SELECT MEDICAL HOLDINGS CORP
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February 21, 2019
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us-gaap:BaseRateMember 2018-03-22 2018-03-22 0001320414 sem:ConcentraIncMember
sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember
sem:AdjustedLIBORateFloorMember 2018-02-01 2018-02-01 0001320414 sem:ConcentraIncMember
sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember
sem:AdjustedLIBORateFloorMember 2018-02-01 2018-02-01 0001320414 sem:ConcentraIncMember
srt:MaximumMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember
us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26 2018-10-26 0001320414
sem:ConcentraIncMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember
us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-01-01 2018-12-31 0001320414
sem:ConcentraIncMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember
us-gaap:LineOfCreditMember 2015-06-01 0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember
sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember
sem:AdjustedLIBORateMember 2018-03-22 2018-03-22 0001320414 sem:ConcentraIncMember
sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember
us-gaap:BaseRateMember 2018-02-01 2018-02-01 0001320414 sem:ConcentraIncMember
us-gaap:RevolvingCreditFacilityMember us-gaap:LineOfCreditMember 2018-12-31 0001320414
sem:SelectMedicalCorporationMember srt:MaximumMember sem:TermLoanFacilityMember
sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26
2018-10-26 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember
sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember 2016-09-26 0001320414
sem:ConcentraIncMember sem:LeverageRatioGreaterThan4.25To1.00Member
sem:ConcentraCreditFacilitiesMember us-gaap:LineOfCreditMember 2016-09-26 2016-09-26 0001320414
sem:SelectMedicalCorporationMember srt:MaximumMember us-gaap:RevolvingCreditFacilityMember
sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2017-03-06
2017-03-06 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember
sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateFloorMember
2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember
sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember
2018-02-01 2018-02-01 0001320414 sem:ConcentraIncMember
sem:LeverageRatioLessThanOrEqualTo3.75To1.00Member sem:ConcentraCreditFacilitiesMember
us-gaap:LineOfCreditMember 2016-09-26 2016-09-26 0001320414 sem:ConcentraIncMember
sem:LessThanOrEqualTo4.25To1.00AndGreaterThan3.75To1.00Member sem:ConcentraCreditFacilitiesMember
us-gaap:LineOfCreditMember 2016-09-26 2016-09-26 0001320414 sem:ConcentraIncMember
sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember 2015-06-01
0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember
sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-10-26
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sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AlternateBaseRateFloorMember
2018-02-01 2018-02-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember
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sem:LessThanOrEqualTo4.25To1.00AndGreaterThan3.75To1.00Member srt:MinimumMember
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sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26
2018-10-26 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember
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2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember us-gaap:LetterOfCreditMember
us-gaap:LineOfCreditMember 2018-12-31 0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember

sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-03-22 2018-03-22 0001320414 sem:ConcentraIncMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26 2018-10-26 0001320414 sem:SelectMedicalCorporationMember sem:LeverageRatioLessThanOrEqualTo4.00To1.00Member sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 2017-03-06 0001320414 sem:ConcentraIncMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember 2018-02-01 0001320414 sem:ConcentraIncMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember 2018-02-01 2018-02-01 0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26 2018-10-26 0001320414 sem:SelectMedicalCorporationMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 0001320414 sem:SelectMedicalCorporationMember sem:LeverageRatioLessThan6.25To1.00Member srt:MaximumMember us-gaap:RevolvingCreditFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 2017-03-06 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember 2016-01-01 2016-12-31 0001320414 sem:SelectMedicalCorporationMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AlternateBaseRateFloorMember 2017-03-06 2017-03-06 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember us-gaap:LineOfCreditMember 2018-01-01 2018-12-31 0001320414 sem:ConcentraIncMember sem:ConcentraCreditFacilitiesMember us-gaap:LineOfCreditMember 2016-09-26 2016-09-26 0001320414 sem:ConcentraIncMember srt:MaximumMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-10-26 2018-10-26 0001320414 sem:ConcentraIncMember srt:MaximumMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26 2018-10-26 0001320414 sem:SelectMedicalCorporationMember sem:LeverageRatioLessThanOrEqualTo4.50To1.00AndGreaterThan4.00To1.00Member srt:MaximumMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 2017-03-06 0001320414 sem:SelectMedicalCorporationMember sem:AdditionalSeniorNotesMember us-gaap:SeniorNotesMember 2014-03-11 2014-03-11 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember 2018-02-01 0001320414 sem:ConcentraIncMember sem:ConcentraCreditFacilitiesMember us-gaap:LineOfCreditMember 2018-02-01 2018-02-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember us-gaap:LineOfCreditMember 2016-01-01 2016-12-31 0001320414 sem:SelectMedicalCorporationMember sem:TermLoanFacilityMember sem:A2011SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2016-01-01 2016-12-31 0001320414 sem:SelectMedicalCorporationMember srt:MaximumMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-10-26 2018-10-26 0001320414 sem:SelectMedicalCorporationMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-01-01 2018-12-31 0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-10-26 2018-10-26 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateFloorMember 2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AlternateBaseRateFloorMember 2018-02-01 2018-02-01 0001320414 sem:SelectMedicalCorporationMember srt:MaximumMember us-gaap:RevolvingCreditFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-03-22 2018-03-22 0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember sem:TermLoanFacilityMember

sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26 2018-10-26 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2015-06-01 2015-06-01 0001320414 sem:SelectMedicalCorporationMember sem:A6.375SeniorNotesDueJune2021Member us-gaap:SeniorNotesMember 2018-01-01 2018-12-31 0001320414 sem:SelectMedicalCorporationMember sem:LeverageRatioLessThanOrEqualTo4.50To1.00AndGreaterThan4.00To1.00Member srt:MinimumMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 2017-03-06 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2015-06-01 2015-06-01 0001320414 sem:SelectMedicalCorporationMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-03-22 2018-03-22 0001320414 sem:ConcentraIncMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-01-01 2018-12-31 0001320414 sem:SelectMedicalCorporationMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-01-01 2018-12-31 0001320414 sem:ConcentraIncMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2015-06-01 2015-06-01 0001320414 sem:SelectMedicalCorporationMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2017-03-06 2017-03-06 0001320414 sem:SelectMedicalCorporationMember srt:MaximumMember us-gaap:RevolvingCreditFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember us-gaap:BaseRateMember 2018-10-26 2018-10-26 0001320414 sem:ConcentraIncMember sem:LessThanOrEqualTo4.25To1.00AndGreaterThan3.75To1.00Member srt:MaximumMember sem:ConcentraCreditFacilitiesMember us-gaap:LineOfCreditMember 2016-09-26 2016-09-26 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember us-gaap:LineOfCreditMember 2017-01-01 2017-12-31 0001320414 sem:ConcentraIncMember srt:MinimumMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember sem:AdjustedLIBORateMember 2018-10-26 2018-10-26 0001320414 sem:SelectMedicalCorporationMember us-gaap:DebtInstrumentRedemptionPeriodOneMember us-gaap:SeniorNotesMember 2018-01-01 2018-12-31 0001320414 sem:SelectMedicalCorporationMember us-gaap:DebtInstrumentRedemptionPeriodTwoMember us-gaap:SeniorNotesMember 2018-01-01 2018-12-31 0001320414 sem:SelectMedicalCorporationMember sem:TermLoanFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 2017-03-06 0001320414 sem:SelectMedicalCorporationMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2016-01-01 2016-12-31 0001320414 sem:SelectMedicalCorporationMember us-gaap:RevolvingCreditFacilityMember sem:A2017SelectCreditFacilitiesMember us-gaap:LineOfCreditMember 2017-03-06 2017-03-06 0001320414 sem:ConcentraIncMember us-gaap:RevolvingCreditFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember 2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:SecondLienCreditAgreementMember us-gaap:LineOfCreditMember 2015-06-01 2015-06-01 0001320414 sem:ConcentraIncMember sem:TermLoanFacilityMember sem:FirstLienCreditAgreementMember us-gaap:LineOfCreditMember 2015-06-01 2015-06-01 0001320414 sem:CorporateReconcilingItemsAndEliminationsMember 2018-12-31 0001320414 us-gaap:OperatingSegmentsMember sem:OutpatientRehabilitationMember 2018-01-01 2018-12-31 0001320414 us-gaap:OperatingSegmentsMember sem:OutpatientRehabilitationMember 2018-12-31 0001320414 sem:CorporateReconcilingItemsAndEliminationsMember 2018-01-01 2018-12-31 0001320414 us-gaap:OperatingSegmentsMember sem:RehabilitationHospitalMember 2018-12-31 0001320414 us-gaap:OperatingSegmentsMember sem:ConcentraMember 2018-01-01 2018-12-31 0001320414 us-gaap:OperatingSegmentsMember sem:CriticalIllnessRecoveryHospitalMember 2018-01-01 2018-12-31 0001320414 us-gaap:OperatingSegmentsMember sem:ConcentraMember 2018-12-31 0001320414

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us-gaap:HealthCarePatientServiceMember sem:CriticalIllnessRecoveryHospitalMember 2018-01-01 2018-12-31
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2018-12-31 0001320414 sem:HealthCarePatientServiceNonMedicareMember sem:OutpatientRehabilitationMember
2018-01-01 2018-12-31 0001320414 us-gaap:HealthCarePatientServiceMember sem:ConcentraMember 2018-01-01
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2018-01-01 2018-12-31 0001320414 us-gaap:ServiceOtherMember sem:ConcentraMember 2018-01-01 2018-12-31
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2018-01-01 2018-12-31 0001320414 sem:HealthCarePatientServiceNonMedicareMember
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

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

For fiscal year ended December 31, 2018

OR

o **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 and 001-31441

SELECT MEDICAL HOLDINGS CORPORATION
SELECT MEDICAL CORPORATION

(Exact name of Registrants as specified in their Charter)

Delaware	**20-1764048**
Delaware	**23-2872718**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification Number)
4714 Gettysburg Road, P.O. Box 2034 Mechanicsburg, PA (Address of Principal Executive Offices)	**17055** (Zip Code)

(717) 972-1100
(Registrants' telephone number, including area code)

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

Title of Each Class	**Name of Each Exchange on Which Registered**
Select Medical Holdings Corporation, Common Stock, $0.001 par value	New York Stock Exchange

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

Indicate by check mark if the registrants are well-known seasoned issuers, as defined in Rule 405 of the Securities Act.
Select Medical Holdings Corporation Yes ý No o
Select Medical Corporation Yes o No ý

Indicate by check mark if the registrants are not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No ý

Indicate by check mark whether the registrants (1) have 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 registrants were required to file such reports), and (2) have been subject to such filing requirements for the past 90 days. Yes ý No o

Indicate by check mark whether the registrants have 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 registrants were required to submit such files). Yes ý No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrants' knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by check mark whether the registrant, Select Medical Holdings Corporation, is a large accelerated filer, an accelerated filer, a non- accelerated filer, 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 ý Accelerated filer o Non-accelerated filer o Smaller reporting company o Emerging growth company o

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. o

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

Large accelerated filer o Accelerated filer o Non-accelerated filer ý Smaller reporting company o Emerging growth company o

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. o

Indicate by check mark whether the registrants are shell companies (as defined in Rule 12b-2 of the Act). Yes o No ý

The aggregate market value of Holdings' voting stock held by non-affiliates at June 29, 2018 (the last business day of Holdings' most recently completed second fiscal quarter) was approximately $1,963,731,627, based on the closing price per share of common stock on that date of $18.15 as reported on the New York Stock Exchange. Shares of common stock known by the registrants to be beneficially owned by directors and officers of Holdings subject to the reporting and other requirements of Section 16 of the Securities Exchange Act of 1934 are not included in the computation. The registrants, however, have made no determination that such persons are "affiliates" within the meaning of Rule 12b-2 under the Securities Exchange Act of 1934.

The number of shares of Holdings' Common Stock, $0.001 par value, outstanding as of February 1,2019 was 135,262,167.

This Form 10-K is a combined annual report being filed separately by two registrants: Select Medical Holdings Corporation and Select Medical Corporation. 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 Inc., the indirect operating subsidiary of Concentra Group Holdings Parent, LLC ("Concentra Group Holdings Parent"), and its subsidiaries. References to the "Company," "we," "us," and "our" refer collectively to Holdings, Select, and Concentra Group Holdings Parent and its subsidiaries.

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 2019 Annual Meeting of Stockholders to be held on or about April 30, 2019 to be filed within 120 days after the registrant's fiscal year endedDecember 31, 2018, 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.

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SELECT MEDICAL HOLDINGS CORPORATION
SELECT MEDICAL CORPORATION
ANNUAL REPORT ON FORM 10-K
FOR THE YEAR ENDED DECEMBER 31, 2018

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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 expressions. These statements include, among others, statements regarding our expected business outlook, anticipated 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:

- changes in government reimbursement for our services and/or new payment policies may result in a reduction in net operating revenues, 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 net operating revenues 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 net operating revenues 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, including the acquisition of U.S. HealthWorks by Concentra, and our ability to realize anticipated synergies;
- private third-party payors for our services may adopt payment policies that could limit our future net operating revenues and profitability;
- the failure to maintain established relationships with the physicians in the areas we serve could reduce our net operating revenues and profitability;
- shortages in qualified nurses, therapists, physicians, or other licensed providers 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 net operating revenues 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.

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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.

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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 (previously referred to as long term acute care hospitals), rehabilitation hospitals (previously referred to as inpatient rehabilitation facilities), outpatient rehabilitation clinics, and occupational health centers in the United States. As of December 31, 2018, we had operations in 47 states and the District of Columbia. As of December 31, 2018, we operated 96 critical illness recovery hospitals in 27 states, 26 rehabilitation hospitals in 11 states, and 1,662 outpatient rehabilitation clinics in 37 states and the District of Columbia. As of December 31, 2018, Concentra, a joint venture subsidiary, operated 524 occupational health centers in 41 states. Concentra also provides contract services at employer worksites and Department of Veterans Affairs community-based outpatient clinics ("CBOCs").

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 net operating revenues of $5,081.3 million for the year ended December 31, 2018. Of this total, we earned approximately 34% of our net operating revenues from our critical illness recovery hospital segment, approximately 14% from our rehabilitation hospital segment, approximately 21% from our outpatient rehabilitation segment, and approximately 31% 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 and contract services provided at employer worksites that deliver occupational medicine, physical therapy, and consumer health services. Additionally, our Concentra segment delivers veteran's healthcare through its Department of Veterans Affairs CBOCs. See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations" and "Notes to Consolidated Financial Statements—Note 11. Segment Information" beginning on F-35 for financial information for each of our segments for the past three fiscal years, which have been recast to reflect the current reportable segment structure of our Company.

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, 2018, we operated 96 critical illness recovery hospitals in 27 states. For the years ended December 31, 2016, 2017, and 2018, approximately 53%, 52% and 51%, respectively, of the net operating revenues of our critical illness recovery hospital segment came from Medicare reimbursement. This percentage declined in 2018 as compared to the prior year because of the changes we implemented at critical illness recovery hospitals operating under Medicare patient criteria as LTCHs, which have resulted in lower Medicare patient volume. As of December 31, 2018, we employed approximately 13,500 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 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 owned 96 critical illness recovery hospitals at December 31, 2018, of which 71 were operated as HIHs and 25 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, suffering 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, 2018, the average length of stay for patients in our critical illness recovery hospitals was 28 days.

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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") and DNV GL Healthcare USA, Inc. ("DNV") are independent, not-for-profit organizations that establish standards related to the operation and management of healthcare facilities. As of December 31, 2018, we operated 96 critical illness recovery hospitals, 95 of which were accredited by TJC. One of our critical illness recovery hospitals was accredited by DNV. Also as of December 31, 2018, 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 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 immediately 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 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, 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. Chronically critically ill 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.

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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 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.

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 in the United States. As of December 31, 2018, we operated 26 rehabilitation hospitals in 11 states. For the years ended December 31, 2016, 2017, and 2018, approximately 38%, 42% and 42%, respectively, of the net operating revenues of our rehabilitation hospital segment came from Medicare reimbursement. As of December 31, 2018, we employed approximately 10,100 people in our rehabilitation hospital segment, consisting primarily of registered nurses, respiratory therapists, physical therapists,

occupational therapists, speech therapists, neuropsychologists, and other psychologists.

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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, 2018, 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, 2018, we operated 26 rehabilitation hospitals, 25 of which were accredited by TJC. One of our rehabilitation hospitals was accredited by DNV. Also as of December 31, 2018, all of our rehabilitation hospitals were certified as Medicare providers as inpatient rehabilitation facilities ("IRFs"). 12 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, DNV, 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 new 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 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, national medical director, chief academic 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."

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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 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.

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.

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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 1,662 facilities throughout 37 states and the District of Columbia as of December 31, 2018. Our outpatient rehabilitation clinics are typically located in a medical complex or retail location. Our outpatient rehabilitation segment employed approximately 10,400 people as of December 31, 2018.

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, and athletic training services. 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. In recent years, a number of states have enacted laws that allow individuals to seek outpatient physical rehabilitation services without a physician order. Currently, this population of patients is not significant. In our outpatient rehabilitation segment, for the year ended December 31, 2018, approximately 84% of our net operating revenues come 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. 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. To increase our presence, we seek to open new clinics in our existing markets. 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 programs and services 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.

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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 evaluate it with the aid of our contract management system. We assess the reasonableness of the reimbursements by evaluating 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, 2018, we operated 524 occupational health centers, 124 onsite clinics at employer worksites, and 31 CBOCs throughout 44 states. In some of our occupational health centers we also provide urgent care services. On February 1, 2018, we acquired U.S HealthWorks, an occupational medicine and urgent care service provider, as part of our Concentra segment. We deliver occupational medicine, consumer health, physical therapy, and veteran's healthcare services in our occupational health centers, onsite clinics located at the workplaces of our employer customers, and our CBOCs. Our Concentra segment employed approximately 11,200 people as of December 31, 2018.

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. Our services at the CBOCs include primary care, specialty care, sub-specialty care, mental health, and pharmacy benefits. 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, 2018, approximately 58% of our Concentra segment operating revenues came from workers' compensation payments.

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Acquisition of U.S. HealthWorks

On February 1, 2018, pursuant to the terms of the Equity Purchase and Contribution Agreement, dated October 22, 2017 with Concentra, Concentra Group Holdings Parent, U.S. HealthWorks ("U.S. Healthworks") and Dignity Health Holding Corporation ("DHHC"), Concentra acquired all of the issued and outstanding shares of stock of U.S. HealthWorks, an occupational medicine and urgent care service provider. Concentra acquired U.S. HealthWorks for $753.6 million. DHHC, a subsidiary of Dignity Health, was issued a 20% equity interest in Concentra Group Holdings Parent, which was valued at $238.0 million. The remainder of the purchase price was paid in cash. Select currently retains a majority voting interest in Concentra Group Holdings Parent.

Concentra used borrowings under its first lien credit agreement and its second lien credit agreement, together with cash on hand, to pay the cash purchase price for all of the issued and outstanding stock of U.S. HealthWorks to DHHC, to finance the redemption and reorganization transactions executed under the Purchase Agreement, and to pay fees and expenses associated with the financing. See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Commitments and Contingencies" for a description of Concentra's indebtedness arrangements.

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, such as the acquisition of U.S. HealthWorks. 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 services and certain other 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 consolidation opportunities, and our experienced management team.

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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 96 critical illness recovery hospitals in 27 states as of December 31, 2018. In our rehabilitation hospital segment, we operated 26 rehabilitation hospitals in 11 states as of December 31, 2018. In our outpatient rehabilitation segment, we operated 1,662 outpatient rehabilitation clinics in 37 states and the District of Columbia as of December 31, 2018. In our Concentra segment, we operated 524 occupational health centers in 41 states as of December 31, 2018. 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 2018, we completed ten significant acquisitions for approximately $3.32 billion, which includes $418.6 million paid to acquire Physiotherapy, $1.05 billion paid to acquire Concentra, and $753.6 million paid to acquire 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 Consolidation Opportunities. We believe that we are well-positioned to capitalize on consolidation opportunities within each of our business segments and selectively augment our internal growth. We believe that each of our business segments is largely fragmented, with many of the nation’s critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation facilities, and occupational health centers operated by independent operators lacking national or broad regional scope. With our geographically diversified portfolio of facilities in the United States, we believe that our footprint provides us with a wide-ranging perspective on multiple potential acquisition opportunities.

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 ensure management continuity.

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Sources of Net Operating Revenues

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

	Year Ended December 31,		
Net Operating Revenues by Payor Source	2016	2017	2018
Medicare	30.0 %	30.1 %	26.6 %
Commercial insurance[1]	34.1 %	34.4 %	31.8 %
Workers' Compensation	17.1 %	17.2 %	22.1 %
Private and other[2]	15.8 %	15.3 %	16.8 %
Medicaid	3.0 %	3.0 %	2.7 %
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 services, self-payors, and non-patient related payments. Self-pay revenues represent less than 1% of total net operating revenues 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, 2018, we operated 96 critical illness recovery hospitals, all of which were certified by Medicare as LTCHs. Also as of December 31, 2018, we operated 26 rehabilitation hospitals, all of which were certified by Medicare as IRFs . Our outpatient rehabilitation clinics regularly receive Medicare payments for their services. Our Concentra segment receives payments from the Department of Veterans Affairs and other governmental programs. 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 net operating revenue include insurance companies, workers' compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies, and employers, as well as patients directly.

Employees

As of December 31, 2018, we employed approximately 47,100 people throughout the United States. Approximately 33,700 of our employees are full-time and the remaining approximately 13,400 are part-time employees. Our critical illness recovery hospital segment employees totaled approximately 13,500, rehabilitation hospital segment employees totaled approximately 10,100, outpatient rehabilitation segment employees totaled approximately 10,400, and Concentra segment employees totaled approximately 11,200. Approximately 1,900 of the remaining employees performed corporate management, administration, and other support services primarily at our Mechanicsburg, Pennsylvania headquarters.

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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 Kindred Healthcare Inc. 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, consumer health, and veteran's healthcare business 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, onsite clinics, and CBOCs) 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.

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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 still 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 ensure that 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.

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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, 2018, all of the critical illness recovery hospitals we operated were certified by Medicare as LTCHs. As of December 31, 2018, 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 and/or CARF. As of December 31, 2018, all of the 96 critical illness recovery hospitals and all of the 26 rehabilitation hospitals we operated were accredited by TJC or DNV. In addition, 12 of our rehabilitation hospitals have also received accreditation from CARF. Where required under our contracts with the Department of Veterans Affairs, our facilities furnishing outpatient services that operate as CBOCs are accredited by TJC or another healthcare accrediting organization. See "—Government Regulations—Veterans Affairs."

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. Net operating revenues generated directly from workers' compensation programs represented approximately 18% of our net operating revenue from our outpatient rehabilitation segment, 1% of our net operating revenue from our critical illness recovery hospital segment, 2% of our net operating revenue from our rehabilitation hospital segment, and 58% of our net operating revenue from our Concentra segment for the year ended December 31, 2018.

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.

Veterans Affairs

As of December 31, 2018, we had 31 CBOCs, which were established to provide services to veterans residing in catchment areas under agreements with the Department of Veterans Affairs. The awarding of such agreements is regulated by laws related to federal government procurements generally, including the Federal Acquisition Regulations. Our contracts with the Department of Veterans Affairs include administrative and clinical services, performance standards, qualifications and other contractor requirements and information and security requirements. In general, our facilities furnishing outpatient services that are CBOCs provide outpatient primary care and mental healthcare in exchange for a capitated monthly fee based on the number of eligible patients then enrolled in that

CBOC.

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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 net operating revenues generated directly from the Medicare program for each of our segments and our company as a whole for the fiscal years ended December 31, 2016, 2017 and 2018.

	Year Ended December 31,		
Medicare Net Operating Revenues by Segment	**2016**	**2017**	**2018**
Critical illness recovery hospital	53.3%	52.4%	50.9%
Rehabilitation hospital	38.4%	41.6%	41.5%
Outpatient rehabilitation	13.9%	14.8%	15.2%
Concentra	0.2 %	0.2 %	0.1 %
Total Company	30.0%	30.1%	26.6%

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 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.

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Patient Criteria

The BBA of 2013, enacted December 26, 2013, establishes 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 will be 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 (ICU) or coronary care unit (CCU) 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 lower "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 will be 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 will be reduced by 4.6% after any annual payment rate update.

In addition, for cost reporting periods beginning on or after October 1, 2019, LTCH patient criteria compliant discharges from an LTCH will continue to be paid at the LTCH-PPS standard federal payment rate, unless the number of Medicare discharges for which payment is made under the site-neutral payment rate is greater than 50% of the total number of discharges from the LTCH for that period. If the number of Medicare discharges for which payment is made under the site-neutral payment rate is greater than 50%, then beginning in the next cost reporting period all Medicare discharges from the LTCH will be reimbursed at the site-neutral payment rate. The BBA of 2013 requires CMS to establish a process for an LTCH subject to only the site-neutral payment rate to be reinstated for payment under the dual-rate LTCH-PPS.

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.

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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 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 other hospitals excluded from the IPPS (e.g., LTCHs and IRFs), 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.

25 Percent Rule

The "25 Percent Rule" was a downward payment adjustment that applied if the percentage of Medicare patients discharged from LTCHs who were admitted from a referring hospital (regardless of whether the LTCH or LTCH satellite is co-located with the referring hospital) exceeded the applicable percentage admissions threshold during a particular cost reporting period.

CMS was precluded from applying the 25 Percent Rule for freestanding LTCHs to cost reporting years beginning before July 1, 2016 and for discharges occurring on or after October 1, 2016 and before October 1, 2017. In addition, the law applied higher percentage admissions thresholds for most LTCHs operating as HIHs and satellites for cost reporting years beginning before July 1, 2016 and effective for discharges occurring on or after October 1, 2016 and before October 1, 2017.

For fiscal year 2018, CMS adopted a regulatory moratorium on the implementation of the 25 Percent Rule.

For fiscal year 2019 and thereafter, CMS eliminated the 25 Percent Rule entirely. The elimination of the 25 Percent Rule is being implemented in a budget-neutral manner by adjusting the standard federal payment rates down such that the projection of aggregate LTCH payments would equal the projection of aggregate LTCH payments that would have been paid if the moratorium ended and the 25 Percent Rule went into effect on October 1, 2018. As a result, the

elimination of the 25 Percent Rule includes a temporary, one-time adjustment of 0.990878 to the fiscal year 2019 LTCH-PPS standard federal payment rate, a temporary, one-time adjustment of 0.990737 to the fiscal year 2020 LTCH-PPS standard federal payment rate, and a permanent, one-time adjustment of 0.991249 to the LTCH-PPS standard federal payment rate in fiscal years 2021 and subsequent years.

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Annual Payment Rate Update

Fiscal Year 2017. On August 22, 2016, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2017 (affecting discharges and cost reporting periods beginning on or after October 1, 2016 through September 30, 2017). The standard federal rate was set at $42,476, an increase from the standard federal rate applicable during fiscal year 2016 of $41,763. The update to the standard federal rate for fiscal year 2017 included a market basket increase of 2.8%, less a productivity adjustment of 0.3%, and less a reduction of 0.75% mandated by the Affordable Care Act (the "ACA"). The fixed loss amount for high cost outlier cases paid under LTCH-PPS was set at $21,943, an increase from the fixed loss amount in the 2016 fiscal year of $16,423. The fixed loss amount for high cost outlier cases paid under the site neutral payment rate was set at $23,573, an increase from the fixed-loss amount in the 2016 fiscal year of $22,538.

Fiscal Year 2018. On August 14, 2017, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2018 (affecting discharges and cost reporting periods beginning on or after October 1, 2017 through September 30, 2018). Certain errors in the final rule published on August 14, 2017 were corrected in a final rule published October 4, 2017. The standard federal rate was set at $41,415, a decrease from the standard federal rate applicable during fiscal year 2017 of $42,476. The update to the standard federal rate for fiscal year 2018 included a market basket increase of 2.7%, less a productivity adjustment of 0.6%, and less a reduction of 0.75% mandated by the ACA. The update to the standard federal rate for fiscal year 2018 was further impacted by the Medicare Access and CHIP Reauthorization Act of 2015, which limits the update for fiscal year 2018 to 1.0%. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $27,381, an increase from the fixed-loss amount in the 2017 fiscal year of $21,943. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $26,537, an increase from the fixed-loss amount in the 2017 fiscal year of $23,573.

Fiscal Year 2019. On August 17, 2018, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2019 (affecting discharges and cost reporting periods beginning on or after October 1, 2018 through September 30, 2019). Certain errors in the final rule were corrected in a final rule published October 3, 2018. The standard federal rate was set at $41,559, an increase from the standard federal rate applicable during fiscal year 2018 of $41,415. The update to the standard federal rate for fiscal year 2019 included a market basket increase of 2.9%, less a productivity adjustment of 0.8%, and less a reduction of 0.75% mandated by the ACA. The standard federal rate also included an area wage budget-neutrality factor of 0.999215 and a temporary, one-time budget-neutrality adjustment of 0.990878 in connection with the elimination of the 25 Percent Rule (described herein). The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $27,121, a decrease from the fixed-loss amount in the 2018 fiscal year of $27,381. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $25,743, a decrease from the fixed-loss amount in the 2018 fiscal year of $26,537.

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.

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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. For fiscal year 2018, CMS revised the 60% Rule's presumptive methodology (i) including 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) revising the presumptive methodology list for major multiple trauma by counting 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 2017. On August 5, 2016, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2017 (affecting discharges and cost reporting periods beginning on or after October 1, 2016 through September 30, 2017). The standard payment conversion factor for discharges for fiscal year 2017 was set at $15,708, an increase from the standard payment conversion factor applicable during fiscal year 2016 of $15,478. The update to the standard payment conversion factor for fiscal year 2017 included a market basket increase of 2.7%, less a productivity adjustment of 0.3%, and less a reduction of 0.75% mandated by the ACA. CMS decreased the outlier threshold amount for fiscal year 2017 to $7,984 from $8,658 established in the final rule for fiscal year 2016.

Fiscal Year 2018. On August 3, 2017, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2018 (affecting discharges and cost reporting periods beginning on or after October 1, 2017 through September 30, 2018). The standard payment conversion factor for discharges for fiscal year 2018 was set at $15,838, an increase from the standard payment conversion factor applicable during fiscal year 2017 of $15,708. The update to the standard payment conversion factor for fiscal year 2018 included a market basket increase of 2.6%, less a productivity adjustment of 0.6%, and less a reduction of 0.75% mandated by the ACA. The standard payment conversion factor for fiscal year 2018 was further impacted by the Medicare Access and CHIP Reauthorization Act of 2015, which limited the update for fiscal year 2018 to 1.0%. CMS increased the outlier threshold amount for fiscal year 2018 to $8,679 from $7,984 established in the final rule for fiscal year 2017.

Fiscal Year 2019. On August 6, 2018, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2019 (affecting discharges and cost reporting periods beginning on or after October 1, 2018 through September 30, 2019). The standard payment conversion factor for discharges for fiscal year 2019 was set at $16,021, an increase from the standard payment conversion factor applicable during fiscal year 2018 of $15,838. The update to the standard payment conversion factor for fiscal year 2019 included a market basket increase of 2.9%, less a productivity adjustment of 0.8%, and less a reduction of 0.75% mandated by the ACA. CMS increased the outlier threshold amount for fiscal year 2019 to $9,402 from $8,679 established in the final rule for fiscal year 2018.

Medicare Reimbursement of Outpatient Rehabilitation Clinic Services

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 will be applied each year to the fee schedule payment rates, subject to an adjustment beginning in 2019 under the Merit-Based Incentive Payment System ("MIPS"). 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 that meet certain criteria would receive annual updates of 0.75%, while all other professionals would receive annual updates of 0.25%.

Beginning in 2019, payments under the fee schedule are subject to adjustment based on performance in MIPS, which measures performance based on certain quality metrics, resource use, and meaningful use of electronic health records. Under the MIPS requirements a provider's performance is assessed according to established performance standards and used to determine an adjustment factor that is then applied to the professional's payment for a year. Each year from 2019 through 2024, professionals who receive a significant share of their revenues through an 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. MIPS and APM apply to physicians and other practitioners included within the definition of “eligible clinicians.” Currently, physical therapists and occupational therapists may voluntarily participate in MIPS and APM. In the Medicare Physician Fee Schedule final rule for calendar year 2019, CMS adopted a final policy to include physical therapists, occupational therapists and qualified speech-language pathologists as “eligible clinicians” and require them to participate in these programs beginning in the 2021 MIPS payment year. The specifics of the MIPS and APM adjustments beginning in 2019 and 2020, respectively, remain subject to future notice and comment rule-making. For the year ended December 31, 2018, we received approximately 15% of our outpatient rehabilitation net operating revenues from Medicare.

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Therapy Caps

Outpatient therapy providers reimbursed under the Medicare physician fee schedule have been subject to annual limits for therapy expenses. For example, for the calendar year beginning January 1, 2017, the annual limit on outpatient therapy services was $1,980 for combined physical and speech language pathology services and $1,980 for occupational therapy services. The Bipartisan Budget Act of 2018 repealed the annual limits on outpatient therapy. The annual limits for therapy expenses historically did not apply to services furnished and billed by outpatient hospital departments. However, the Medicare Access and CHIP Reauthorization Act of 2015 and prior legislation extended the annual limits on therapy expenses in hospital outpatient department settings through December 31, 2017. The application of annual limits to hospital outpatient department settings sunset on December 31, 2017.

Prior to calendar year 2028, all therapy claims exceeding $3,000 are subject to a manual medical review process. The $3,000 threshold is applied to physical therapy and speech therapy services combined and separately applied to occupational therapy. CMS will continue to require that an appropriate modifier be included on claims over the current exception threshold indicating that the therapy services are medically necessary. Beginning in 2028 and in each calendar year thereafter, the threshold amount for claims requiring 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 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. CMS intends to use these modifiers to implement a payment differential that would reimburse services provided by PTAs and OTAs at 85% of the fee schedule rate beginning on January 1, 2022.

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.

Medicare claims for outpatient therapy services furnished by therapy assistants on or after January 1, 2022 must include a modifier indicating the service was furnished by a therapy assistant. CMS is required to develop a modifier to mark services provided by a therapy assistant by January 1, 2019, and then submitted claims have to report the modifier mark starting January 1, 2020. Outpatient therapy services furnished on or after January 1, 2022 in whole or part by a therapy assistant will be paid at an amount equal to 85% of the payment amount otherwise applicable for the service.

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. Net operating revenues generated directly from the Medicaid program represented approximately 7% of our critical illness recovery hospital segment net operating revenues and 1% of our rehabilitation hospital segment net operating revenues for the year ended December 31, 2018.

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Other Healthcare Regulations

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. 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 is now adding 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 (Pub. L. 113-185) (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. The ACA calls for CMS to develop and present to Congress a comprehensive reform plan using Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved. In the preamble to the proposed rule for LTCH-PPS for fiscal year 2012, CMS solicited public comments on ways to redefine the geographic reclassification requirements to more accurately define labor markets. To date, CMS has not presented a comprehensive reform plan to Congress.

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, 2018, we operated six 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. The compensation paid to each RAC is based on a percentage of overpayment recoveries identified by the RAC. CMS has selected and entered into contracts with four RACs, each of which has begun their audit activities in specific jurisdictions. 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, 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.

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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 physician payments for critical care are appropriate and paid in accordance with Medicare requirements, and (3) examine up-coding of inpatient hospital billing by comparing how billing has changed over time and how billing varied among hospitals. 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 $50,000 or imprisonment for each violation, or both, civil monetary penalties of $50,000 and 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 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 (e.g., 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, 2018, we operated 18 critical illness recovery hospitals and six rehabilitation hospitals that were treated as provider-based satellites of certain of our other facilities, 234 of the outpatient rehabilitation clinics we operated were provider-based and are operated as departments of the rehabilitation hospitals we operated, and we 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.

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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 ensure the integrity and confidentiality of electronic protected health information.

We maintain a HIPAA committee that is charged with evaluating and monitoring our compliance with HIPAA. The HIPAA 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.

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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 HIPAA 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 ensure 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, as amended, 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.

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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 21, 2019:

Name	Age	Position
Robert A. Ortenzio	61	Executive Chairman and Co-Founder
Rocco A. Ortenzio	86	Vice Chairman and Co-Founder
David S. Chernow	61	President and Chief Executive Officer
Martin F. Jackson	64	Executive Vice President and Chief Financial Officer
John A. Saich	50	Executive Vice President and Chief Administrative Officer
Michael E. Tarvin	58	Executive Vice President, General Counsel and Secretary
Scott A. Romberger	58	Senior Vice President, Controller and Chief Accounting Officer
Robert G. Breighner, Jr.	49	Vice President, Compliance and Audit Services and Corporate Compliance Officer

Robert A. Ortenzio has served as our Executive Chairman and Co-Founder since January 1, 2014. Mr. Ortenzio served as our Chief Executive Officer from January 1, 2005 until December 31, 2013, and Mr. Ortenzio served as our President and Chief Executive Officer from September 2001 to January 1, 2005. Mr. Ortenzio also served as our President and Chief Operating Officer from February 1997 to September 2001. Mr. Ortenzio co-founded the Company and has served as a director since February 1997. Mr. Ortenzio also 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., serving 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 served as our Executive Chairman from September 2001 until December 2013. From February 1997 to September 2001, Mr. Ortenzio served as our Chief Executive Officer. Mr. Ortenzio co-founded the Company and has served as a director since February 1997. 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, our 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.

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John A. Saich has served as our Executive Vice President and Chief Administrative Officer since October 1, 2018. Prior to his most recent promotion, 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 Controller since February 2007. He served as our Vice President and Controller from February 1997 to February 2007. In addition, he has served as our Chief Accounting Officer since 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.

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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

If there are changes in the rates or methods of government reimbursements for our services, our net operating revenues and profitability could decline.

Approximately 30% of our net operating revenues for the year ended December 31, 2016, 30% of our net operating revenues for the year ended December 31, 2017, and 27% of our net operating revenues for the year ended December 31, 2018, 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. 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 net operating revenues 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.

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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 net operating revenues and profitability may decline.

As of December 31, 2018, we operated 96 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.

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 net operating revenues and profitability.

Our outpatient rehabilitation clinics receive payments from the Medicare program under a fee schedule. The Medicare Access and CHIP Reauthorization Act of 2015 requires that payments under the fee schedule be adjusted starting in 2019 based on performance in a MIPS and, beginning in 2020, incentives for participation in alternative payment models. The specifics of the MIPS and incentives for participation in alternative payment models will be subject to future notice and comment rule-making. 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 decrease in payment may reduce our future net operating revenues 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, 37 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.

In Concentra’s veteran’s healthcare business, reimbursement rates are generally set according to the capitated monthly rate based on the number of then enrolled patients at that CBOC. Evolving legislative and regulatory changes aimed at improving veteran’s access to care in the wake of Department of Veterans Affairs scandals (none of which involved Concentra’s CBOCs) could result in fewer patients enrolling in CBOCs. Federal legislation that permits certain veterans to receive their healthcare outside of the Department of Veterans Affairs facilities, for example, may reduce demand for services at some of Concentra’s CBOCs. Moreover, changes in the methods, manner or amounts of compensation payable for Concentra’s services, including, amounts reimbursable to the CBOCs under its agreements with the Department of Veterans Affairs, due to legislative or other changes or shifting budget priorities could result in lower reimbursement for services provided at Concentra’s CBOCs. Concentra may receive lower payments from the Veterans Health Administration if fewer eligible veterans are considered to live within the catchments of its CBOCs. These trends could have an adverse effect on our financial condition and results of operations.

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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 net operating revenues and profitability may decline.

As of December 31, 2018, we operated 26 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 either method and are classified as general acute care hospitals, our net operating revenue and profitability may be adversely affected.

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.

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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 patient's and employee's 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 ensure 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 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.

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 training and regular reminders on important measures they can take to prevent breaches. 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. 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.

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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, the reporting of standardized patient assessment data with regard to quality measures, resource use, and other measures. Failure to report data as required will subject providers to a 2% reduction in market basket prices then in effect. Additionally, reporting activities associated with the IMPACT Act are anticipated to be quite burdensome. CMS proposes to require hospitals to have a discharge planning process that focuses on patients' goals and preferences and on preparing them and, as appropriate, their caregivers, to be active partners in their post-discharge care. 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 agencies will continue to meet quality reporting requirements in the future which may result in one or more of our agencies 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.

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, including the acquisition of U.S. HealthWorks by Concentra, 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, including that of U.S. HealthWorks, 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, including the acquisition of U.S. HealthWorks by Concentra, 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.

Risks associated with our potential international operations.

We are expanding our operations into other countries. International operations are subject to risks that may materially adversely affect our business, results of operations, and financial condition. The risks that our potential international operations would be subject to include, among other things: difficulties and costs relating to staffing and managing

foreign operations; fluctuations in the value of foreign currencies; repatriation of cash from our foreign operations to the United States; foreign countries may impose additional withholding taxes or otherwise tax our foreign income; separate operating and financial systems; disaster recovery; and unexpected regulatory, economic, and political changes in foreign markets. In addition to the foregoing, our potential international operations will face risks associated with complying with laws governing our foreign business operations, including the United States Foreign Corrupt Practices Act and applicable regulatory requirements.

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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 or some actions of the board may require supermajority votes. As a result, the joint venture may elect 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 net operating revenues 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 net operating revenues 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, including those of U.S. HealthWorks, 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 and veteran's healthcare businesses 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. Similarly, competitive pricing pressures from our competitors could cause Concentra to lose existing or future CBOC contracts with the Department of Veterans Affairs, which may also cause Concentra to experience an overall decline in revenue.

Future cost containment initiatives undertaken by private third-party payors may limit our future net operating revenues 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.

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If we fail to maintain established relationships with the physicians in the areas we serve, our net operating revenues 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 net operating revenues may decline.

We could experience significant increases to our operating costs due to shortages of healthcare professionals or union activity.

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. We cannot assure you 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.

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 continuing legislative proposals that could result in increased union activity. We could experience an increase in labor and other costs from such union activity.

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.

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

Approximately 58% of Concentra's revenue in 2018 was generated from the treatment of workers' compensation claims. In the past decade, the number of workers' compensation claims has decreased, which Concentra primarily attributes to improvements in workplace safety, improved risk management by employers, and changes in the type and composition of jobs. During the economic downturn, the number of employees with workers' compensation insurance substantially decreased. Although the number of covered employees has increased more in recent years as the employment rate has increased, adverse economic conditions can cause the number of covered employees to decline which can cause further 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, spurred in part by the ACA, have led to fitter and healthier employees who may be less likely to injure themselves on the job. 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. 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, its results may be adversely affected.

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

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 17 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 $40.0 million. 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 numerous programs that are designed to respond to the risks of the specific joint venture. The annual aggregate limit under these programs ranges from $5.0 million to $20.0 million. The policies are generally written on a "claims-made" basis. Each of these programs has either a deductible or self-insured retention limit. We review our insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. In addition, our insurance coverage does not generally cover punitive damages and may not cover all claims against us. 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 19.5% of Holdings' outstanding common stock as of February 1, 2019. 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.

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Risks Related to Our Capital Structure

If WCAS and the other members of Concentra Group Holdings Parent or Dignity Health exercise their Put Right, it may have an adverse effect on our liquidity. Additionally, we may not have adequate funds to pay amounts due in connection with the Put Right, if exercised, in which case we would be required to issue Holdings' common stock to purchase interests of Concentra Group Holdings Parent and our stockholders' ownership interest will be diluted.

Pursuant to the Amended and Restated Limited Liability Company Agreement of Concentra Group Holdings Parent, WCAS and the other members of Concentra Group Holdings Parent and Dignity Health have separate put rights (each, a "Put Right") with respect to their equity interests in Concentra Group Holdings Parent. If a Put Right is exercised by WCAS or Dignity Health, Select will be obligated to purchase up to 331/3% of the equity interests of Concentra Group Holdings Parent that WCAS or Dignity Health, respectively, owned as of February 1, 2018, at a purchase price based on a valuation of Concentra Group Holdings Parent performed by an investment bank to be agreed between Select and one of WCAS or Dignity Health, which valuation will be based on certain precedent transactions using multiples of EBITDA (as defined in the Amended and Restated Limited Liability Company Agreement of Concentra Group Holdings Parent) and capped at an agreed upon multiple of EBITDA. Select has the right to elect to pay the purchase price in cash or in shares of Holdings' common stock. WCAS and Dignity Health may first exercise their respective Put Right during a sixty-day period following the second anniversary of the date of the Amended and Restated LLC Agreement in 2020, and then may exercise their respective Put Right again annually during a sixty-day period in each calendar year thereafter. If WCAS exercises its Put Right, the other members of Concentra Group Holdings Parent, other than Dignity Health, may elect to sell to Select, on the same terms as WCAS, a percentage of their equity interests of Concentra Group Holdings Parent that such member owned as of the date of the Amended and Restated LLC Agreement, up to but not exceeding the percentage of equity interests owned by WCAS as of the date of the Amended and Restated LLC Agreement that WCAS has determined to sell to Select in the exercise of its Put Right.

Furthermore, WCAS, Dignity Health, and the other members of Concentra Group Holdings Parent have a put right with respect to their equity interest in Concentra Group Holdings Parent that may only be exercised in the event Holdings or Select experiences a change of control that has not been previously approved by WCAS and Dignity Health, and which results in change in the senior management of Select (an "SEM COC Put Right"). If an SEM COC Put Right is exercised by WCAS, Select will be obligated to purchase all (but not less than all) of the equity interests of WCAS and the other members of Concentra Group Holdings Parent (other than Dignity Health) offered by such members at a purchase price based on a valuation of Concentra Group Holdings Parent performed by an investment bank to be agreed between Select and one of WCAS or Dignity Health, which valuation will be based on certain precedent transactions using multiples of EBITDA and capped at an agreed upon multiple of EBITDA. Similarly, if an SEM COC Put Right is exercised by Dignity Health, Select will be obligated to purchase all (but not less than all) of the equity interests of Dignity Health at a purchase price based on a valuation of Concentra Group Holdings Parent performed by an investment bank to be agreed between Select and one of WCAS or Dignity Health, which valuation will be based on certain precedent transactions using multiples of EBITDA and capped at an agreed upon multiple of EBITDA.

We may not have sufficient funds, borrowing capacity, or other capital resources available to pay for the interests of Concentra Group Holdings Parent in cash if WCAS, Dignity Health, and the other members of Concentra Group Holdings Parent exercise the Put Right or the SEM COC Put Right, or may be prohibited from doing so under the terms of our debt agreements. Such lack of available funds upon the exercising of the Put Right or the SEM COC Put Right would force us to issue stock at a time we might not otherwise desire to do so in order to purchase the interests of Concentra Group Holdings Parent. To the extent that the interests of Concentra Group Holdings Parent are purchased by issuing shares of our common stock, the increase in the number of shares of our common stock issued and outstanding may depress the price of our common stock and our stockholders will experience dilution in their respective percentage ownership in us. In addition, shares issued to purchase the interests in Concentra Group Holdings Parent will be valued at the twenty-one trading day volume-weighted average sales price of such shares for the period beginning ten trading days immediately preceding the first public announcement of the Put Right or the SEM COC Put Right being exercised and ending ten trading days immediately following such announcement.

Because the value of the common stock issued to purchase the interests in Concentra Group Holdings Parent is, in part, determined by the sales price of our common stock following the announcement that the Put Right or the SEM COC Put Right is being exercised, which may cause the sales price of our common stock to decline, the amount of common stock we may have to issue to purchase the interests in Concentra Group Holdings Parent may increase, resulting in further dilution to our existing stockholders.

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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, 2018, Select had approximately $1,892.7 million of total indebtedness, and Concentra had approximately $1,400.7 million of total indebtedness. As of December 31, 2018, our total indebtedness was $3,293.4 million. 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;
- 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.”

The Select credit facilities and the indenture governing Select’s 6.375% senior notes require Select to comply with certain financial covenants and obligations, the default of which may result in the acceleration of certain of Select’s indebtedness.

In the case of an event of default under the agreements governing the Select credit facilities (as defined below), the lenders 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 Select is unable to obtain a waiver from the requisite lenders under such circumstances, these lenders could exercise their rights, then Select’s financial condition and results of operations could be adversely affected, and Select could become bankrupt or insolvent.

The Select credit facilities require Select to maintain a leverage ratio (based upon the ratio of indebtedness to consolidated EBITDA as defined in the agreements governing the Select credit facilities), which is tested quarterly. Failure to comply with these covenants would result in an event of default under the Select credit facilities and, absent a waiver or an amendment from the lenders, preclude Select from making further borrowings under its revolving facility and permit the lenders to accelerate all outstanding borrowings under the Select credit facilities.

As of December 31, 2018, Select was required to maintain its leverage ratio (its ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters) at less than 6.25 to 1.00. At December 31, 2018, Select’s leverage ratio was 4.64 to 1.00.

While Select has never defaulted on compliance with any of its financial covenants, Select’s ability to comply with these ratios in the future may be affected by events beyond its control. Inability to comply with the required financial covenants could result in a default under the Select credit facilities. In the event of any default under Select’s credit facilities, the 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 Select’s indenture, the trustee or holders of 25% of the notes could declare all outstanding 6.375% senior notes immediately due and payable.

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The Concentra credit facilities require Concentra to comply with certain financial covenants and obligations, the default of which may result in the acceleration of certain of Concentra's indebtedness.

In the case of an event of default under the agreements governing the Concentra credit facilities (as defined below), which is nonrecourse to Select, the lenders 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 Concentra is unable to obtain a waiver from these lenders under such circumstances, the lenders could exercise their rights, then Concentra's financial condition and results of operations could be adversely affected, and Concentra could become bankrupt or insolvent.

The Concentra first lien credit agreement (as defined below) requires Concentra to maintain a leverage ratio (based upon the ratio of indebtedness for money borrowed to consolidated EBITDA) of 5.75 to 1.00, which is tested quarterly, but only if Revolving Exposure (as defined in the Concentra credit facilities) exceeds 30% of Revolving Commitments (as defined in the Concentra credit facilities) on such day. Failure to comply with this covenant would result in an event of default under the Concentra revolving facility (as defined below) only and, absent a waiver or an amendment from the lenders, preclude Concentra from making further borrowings under the Concentra revolving facility and permit the lenders to accelerate all outstanding borrowings under the Concentra revolving facility. Upon such acceleration, Concentra's failure to comply with the financial covenant would result in an Event of Default (as defined in the Concentra credit facilities) with respect to the Concentra first lien term loan (as defined below). Upon the acceleration of outstanding borrowings under the Concentra revolving facility and the Concentra first lien term loan, an Event of Default would result with respect to the Concentra second lien credit agreement.

The Concentra credit facilities also contain a number of 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. The Concentra credit facilities contain events of default for non-payment of principal and interest when due (subject to a grace period for interest), cross-default and cross-acceleration provisions and an event of default that would be triggered by a change of control.

While Concentra has never defaulted on compliance with any of its financial covenants, Concentra's ability to comply with these ratios in the future may be affected by events beyond our control. Inability to comply with the required financial covenants could result in a default under the Concentra credit facilities. In the event of any default under the Concentra credit facilities, the 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.

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. For example, as a general matter, Concentra is restricted from paying dividends under the Concentra credit facilities and therefore we cannot rely on Concentra's cash flow to repay Select's 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 the Select credit facilities and the Concentra credit facilities 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, 2018, Select had $392.5 million of availability under the Select revolving facility (as defined below) (after giving effect to $37.5 million of outstanding letters of credit) and Concentra had $62.3 million of availability under the Concentra revolving facility (after giving effect to $12.7 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.

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Concentra's inability to meet the conditions and payments under the Concentra credit facilities, although nonrecourse to Select, could jeopardize Select's equity contribution to Concentra Group Holdings Parent.
Select is not a party to the Concentra credit facilities and is not an obligor with respect to Concentra's debt under such agreements; however, if Concentra fails to meet its obligations and defaults on the Concentra credit facilities, a portion of or all of Select's equity investment in Concentra Group Holdings Parent, the indirect parent company of Concentra, could be at risk of loss.

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 the Select credit facilities would permit lenders to foreclose on our assets and would also be deemed a default under the indenture governing Select's 6.375% senior notes, which may also result in the acceleration of that indebtedness, and, although Select is not a party to the Concentra credit facilities and is not an obligor with respect to Concentra's debt under such agreements, if Concentra fails to meet its obligations and defaults on the Concentra credit facilities, a portion of or all of Select's equity investment in Concentra Group Holdings Parent, the indirect parent company of Concentra, could be at risk of loss.
See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources."

Item 1B. ***Unresolved Staff Comments.***
None.

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Item 2. ***Properties.***

We currently lease most of our consolidated facilities, including critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, occupational health centers, CBOCs, and our corporate headquarters. We own 19 of our critical illness recovery hospitals, seven of our rehabilitation hospitals, one of our outpatient rehabilitation clinics, and eight of our Concentra occupational health centers throughout the United States. As of December 31, 2018, we leased 77 of our critical illness recovery hospitals, 10 of our rehabilitation hospitals, 1,422 of our outpatient rehabilitation clinics, 516 of our Concentra occupational health centers, and 31 CBOCs throughout the United States.

We lease our corporate headquarters from companies owned by a related party affiliated with us through common ownership or management. Our corporate headquarters is approximately 221,453 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, 2018.

	Critical Illness Recovery Hospitals[1]	Rehabilitation Hospitals[1]	Outpatient Rehabilitation Clinics[1]	Concentra Occupational Health Centers[2]	Total Facilities
Alabama	1		24		25
Alaska			7	5	12
Arizona	2	1	40	18	61
Arkansas	2		1	2	5
California		1	69	97	167
Colorado			40	23	63
Connecticut			56	10	66
Delaware	1		12	1	14
District of Columbia			4		4
Florida	9	1	120	33	163
Georgia	5	1	68	17	91
Hawaii				1	1
Illinois			63	16	79
Indiana	3		29	14	46
Iowa	2		19	3	24
Kansas	2		14	4	20
Kentucky	2		58	9	69
Louisiana		1	3	3	7
Maine			16	7	23
Maryland			64	12	76
Massachusetts			12	2	14
Michigan	11		37	18	66
Minnesota	1		27	6	34
Mississippi	4		1		5
Missouri	4	3	92	17	116
Nebraska	2		2	3	7
Nevada			11	7	18
New Hampshire				3	3
New Jersey	1	4	162	21	188
New Mexico			2	4	6
North Carolina	2		37	8	47
Ohio	16	5	86	17	124
Oklahoma	2		23	7	32
Oregon				4	4

Pennsylvania	9	2	227	17	255
Rhode Island				2	2

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South Carolina	2		26	3	31
South Dakota	1				1
Tennessee	5		21	10	36
Texas	2	6	126	56	190
Utah				6	6
Vermont				2	2
Virginia	1	1	45	6	53
Washington			5	18	23
West Virginia	1				1
Wisconsin	3		13	12	28
Total Company	96	26	1,662	524	2,308

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

(2) Our Concentra segment also had operations in New York, West Virginia, and Wyoming.

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

We are 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. We cannot predict the ultimate outcome of pending litigation, proceedings, and regulatory and other governmental audits and investigations. These matters could potentially subject us to sanctions, damages, recoupments, fines, and other penalties. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future that may, either individually or in the aggregate, have a material adverse effect on our business, financial position, results of operations, and liquidity.

To address claims arising out of the our operations, we 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 $40.0 million. 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 numerous programs that are designed to respond to the risks of the specific joint venture. The annual aggregate limit under these programs ranges from $5.0 million to $20.0 million. The policies are generally written on a “claims-made” basis. Each of these programs has either a deductible or self-insured retention limit. We review our insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. We also maintain umbrella liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by our other insurance policies. These insurance policies also do not generally cover punitive damages and are subject to various deductibles and policy limits. Significant legal actions, as well as the cost and possible lack of available insurance, could subject us to substantial uninsured liabilities. In our 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. We are and have 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.

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Evansville Litigation

On October 19, 2015, the plaintiff-relators filed a Second Amended Complaint in United States of America, ex rel. Tracy Conroy, Pamela Schenk and Lisa Wilson v. Select Medical Corporation, Select Specialty Hospital—Evansville, LLC ("SSH-Evansville"), Select Employment Services, Inc., and Dr. Richard Sloan. The case is a civil action filed in the United States District Court for the Southern District of Indiana by private plaintiff-relators on behalf of the United States under the federal False Claims Act. The plaintiff-relators are the former CEO and two former case managers at SSH-Evansville, and the defendants currently include us, SSH-Evansville, one of our subsidiaries serving as common paymaster for its employees, and a physician who practices at SSH-Evansville. The plaintiff-relators allege that SSH-Evansville discharged patients too early or held patients too long, improperly discharged patients to and readmitted them from short stay hospitals, up-coded diagnoses at admission, and admitted patients for whom long term acute care was not medically necessary. They also allege that the defendants engaged in retaliation in violation of federal and state law. The Second Amended Complaint replaced a prior complaint that was filed under seal on September 28, 2012 and served on us on February 15, 2013, after a federal magistrate judge unsealed it on January 8, 2013. All deadlines in the case had been stayed after the seal was lifted in order to allow the government time to complete its investigation and to decide whether or not to intervene. On June 19, 2015, the United States Department of Justice notified the District Court of its decision not to intervene in the case.

In December 2015, the defendants filed a motion to dismiss the second amended complaint on multiple grounds, including that the action is disallowed by the False Claims Act's public disclosure bar, which disqualifies qui tam actions that are based on fraud already publicly disclosed through enumerated sources, unless the relator is an original source, and that the plaintiff-relators did not plead their claims with sufficient particularity, as required by the Federal Rules of Civil Procedure.

Thereafter, the United States filed a notice asserting a veto of the defendants' use of the public disclosure bar for claims arising from conduct from and after March 23, 2010, which was based on certain statutory changes to the public disclosure bar language included in the ACA. On September 30, 2016, the District Court partially granted and partially denied the defendants' motion to dismiss. It ruled that the plaintiff-relators alleged substantially the same conduct as had been publicly disclosed and that the plaintiff-relators are not original sources, so that the public disclosure bar requires dismissal of all non-retaliation claims arising from conduct before March 23, 2010. The District Court also ruled that the statutory changes to the public disclosure bar gave the United States the power to veto its applicability to claims arising from conduct on and after March 23, 2010, and therefore did not dismiss those claims based on the public disclosure bar. However, the District Court ruled that the plaintiff-relators did not plead certain of their claims relating to interrupted stay manipulation and premature discharging of patients with the requisite particularity, and dismissed those claims. The District Court declined to dismiss the plaintiff-relators' claims arising from conduct from and after March 23, 2010 relating to delayed discharging of patients and up-coding and the plaintiff-relators' retaliation claims. The plaintiff-relators then proposed a case management plan seeking nationwide discovery involving all of the Company's LTCHs for the period from March 23, 2010 through the present and allowing discovery that would facilitate the use of statistical sampling to prove liability, which the Select defendants opposed.

In April 2018, a U.S. magistrate judge ruled that the plaintiff relators' discovery will be limited to only SSH-Evansville for the period from March 23, 2010 through September 30, 2016, and that the plaintiff relators will be required to prove the fraud that they allege on a claim-by-claim basis, rather than using statistical sampling. The plaintiff-relators have appealed this decision to the District Judge.

predict the timing and outcome of this matter.

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Wilmington Litigation

On January 19, 2017, the United States District Court for the District of Delaware unsealed a qui tam Complaint in United States of America and State of Delaware ex rel. Theresa Kelly v. Select Specialty Hospital—Wilmington, Inc. ("SSH-Wilmington"), Select Specialty Hospitals, Inc., Select Employment Services, Inc., Select Medical Corporation, and Crystal Cheek, No. 16-347-LPS. The complaint was initially filed under seal in May 2016 by a former chief nursing officer at SSH-Wilmington and was unsealed after the United States filed a Notice of Election to Decline Intervention in January 2017. The corporate defendants were served in March 2017. In the complaint, the plaintiff-relator alleges that the Select defendants and an individual defendant, who is a former health information manager at SSH-Wilmington, violated the False Claims Act and the Delaware False Claims and Reporting Act based on allegedly falsifying medical practitioner signatures on medical records and failing to properly examine the credentials of medical practitioners at SSH-Wilmington. In response to the Select defendants' motion to dismiss the complaint, in May 2017, the plaintiff-relator filed an amended complaint asserting the same causes of action. The Select defendants filed a motion to dismiss the amended complaint based on numerous grounds, including that the amended complaint did not plead any alleged fraud with sufficient particularity, failed to plead that the alleged fraud was material to the government's payment decision, failed to plead sufficient facts to establish that the Select defendants knowingly submitted false claims or records, and failed to allege any reverse false claim. In March 2018, the District Court dismissed the plaintiff relator's claims related to the alleged failure to properly examine medical practitioners' credentials, her reverse false claims allegations, and her claim that the Select defendants violated the Delaware False Claims and Reporting Act. It denied the Select defendants' motion to dismiss claims that the allegedly falsified medical practitioner signatures violated the False Claims Act. Separately, the District Court dismissed the individual defendant due to the plaintiff-relator's failure to timely serve the amended complaint upon her.

In March 2017, the plaintiff-relator initiated a second action by filing a complaint in the Superior Court of the State of Delaware in Theresa Kelly v. Select Medical Corporation, Select Employment Services, Inc. and SSH-Wilmington, C.A. No. N17C-03-293 CLS. The Delaware complaint alleges that the defendants retaliated against her in violation of the Delaware Whistleblowers' Protection Act for reporting the same alleged violations that are the subject of the federal amended complaint. The defendants filed a motion to dismiss, or alternatively to stay, the Delaware complaint based on the pending federal amended complaint and the failure to allege facts to support a violation of the Delaware Whistleblowers' Protection Act.

We intend to vigorously defend these actions, but at this time we are unable to predict the timing and outcome of this matter.

Contract Therapy Subpoena

On May 18, 2017, we received a subpoena from the U.S. Attorney's Office for the District of New Jersey seeking various documents principally relating to our contract therapy division, which contracted to furnish rehabilitation therapy services to residents of skilled nursing facilities ("SNFs") and other providers. We operated our contract therapy division through a subsidiary until March 31, 2016, when we sold the stock of the subsidiary. The subpoena seeks documents that appear to be aimed at assessing whether therapy services were furnished and billed in compliance with Medicare SNF billing requirements, including whether therapy services were coded at inappropriate levels and whether excessive or unnecessary therapy was furnished to justify coding at higher paying levels. We do 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. We are producing documents in response to the subpoena and intends to fully cooperate with this investigation. At this time, we are unable to predict the timing and outcome of this matter.

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

None.

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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, 2019, Holdings had 135,262,167 shares of common stock issued and outstanding. As of that date, there were 123 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 has not paid or declared any dividends on its common stock at any point during the last three fiscal years. We do not anticipate paying any further dividends on Holdings' common stock in the foreseeable future. We intend to retain future earnings to finance the ongoing operations and growth of our business. Any future determination relating to our dividend policy will be made at the discretion of Holdings' board of directors and will depend on conditions at that time, including our financial condition, results of operations, contractual restrictions, capital requirements, business prospects, and other factors the board of directors may deem relevant. Additionally, certain contractual agreements we are party to, including the Select credit facilities and the Indenture governing Select's 6.375% 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."

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Stock Performance Graph

The graph below compares the cumulative total stockholder return on $100 invested at the close of the market on December 31, 2013, with dividends being reinvested on the date paid through and including the market close on December 31, 2018 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.

	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Select Medical Holdings Corporation (SEM)	$ 100.00	$ 127.71	$ 106.43	$ 118.40	$ 157.72	$ 137.17
S&P Health Care Services Select Industry Index (SPSIHP)	$ 100.00	$ 125.01	$ 128.86	$ 117.98	$ 137.90	$ 141.15
S&P 500	$ 100.00	$ 111.36	$ 110.53	$ 121.09	$ 144.61	$ 135.59

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Purchases of Equity Securities by the Issuer

Holdings' board of directors has authorized a common stock repurchase program to repurchase up to $500.0 million worth of shares of its common stock. The program has been extended until December 31, 2019 and 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 did not repurchase shares during the three months ended December 31, 2018 under the authorized common stock repurchase program.

The following table provides information regarding repurchases of our common stock during the three months ended December 31, 2018. As set forth below, the shares repurchased during the three months ended December 31, 2018 relate entirely to shares of 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.

	Total Number of Shares Purchased	Average Price Paid Per Share