,831	276,482	(108,130)	710,908
Total assets	2,099,833	1,127,028	1,289,190	2,372,187	452,050	7,340,288
Capital expenditures	45,573	27,216	33,628	44,101	6,608	157,126

	For the Year Ended December 31, 2020					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Revenue	$ 2,077,499	$ 734,673	$ 919,913	$ 1,501,434	$ 298,194	$ 5,531,713
Adjusted EBITDA	342,427	153,203	79,164	252,892	(27,120)	800,566
Total assets	2,213,892	1,148,617	1,302,110	2,400,646	590,134	7,655,399
Capital expenditures	49,726	7,571	28,876	50,114	10,153	146,440

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15. Segment Information (Continued)

	For the Year Ended December 31, 2021					
	Critical Illness Recovery Hospitals	Rehabilitation Hospitals	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Revenue	$ 2,246,772	$ 849,340	$ 1,084,361	$ 1,732,041	$ 292,001	$ 6,204,515
Adjusted EBITDA	267,993	184,704	138,275	389,616	(33,229)	947,359
Total assets	2,304,116	1,194,136	1,348,316	2,275,345	238,258	7,360,171
Capital expenditures	65,690	13,003	36,301	46,787	18,756	180,537

A reconciliation of Adjusted EBITDA to income before income taxes is as follows:

	For the Year Ended December 31, 2019					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Adjusted EBITDA	$ 254,868	$ 135,857	$ 151,831	$ 276,482	$ (108,130)	
Depreciation and amortization	(50,763)	(27,322)	(28,301)	(96,807)	(9,383)	
Stock compensation expense	—	—	—	(3,069)	(23,382)	
Income (loss) from operations	$ 204,105	$ 108,535	$ 123,530	$ 176,606	$ (140,895)	$ 471,881
Loss on early retirement of debt						(38,083)
Equity in earnings of unconsolidated subsidiaries						24,989
Gain on sale of businesses						6,532
Interest expense						(200,570)
Income before income taxes						$ 264,749

	For the Year Ended December 31, 2020					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Adjusted EBITDA	$ 342,427	$ 153,203	$ 79,164	$ 252,892	$ (27,120)	
Depreciation and amortization	(51,531)	(27,727)	(29,009)	(87,865)	(9,527)	
Stock compensation expense	—	—	—	(2,512)	(24,738)	
Income (loss) from operations	$ 290,896	$ 125,476	$ 50,155	$ 162,515	$ (61,385)	$ 567,657
Equity in earnings of unconsolidated subsidiaries						29,440
Gain on sale of businesses						12,387
Interest expense						(153,011)
Income before income taxes						$ 456,473

15. Segment Information (Continued)

	For the Year Ended December 31, 2021					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Adjusted EBITDA	$ 267,993	$ 184,704	$ 138,275	$ 389,616	$ (33,229)	
Depreciation and amortization	(53,094)	(27,677)	(29,592)	(82,210)	(10,072)	
Stock compensation expense	—	—	—	(2,142)	(28,798)	
Income (loss) from operations	$ 214,899	$ 157,027	$ 108,683	$ 305,264	$ (72,099)	$ 713,774
Equity in earnings of unconsolidated subsidiaries						44,428
Gain on sale of businesses						2,155
Interest income						5,350
Interest expense						(135,985)
Income before income taxes						$ 629,722

16. Revenue from Contracts with Customers

The following tables disaggregate the Company's revenue:

	For the Year Ended December 31, 2019					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Patient service revenue:						
Medicare	$ 907,963	$ 332,514	$ 171,690	$ 1,965	$ —	$ 1,414,132
Non-Medicare	916,650	300,113	794,288	1,615,529	—	3,626,580
Total patient services revenue	1,824,613	632,627	965,978	1,617,494	—	5,040,712
Other revenue	11,905	38,344	80,033	11,323	271,605	413,210
Total revenue	$ 1,836,518	$ 670,971	$ 1,046,011	$ 1,628,817	$ 271,605	$ 5,453,922

	For the Year Ended December 31, 2020					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Patient service revenue:						
Medicare	$ 900,593	$ 345,642	$ 137,447	$ 1,284	$ —	$ 1,384,966
Non-Medicare	1,164,410	349,530	719,600	1,488,976	—	3,722,516
Total patient services revenue	2,065,003	695,172	857,047	1,490,260	—	5,107,482
Other revenue	12,496	39,501	62,866	11,174	298,194	424,231
Total revenue	$ 2,077,499	$ 734,673	$ 919,913	$ 1,501,434	$ 298,194	$ 5,531,713

	For the Year Ended December 31, 2021					
	Critical Illness Recovery Hospital	Rehabilitation Hospital	Outpatient Rehabilitation	Concentra	Other	Total
	(in thousands)					
Patient service revenue:						
Medicare	$ 833,387	$ 412,440	$ 172,064	$ 1,079	$ —	$ 1,418,970
Non-Medicare	1,401,414	394,809	843,803	1,723,804	—	4,363,830
Total patient services revenue	2,234,801	807,249	1,015,867	1,724,883	—	5,782,800
Other revenue	11,971	42,091	68,494	7,158	292,001	421,715
Total revenue	$ 2,246,772	$ 849,340	$ 1,084,361	$ 1,732,041	$ 292,001	$ 6,204,515

17. Sale of Businesses

The Company recognized a gain of $6.5 million during the year ended December 31, 2019. The gain resulted principally from the sale of outpatient rehabilitation businesses to equity method investees.

During the year ended December 31, 2020, the Company sold three businesses, including Concentra's Department of Veterans Affairs community-based outpatient clinic business, for a total selling price of approximately $87.0 million, which excludes transaction expenses and certain other adjustments set forth in each respective purchase agreement. These sales resulted in gains of approximately $21.4 million. During the year ended December 31, 2020, the Company also accrued a liability and incurred a loss of $9.0 million related to the indemnity provision associated with a previously sold business. The Company paid the $9.0 million during the year ended December 31, 2021.

The Company recognized a gain of $2.2 million during the year ended December 31, 2021. The gain resulted from the sale of a Concentra business.

18. Stock-based Compensation

Holdings' equity incentive plan provides for the issuance of various stock-based awards. Under its current plan, Holdings has issued restricted stock awards. The equity plan currently allows for the issuance of 7,502,000 awards, as adjusted for cancelled or forfeited awards through December 31, 2021. As of December 31, 2021, Holdings has capacity to issue 4,660,593 stock-based awards under its equity plan. The equity plan allows for authorized but previously unissued shares or shares previously issued and outstanding and reacquired by Holdings to satisfy these awards.

The Company measures the compensation costs of stock-based compensation arrangements based on the grant-date fair value and recognizes the costs over the period during which employees are required to provide services. Restricted stock awards are valued using the closing market price of Holdings' stock on the date of grant. These restricted stock awards generally vest over three to four years. Forfeitures are recognized as they occur.

Transactions related to restricted stock awards are as follows:

	Shares	Weighted Average Grant Date Fair Value
	(share amounts in thousands)	
Unvested balance, January 1, 2021	4,523	$ 17.74
Granted	1,363	38.59
Vested	(1,409)	19.57
Forfeited	(18)	15.88
Unvested balance, December 31, 2021	4,459	$ 23.54

For the years ended December 31, 2019, 2020, and 2021, the weighted average grant date fair values of restricted stock awards granted were $16.60, $17.17, and $38.59, respectively. For the years ended December 31, 2019, 2020, and 2021, the fair values of restricted stock awards vested were $15.6 million, $22.2 million, and $27.6 million, respectively.

For the year ended December 31, 2019, the intrinsic value of stock options exercised was $0.7 million. Holdings did not have any stock options outstanding or exercisable during the years ended December 31, 2020 and 2021.

18. Stock-based Compensation (Continued)

Stock compensation expense recognized by the Company is as follows:

	For the Year Ended December 31,		
	2019	2020	2021
	(in thousands)		
Stock compensation expense:			
Included in general and administrative	$ 20,334	$ 22,053	$ 24,598
Included in cost of services	6,117	5,197	6,342
Total	$ 26,451	$ 27,250	$ 30,940

Future stock compensation expense based on current stock-based awards is estimated to be as follows:

	2022	2023	2024	2025	2026
	(in thousands)				
Stock compensation expense	$ 31,762	$ 21,749	$ 11,990	$ 2,093	$ 60

19. Income Taxes

The components of the Company's income tax expense for the years ended December 31, 2019, 2020, and 2021 are as follows:

	For the Year Ended December 31,		
	2019	2020	2021
	(in thousands)		
Current income tax expense:			
Federal	$ 55,822	$ 95,633	$ 99,254
State and local	15,331	30,949	25,464
Total current income tax expense	71,153	126,582	124,718
Deferred income tax expense (benefit)	(7,435)	(14,715)	5,055
Total income tax expense	$ 63,718	$ 111,867	$ 129,773

Reconciliations of the statutory federal income tax rate to the effective income tax rate are as follows:

	For the Year Ended December 31,		
	2019	2020	2021
Federal income tax at statutory rate	21.0 %	21.0 %	21.0 %
State and local income taxes, less federal income tax benefit	4.2	5.8	4.2
Permanent differences	0.4	0.5	0.5
Deferred income taxes - state income tax rate adjustment	0.8	0.0	(1.2)
Uncertain tax positions	(0.1)	(0.1)	0.0
Valuation allowance	0.5	0.0	0.2
Limitation on Officers' compensation	1.3	1.1	0.9
Stock-based compensation	(0.7)	(1.4)	(1.7)
Non-controlling interest	(2.9)	(3.3)	(1.9)
Other	(0.4)	0.9	(1.4)
Effective income tax rate	24.1 %	24.5 %	20.6 %

19. Income Taxes (Continued)

The Company's deferred tax assets and liabilities are as follows:

	December 31,	
	2020	2021
	(in thousands)	
Deferred tax assets		
Implicit discounts and adjustments	$ 13,825	$ 13,058
Compensation and benefit-related accruals	54,464	57,604
Professional malpractice liability insurance	17,330	18,462
Deferred revenue	163	95
Federal and state net operating loss and state tax credit carryforwards	34,417	38,022
Interest limitation carryforward	686	494
Stock awards	3,638	4,285
Equity investments	4,627	4,414
Operating lease liabilities	223,875	230,416
CARES Act employer payroll tax deferral	23,001	11,594
Derivatives	705	—
Other	2,489	4,850
Deferred tax assets	$ 379,220	$ 383,294
Valuation allowance	(17,339)	(17,773)
Deferred tax assets, net of valuation allowance	$ 361,881	$ 365,521
Deferred tax liabilities		
Deferred income	$ (4,595)	$ —
Investment in unconsolidated affiliates	(10,401)	(12,606)
Depreciation and amortization	(238,655)	(245,859)
Deferred financing costs	(5,003)	(3,696)
Operating lease right-of-use assets	(210,045)	(215,640)
Derivatives	—	(4,094)
Other	(4,844)	(4,252)
Deferred tax liabilities	$ (473,543)	$ (486,147)
Deferred tax liabilities, net of deferred tax assets	$ (111,662)	$ (120,626)

The Company's deferred tax assets and liabilities are included in the consolidated balance sheet captions as follows:

	December 31,	
	2020	2021
	(in thousands)	
Other assets	$ 20,759	$ 22,166
Non-current deferred tax liability	(132,421)	(142,792)
	$ (111,662)	$ (120,626)

19. Income Taxes (Continued)

The CARES Act, which was enacted on March 27, 2020, includes changes to certain tax law related to net operating losses and the deductibility of interest expense and depreciation. The effects of changes in tax rates and laws on deferred tax balances are recognized in the period in which the legislation was enacted. In 2020, this legislation had the effect of increasing the Company's deferred income taxes and decreasing its current income taxes payable by approximately $15.5 million. This resulted from bonus depreciation on certain types of qualified property for tax years beginning January 1, 2018, and the provision for an increase in the amounts allowed for interest expense deductions for tax years beginning January 1, 2019. The legislation related to net operating losses did not impact the Company's deferred tax balances. The CARES Act also allowed eligible employers to defer payment on their share of payroll taxes otherwise required to be deposited between March 27, 2020 and December 31, 2020, as described further in Note 22 – CARES Act. In 2020, this legislation had the effect of decreasing the Company's deferred income taxes and increasing its current income taxes payable by approximately $23.0 million. In 2021, the Company paid 50% of the deferred payroll tax amount as mandated by the CARES Act. This increased the Company's deferred income taxes and decreased its current income taxes payable by approximately $11.5 million. Payment of the remaining 50% is required by December 31, 2022.

As of December 31, 2020 and 2021, the Company's valuation allowance is primarily attributable to the uncertainty regarding the realization of state net operating losses and other net deferred tax assets of loss entities. The state net deferred tax assets have a full valuation allowance recorded for entities that have a cumulative history of pre-tax losses (current year in addition to the two prior years). For the year ended December 31, 2020, the Company recorded a net valuation allowance decrease of $1.1 million. These changes resulted from net changes in state net operating losses, as well as the sale of a business. For the year ended December 31, 2021, the Company recorded a net valuation allowance increase of $0.4 million. These changes resulted from net changes in state net operating losses. The changes in the Company's valuation allowance were recognized as a result of management's reassessment of the amount of its deferred tax assets that are more likely than not to be realized.

At December 31, 2020 and 2021, the Company's net deferred tax liabilities of approximately $111.7 million and $120.6 million, respectively, consist of items which have been recognized for tax reporting purposes, but which will increase tax on returns to be filed in the future. The Company has performed an assessment of positive and negative evidence regarding the realization of the net deferred tax assets. This assessment included a review of legal entities with three years of cumulative losses, estimates of projected future taxable income, the effect on future taxable income resulting from the reversal of existing deferred tax liabilities in future periods, and the impact of tax planning strategies that management would and could implement in order to keep deferred tax assets from expiring unused. Although realization is not assured, based on the Company's assessment, it has concluded that it is more likely than not that such assets, net of the determined valuation allowance, will be realized.

The total state net operating losses are approximately $620.3 million. State net operating loss carryforwards expire and are subject to valuation allowances as follows:

	State Net Operating Losses	Gross Valuation Allowance
	(in thousands)	
2022	$ 25,823	$ 9,755
2023	16,718	8,636
2024	25,737	8,761
2025	36,614	7,743
Thereafter through 2040	515,430	305,621

20. Earnings per Share

The following table sets forth the net income attributable to the Company, its common shares outstanding, and its participating securities outstanding. There were no contractual dividends paid for the years ended December 31, 2019, 2020, and 2021.

	Basic EPS			Diluted EPS		
	For the Year Ended December 31,			For the Year Ended December 31,		
	2019	2020	2021	2019	2020	2021
	(in thousands)					
Net income	$ 201,031	$ 344,606	$ 499,949	$ 201,031	$ 344,606	$ 499,949
Less: net income attributable to non-controlling interests	52,582	85,611	97,724	52,582	85,611	97,724
Net income attributable to the Company	148,449	258,995	402,225	148,449	258,995	402,225
Less: Distributed and undistributed income attributable to participating securities	4,995	8,896	13,435	4,994	8,896	13,435
Distributed and undistributed income attributable to common shares	$ 143,454	$ 250,099	$ 388,790	$ 143,455	$ 250,099	$ 388,790

The following tables set forth the computation of EPS under the two-class method:

	For the Year Ended December 31, 2019					
	Net Income Allocation	Shares[1]	Basic EPS	Net Income Allocation	Shares[1]	Diluted EPS
	(in thousands, except for per share amounts)					
Common shares	$ 143,454	130,248	$ 1.10	$ 143,455	130,276	$ 1.10
Participating securities	4,995	4,535	1.10	4,994	4,535	1.10
Total Company	$ 148,449			$ 148,449		

	For the Year Ended December 31, 2020					
	Net Income Allocation	Shares[1]	Basic EPS	Net Income Allocation	Shares[1]	Diluted EPS
	(in thousands, except for per share amounts)					
Common shares	$ 250,099	129,780	$ 1.93	$ 250,099	129,780	$ 1.93
Participating securities	8,896	4,616	1.93	8,896	4,616	1.93
Total Company	$ 258,995			$ 258,995		

	For the Year Ended December 31, 2021					
	Net Income Allocation	Shares[1]	Basic EPS	Net Income Allocation	Shares[1]	Diluted EPS
	(in thousands, except for per share amounts)					
Common shares	$ 388,790	130,249	$ 2.98	$ 388,790	130,249	$ 2.98
Participating securities	13,435	4,501	$ 2.98	13,435	4,501	$ 2.98
Total Company	$ 402,225			$ 402,225		

(1) Represents the weighted average share count outstanding during the period.

21. Commitments and Contingencies

Construction Commitments

At December 31, 2021, the Company had outstanding commitments under construction contracts related to new construction, improvements, and renovations totaling approximately $18.8 million.

Litigation

The Company is a party to various legal actions, proceedings, and claims (some of which are not insured), and regulatory and other governmental audits and investigations in the ordinary course of its business. The Company cannot predict the ultimate outcome of pending litigation, proceedings, and regulatory and other governmental audits and investigations. These matters could potentially subject the Company to sanctions, damages, recoupments, fines, and other penalties. The Department of Justice, Centers for Medicare & Medicaid Services ("CMS"), or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future that may, either individually or in the aggregate, have a material adverse effect on the Company's business, financial position, results of operations, and liquidity.

To address claims arising out of the Company's operations, the Company maintains professional malpractice liability insurance and general liability insurance coverages through a number of different programs that are dependent upon such factors as the state where the Company is operating and whether the operations are wholly owned or are operated through a joint venture. For the Company's wholly owned operations, the Company currently maintains insurance coverages under a combination of policies with a total annual aggregate limit of up to $37.0 million for professional malpractice liability insurance and $40.0 million for general liability insurance. The Company's insurance for the professional liability coverage is written on a "claims-made" basis, and its commercial general liability coverage is maintained on an "occurrence" basis. These coverages apply after a self-insured retention limit is exceeded. For the Company's joint venture operations, the Company has designed a separate insurance program that responds to the risks of specific joint ventures. Most of the Company's joint ventures are insured under a master program with an annual aggregate limit of up to $80.0 million, subject to a sublimit aggregate ranging from $23.0 million to $33.0 million for most joint ventures. The policies are generally written on a "claims-made" basis. Each of these programs has either a deductible or self-insured retention limit. The Company also maintains additional types of liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by the Company's professional and general liability insurance policies. These insurance policies also do not generally cover punitive damages and are subject to various deductibles and policy limits. The Company reviews its insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. Significant legal actions, as well as the cost and possible lack of available insurance, could subject the Company to substantial uninsured liabilities. In the Company's opinion, the outcome of these actions, individually or in the aggregate, will not have a material adverse effect on its financial position, results of operations, or cash flows.

Healthcare providers are subject to lawsuits under the qui tam provisions of the federal False Claims Act. Qui tam lawsuits typically remain under seal (hence, usually unknown to the defendant) for some time while the government decides whether or not to intervene on behalf of a private qui tam plaintiff (known as a relator) and take the lead in the litigation. These lawsuits can involve significant monetary damages and penalties and award bounties to private plaintiffs who successfully bring the suits. The Company is and has been a defendant in these cases in the past, and may be named as a defendant in similar cases from time to time in the future.

Oklahoma City Subpoena. On August 24, 2020, the Company and Select Specialty Hospital – Oklahoma City, Inc. ("SSH–Oklahoma City") received Civil Investigative Demands from the U.S. Attorney's Office for the Western District of Oklahoma seeking responses to interrogatories and the production of various documents principally relating to the documentation, billing and reviews of medical services furnished to patients at SSH-Oklahoma City. The Company does not know whether the subpoena has been issued in connection with a qui tam lawsuit or in connection with possible civil, criminal or administrative proceedings by the government. The Company is producing documents in response to the subpoena and intends to fully cooperate with this investigation. At this time, the Company is unable to predict the timing and outcome of this matter.

21. Commitments and Contingencies (Continued)

New Jersey Litigation. In December 2020, the United States District Court for the District of New Jersey unsealed a qui tam complaint in the United States of America and State of New Jersey ex rel. Keith A. DiLello, Sr. v. Hackensack Meridian Health, Jersey Shore University Medical Center, Ocean Medical Center, Seaview Orthopaedics, Shrewsbury Surgery Center, Kessler Rehabilitation, Dr. Halambros Demetriades, Dr. Theodore Kutzan, Dr. Adam Myers, Dr. Hoan-Vu Nguyen, Dr. Frederick De Paola, ABC Corporations 1-10, and John/Jane Does 1-10, Case 3:20-cv-02949-FLW-ZNQ. The complaint was filed under seal in March 2020 and was unsealed after the United States and the State of New Jersey declined to intervene in the case. In the complaint, the plaintiff-relator, an automobile accident victim and former patient of the defendant providers, alleges that they routinely billed both personal injury protection ("PIP") carriers and CMS. He alleges that they violated federal and state law by billing CMS when other insurance is available and failing to return payment to CMS after payment was made by the PIP carriers. In March 2021, defendant Kessler Rehabilitation waived service of process of the complaint. The Company intends to vigorously defend this action, but at this time the Company is unable to predict the timing and outcome of this matter.

Physical Therapy Billing. On October 7, 2021, the Company received a one-page letter from a Trial Attorney at the U.S. Department of Justice, Civil Division, Commercial Litigation Branch, Fraud Section ("DOJ"). The letter stated that the DOJ, in conjunction with the U.S. Department of Health and Human Services, is investigating the Company in connection with potential violations of the False Claims Act, 31 U.S.C. § 3729, et seq. The letter specified that the investigation relates to the Company's billing of physical therapy services. The Company intends to produce documents and data in response to such letter and to fully cooperate with this investigation. At this time, the Company is unable to predict the timing and outcome of this matter.

Medicare Dual-Eligible Litigation

The Company's critical illness recovery hospitals have pursued claims against CMS involving denied Medicare bad debt reimbursement for copayments and deductibles of dual-eligible Medicaid beneficiaries for cost reporting periods ending in 2005 through 2010. A U.S. District Court ruled in favor of the Company and ordered CMS to pay the Medicare bad debt reimbursement plus interest and, during the year ended December 31, 2021, the Company received reimbursement proceeds of $19.9 million plus accrued interest of $5.4 million. These amounts were recognized as other operating income and interest income, respectively, during the year ended December 31, 2021.

22. CARES Act

Provider Relief Funds

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") was enacted. Since the enactment of the CARES Act, the Company's consolidated subsidiaries have received approximately $215.8 million of payments from the Public Health and Social Services Emergency Fund, also referred to as the Provider Relief Fund. The Company is able to use payments received under the Provider Relief Fund for "health care related expenses or lost revenues that are attributable to coronavirus." The Provider Relief Fund payments must first be applied against health care related expenses attributable to COVID-19. Provider Relief Fund payments not fully expended on health care related expenses attributable to COVID-19 are then applied to lost revenues. The provisions of the Provider Relief Fund payments permit a parent organization to allocate all or a portion of its general and targeted distributions among its subsidiaries which are eligible health care providers.

The Department of Health and Human Services ("HHS") has issued a series of post-payment notices of reporting requirements and other guidance which, in some instances, have significantly altered the terms and conditions surrounding the Provider Relief Fund payments since the enactment of the CARES Act. Certain of the provisions and reporting requirements associated with the Provider Relief Fund payments were signed into law as part of the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 ("CRRSA Act") on December 27, 2020.

As part of the terms and conditions of the Provider Relief Fund program, the Company must adhere to certain reporting requirements associated with payments received from the Provider Relief Fund. Recipients must report to HHS on their use of Provider Relief Fund payments by specified deadlines; these deadlines differ depending on when the payments were received by the recipient. The Company has adhered with these reporting requirements and completed such reporting for the payments it received between April 10, 2020 and June 30, 2020. The Company will complete its remaining reporting obligations for payments received after June 30, 2020 as the reporting becomes due.

22. CARES Act (Continued)

In the absence of specific guidance for government grants under U.S. GAAP, the Company accounted for the payments it received in accordance with IAS 20, *Accounting for Government Grants and Disclosure of Government Assistanc*e. Under the Company's accounting policy, payments are recognized as other operating income when it is probable that it has complied with the terms and conditions of the payments. The Company assessed its eligibility to utilize certain Provider Relief Fund payments and whether those payments were used in accordance with the terms and conditions set forth within the CRRSA Act and by HHS. During the year ended December 31, 2021, the Company updated its assessment of uncertainties surrounding its ability to utilize certain of its Provider Relief Fund payments, including its ability to allocate general distributions among the Company's subsidiaries, for additional information obtained during the period. Based on the Company's assessments, during the years ended December 31, 2020 and 2021, the Company determined that it has complied with the terms and conditions associated with the Provider Relief Fund payments and was eligible to recognize approximately $90.0 million and $123.8 million, respectively, of Provider Relief Fund payments as other operating income.

As of December 31, 2021, $93 thousand of Provider Relief Fund payments have not yet been utilized by the Company in accordance with the regulations promulgated by HHS and the CRRSA Act and are reported as unearned government assistance in the accompanying consolidated balance sheet. These Provider Relief Fund payments may need to be repaid to the extent they cannot be utilized in accordance with the terms and conditions set forth within the CRRSA Act and by HHS. Further changes to the regulations surrounding the Provider Relief Fund payments or amended interpretations of existing guidance may change the Company's assessment of whether it is probable that it has complied with the terms and conditions of the Provider Relief Fund payments. These changes may result in the Company being unable to recognize additional Provider Relief Fund payments as other operating income or the reversal of amounts previously recognized.

Medicare Accelerated and Advance Payments Program

The Company's consolidated subsidiaries received approximately $325.0 million of advance payments under CMS's Accelerated and Advance Payment Program, which was temporarily expanded by the CARES Act during the year ended December 31, 2020. Repayment of the advance payments began one year from the issuance date of the payment. After that first year, the Medicare program automatically recoups 25.0% of the Medicare payments otherwise owed to the provider or supplier for eleven months. At the end of the eleven-month period, recoupment increases to 50.0% for another six months. Any amounts that remain unpaid after 29 months are subject to a 4.0% interest rate.

The Company received the majority of its advance payments in April 2020. Accordingly, CMS began recouping a portion of the Medicare payments due to the Company beginning in April 2021. CMS recouped $241.2 million of Medicare payments during the year ended December 31, 2021. As of December 31, 2021, the Company owes CMS $83.8 million which is reported as government advances in the accompanying consolidated balance sheet.

Employer Payroll Tax Deferral

In April 2020, the Company began deferring payment on its share of payroll taxes owed, as allowed by the CARES Act, through December 31, 2020. The Company was able to defer half of its share of payroll taxes owed until December 31, 2021, with the remaining half due on December 31, 2022. As of December 31, 2020, the Company owed approximately $106.2 million related to these payroll taxes, which is reported in accrued payroll and other non-current liabilities on the accompanying consolidated balance sheet. As of December 31, 2021, the Company owed approximately $53.0 million related to these payroll taxes. This amount is reflected in accrued payroll on the accompanying consolidated balance sheet.

23. Subsequent Event

On February 17, 2022, the Company's board of directors declared a cash dividend of $0.125 per share. The dividend will be payable on or about March 16, 2022 to stockholders of record as of the close of business on March 4, 2022.

The following Financial Statement Schedule along with the report thereon of PricewaterhouseCoopers LLP dated February 24, 2022, should be read in conjunction with the consolidated financial statements. Financial Statement Schedules not included in this filing have been omitted because they are not applicable or the required information is shown in the consolidated financial statements or notes thereto.

Schedule II—Valuation and Qualifying Accounts

	Balance at Beginning of Year	Charged to Cost and Expenses	Acquisitions[1]	Deductions[2]	Balance at End of Year
			(in thousands)		
Income Tax Valuation Allowance					
Year ended December 31, 2021	$ 17,339	$ 434	$ —	$ —	$ 17,773
Year ended December 31, 2020	$ 18,461	$ (484)	$ —	$ (638)	$ 17,339
Year ended December 31, 2019	$ 17,893	$ 568	$ —	$ —	$ 18,461

(1) Includes valuation allowance reserves resulting from business combinations.

(2) Valuation allowance deductions relate to the disposition of certain subsidiaries.