# UNITED STATES
# SECURITIES AND EXCHANGE COMMISSION
**Washington, D.C. 20549**
# Form 10-K

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

**For fiscal year ended December 31, 2024**

**OR**

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

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

# SELECT MEDICAL HOLDINGS CORPORATION
(Exact name of Registrant as specified in its Charter)

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

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

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

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

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

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

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

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

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

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

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

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

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

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously held financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to Section 240.10D-1(b). ☐

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

The aggregate market value of the registrant's voting stock held by non-affiliates at June 30, 2024 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $3,622,619,762, based on the closing price per share of common stock on that date of $35.06 as reported on the New York Stock Exchange. Shares of common stock known by the registrant to be beneficially owned by directors and officers of the registrant subject to the reporting and other requirements of Section 16 of the Securities Exchange Act of 1934 are not included in the computation. The registrant, however, has made no determination that such persons are "affiliates" within the meaning of Rule 12b-2 under the Securities Exchange Act of 1934.

As of February 1, 2025, the number of shares of Holdings' Common Stock, $0.001 par value, outstanding was 128,962,850.

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

**Documents Incorporated by Reference**

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

1. The registrant's definitive proxy statement for use in connection with the 2025 Annual Meeting of Stockholders to be held on or about April 30, 2025 to be filed within 120 days after the registrant's fiscal year ended December 31, 2024, portions of which are incorporated by reference into Part III of this Form 10-K. Such definitive proxy statement, except for the parts therein which have been specifically incorporated by reference, should not be deemed "filed" for the purposes of this form 10-K.

**SELECT MEDICAL HOLDINGS CORPORATION**

**ANNUAL REPORT ON FORM 10-K**

**FOR THE YEAR ENDED DECEMBER 31, 2024**

# PART I

***Forward-Looking Statements***

This annual report on Form 10-K contains forward-looking statements within the meaning of the federal securities laws. Statements that are not historical facts, including statements about our beliefs and expectations, are forward-looking statements. Forward-looking statements include statements preceded by, followed by or that include the words “may,” “could,” “would,” “should,” “believe,” “expect,” “anticipate,” “plan,” “target,” “estimate,” “project,” “intend,” and similar expressions. These statements include, among others, statements regarding our expected business outlook, anticipated financial and operating results, including 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 revenue, an increase in costs, and a reduction in profitability;
- adverse economic conditions including an inflationary environment could cause us to continue to experience increases in the prices of labor and other costs of doing business resulting in a negative impact on our business, operating results, cash flows, and financial condition;
- shortages in qualified nurses, therapists, physicians, or other licensed providers, and/or the inability to attract or retain qualified healthcare professionals could limit our ability to staff our facilities;
- shortages in qualified health professionals could cause us to increase our dependence on contract labor, increase our efforts to recruit and train new employees, and expand upon our initiatives to retain existing staff, which could increase our operating costs significantly;
- the negative impact of public threats such as a global pandemic or widespread outbreak of an infectious disease similar to the COVID-19 pandemic;
- the failure of our Medicare-certified long term care hospitals or inpatient rehabilitation facilities to maintain their Medicare certifications may cause our revenue and profitability to decline;
- the failure of our Medicare-certified long term care hospitals and inpatient rehabilitation facilities operated as “hospitals within hospitals” to qualify as hospitals separate from their host hospitals may cause our revenue and profitability to decline;
- a government investigation or assertion that we have violated applicable regulations may result in sanctions or reputational harm and increased costs;
- acquisitions or joint ventures may prove difficult or unsuccessful, use significant resources, or expose us to unforeseen liabilities;
- our plans and expectations related to our acquisitions and our ability to realize anticipated synergies;
- failure to complete or achieve some or all the expected benefits of the separation of Concentra;
- private third-party payors for our services may adopt payment policies that could limit our future revenue and profitability;
- the failure to maintain established relationships with the physicians in the areas we serve could reduce our revenue and profitability;
- competition may limit our ability to grow and result in a decrease in our revenue and profitability;
- the loss of key members of our management team could significantly disrupt our operations;
- the effect of claims asserted against us could subject us to substantial uninsured liabilities;

- a security breach of our or our third-party vendors' information technology systems may subject us to potential legal and reputational harm and may result in a violation of the Health Insurance Portability and Accountability Act of 1996 or the Health Information Technology for Economic and Clinical Health Act; and
- other factors discussed from time to time in our filings with the Securities and Exchange Commission (the "SEC"), including factors discussed under the heading "Risk Factors" of this annual report on Form 10-K.

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

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

## Item 1. *Business.*

### Overview

We began operations in 1997 and, based on the number of facilities, are one of the largest operators of critical illness recovery hospitals, rehabilitation hospitals, and outpatient rehabilitation clinics in the United States. As of December 31, 2024, we had operations in 40 states and the District of Columbia. As of December 31, 2024, we operated 104 critical illness recovery hospitals in 29 states, 35 rehabilitation hospitals in 14 states, and 1,914 outpatient rehabilitation clinics in 39 states and the District of Columbia.

On July 26, 2024, Concentra Group Holdings Parent ("Concentra"), a then wholly-owned subsidiary of Select, completed an initial public offering ("IPO") of 22,500,000 shares of its common stock, par value $0.01 per share, at an initial public offering price of $23.50 per share for net proceeds of $499.7 million after deducting underwriting discounts and commission of $29.1 million. In addition, the underwriters exercised the option to purchase an additional 750,000 shares of Concentra's common stock for net proceeds of $16.7 million after deducting discounts and commission of $1.0 million. Concentra shares began trading on the New York Stock Exchange under the symbol "CON" on July 25, 2024.

After the closing of the IPO and underwriters option, Select owned 81.74% of the total outstanding shares of Concentra common stock. On November 25, 2024, Select made a tax-free distribution to its stockholders of all of its remaining equity interest in Concentra ("the Distribution"). Holders of the Company's common stock received 0.806971 shares of Concentra common stock for each outstanding share of the Company's common stock they owned as of November 18, 2024 (the "Record Date"). Following the completion of the distribution, the Company no longer owns any shares of Concentra common stock. The historical results of Concentra (which previously represented the Concentra business segment) are reflected as discontinued operations in the Company's Consolidated Financial Statements through the date of the distribution.

Following the completion of the distribution of Concentra in November 2024, we now manage our Company through three business segments: our critical illness recovery hospital segment, our rehabilitation hospital segment, and our outpatient rehabilitation segment. We had revenue of $5,187.1 million for the year ended December 31, 2024. Of this total, we earned approximately 47% of our revenue from our critical illness recovery hospital segment, approximately 21% from our rehabilitation hospital segment, and approximately 24% from our outpatient rehabilitation segment. We also recognized other revenue associated with employee leasing services provided to the Company's non-consolidating subsidiaries.

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. See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations" and "Notes to Consolidated Financial Statements—Note 15. Segment Information" beginning on F-28 for financial information for each of our segments for the past three fiscal years.

**Critical Illness Recovery Hospitals**

We are a leading operator of critical illness recovery hospitals in the United States. Our hospitals are certified by Medicare as long term care hospitals ("LTCHs"). As of December 31, 2024, we operated 104 critical illness recovery hospitals in 29 states. For the years ended December 31, 2022, 2023, and 2024, approximately 38%, 37%, and 33%, respectively, of the revenue of our critical illness recovery hospital segment came from Medicare reimbursement. As of December 31, 2024, we employed approximately 16,500 people in our critical illness recovery hospital segment, consisting primarily of registered nurses, respiratory therapists, physical therapists, occupational therapists, and speech therapists.

We operate the majority of our critical illness recovery hospitals as a hospital within a hospital (an "HIH"). A critical illness recovery hospital that operates as an HIH typically leases space from a general acute care hospital, or "host hospital," and operates as a separately licensed hospital within the host hospital, or on the same campus as the host hospital. In contrast, a free-standing critical illness recovery hospital does not operate on a host hospital campus. We operated 104 critical illness recovery hospitals at December 31, 2024, of which 70 were operated as HIHs and 34 were operated as free-standing hospitals.

Patients are typically admitted to our critical illness recovery hospitals from general acute care hospitals, likely following an intensive care unit stay, and suffer from chronic critical illness. These patients have highly specialized needs, with serious and complex medical conditions involving multiple organ systems. These conditions are often a result of complications related to heart failure, complex infectious disease, respiratory failure and pulmonary disease, complex surgery requiring prolonged recovery, renal disease, neurological events, and trauma. Given their complex medical needs, these patients require a longer length of stay than patients in a general acute care hospital and benefit from being treated in a critical illness recovery hospital that is designed to meet their unique medical needs. For the year ended December 31, 2024, the average length of stay for patients in our critical illness recovery hospitals was 31 days.

Additionally, we continually seek to increase our admissions by demonstrating our quality outcomes and, by doing so, expanding and improving our relationships with the physicians and general acute care hospitals in the markets where we operate. We maintain a strong focus on the provision of high-quality medical care within our facilities. The Joint Commission ("TJC"), DNV GL Healthcare USA, Inc. ("DNV"), and the Center for Improvement in Healthcare Quality ("CIHQ") are independent accreditation organizations that establish standards related to the operation and management of healthcare facilities. As of December 31, 2024, we operated 104 critical illness recovery hospitals, 102 of which were accredited by TJC and two of which were accredited by DNV. Also as of December 31, 2024, all of our critical illness recovery hospitals were certified by Medicare as LTCHs. Each of our critical illness recovery hospitals must regularly demonstrate to a survey team conformance to the standards established by TJC, DNV, CIHQ, or the Medicare program, as applicable.

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

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

Each of our critical illness recovery hospitals has a distinct medical staff that is composed of physicians from multiple specialties that have successfully completed the required privileging and credentialing process. In general, physicians on the medical staff are not directly employed, but are more commonly independent, and practice at multiple hospitals in the community. Attending physicians conduct daily rounds on their patients while consulting physicians provide consulting services based on the specific medical needs of our patients. Each critical illness recovery hospital develops on-call arrangements with individual physicians to help ensure that a physician is available to care for our patients. When determining the appropriate composition of the medical staff of a critical illness recovery hospital, we consider the size of the critical illness recovery hospital, services provided by the critical illness recovery hospital, and the size and capabilities of the medical staff of the general acute care hospital that hosts that HIH or 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 medical officer, chief nursing officer, and chief quality officer. Each of our critical illness recovery hospitals has an onsite management team consisting of a chief executive officer, a medical director, a chief nursing officer, and a director of business development. These teams manage local strategy and day-to-day operations, including oversight of clinical care and treatment. They also assume primary responsibility for developing relationships with the general acute care providers and clinicians in the local areas we serve that refer patients to our critical illness recovery hospitals. We provide our critical illness recovery hospitals with centralized accounting, treasury, payroll, legal, operational support, human resources, compliance, management information systems, health information, credentialing, physician contracting support, and billing and collection services. The centralization of these services improves efficiency and permits staff at our critical illness recovery hospitals to focus their time on patient care.

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

**Critical Illness Recovery Hospital Strategy**

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

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

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

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

Our critical illness recovery hospitals demonstrated a pivotal role in caring for patients during the COVID-19 pandemic. Our critical illness recovery hospitals were and continue to be in a position to enhance and promote recovery of patients with COVID-19, as many patients with severe manifestations of COVID-19 require prolonged mechanical ventilation. We have developed specialized strategies for liberation from prolonged mechanical ventilation, promoting physical recovery through innovative therapies and rehabilitation programs while reducing risk of adverse ventilator-associated events.

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 Healthcare 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, health information, credentialing, compliance, and billing and collection;
- standardizing management information systems to assist in capturing the medical record, accounting, billing, collections, and data capture and analysis; and

- centralizing sourcing and contracting to receive discounted prices for pharmaceuticals, medical supplies, and other commodities used in our operations.

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

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

**Rehabilitation Hospitals**

Our rehabilitation hospitals provide comprehensive physical medicine, as well as rehabilitation programs and services, which serve to optimize patient health, function, and quality of life. As of December 31, 2024, we operated 35 rehabilitation hospitals in 14 states. For the years ended December 31, 2022, 2023, and 2024, approximately 46%, 47%, and 45% respectively, of the revenue of our rehabilitation hospital segment came from Medicare reimbursement. As of December 31, 2024, we employed approximately 13,700 people in our rehabilitation hospital segment, consisting primarily of registered nurses, respiratory therapists, physical therapists, occupational therapists, speech therapists, neuropsychologists, and other psychologists.

Patients at our rehabilitation hospitals have specialized needs, with serious and often complex medical conditions requiring rehabilitative healthcare services in an inpatient setting. These conditions require targeted therapy and rehabilitation treatment, including comprehensive rehabilitative services for brain and spinal cord injuries, strokes, amputations, neurological disorders, orthopedic conditions, pediatric congenital or acquired disabilities, and cancer. Given their complex medical needs and gradual and prolonged recovery, these patients generally require a longer length of stay than patients in a general acute care hospital. For the year ended December 31, 2024, 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, 2024, we operated 35 rehabilitation hospitals, all of which were accredited by TJC. Also as of December 31, 2024, 34 of our rehabilitation hospitals were certified by Medicare as inpatient rehabilitation facilities (“IRFs”). 30 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 standards established by TJC, the Medicare program, or CARF, as applicable.

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

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

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

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

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

**Rehabilitation Hospital Strategy**

The key elements of our rehabilitation hospital strategy are to:

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

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

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

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 Healthcare 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, health information, credentialing, 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 identify the specific needs of a joint venture, which could include working capital, the construction of new space, or the leasing and renovation of existing space. A joint venture typically consists of us and the healthcare system contributing certain post-acute care businesses into a newly formed entity. We typically function as the manager and hold either a majority or minority ownership interest. We bring clinical expertise and clinical programs that attract commercial payors and implement our standardized resource management programs, which may improve the clinical outcome and enhance the financial performance of the joint venture.

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

**Outpatient Rehabilitation**

We are the largest operator of outpatient rehabilitation clinics in the United States based on number of facilities, with 1,914 facilities throughout 39 states and the District of Columbia as of December 31, 2024. Our outpatient rehabilitation clinics are typically located in a medical complex or retail location. Our outpatient rehabilitation segment employed approximately 11,300 people as of December 31, 2024.

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, pelvic health rehabilitation, pediatric rehabilitation, cancer 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. Although individuals in all states may have some form of direct access to physical therapy services, the level of direct access varies based on provisions and limitations in each jurisdiction. In recent years, all states have enacted laws that allow individuals to seek outpatient physical rehabilitation services without a physician order. In our outpatient rehabilitation segment, for the year ended December 31, 2024, approximately 82% of our revenue comes from commercial payors, including healthcare insurers, managed care organizations, workers' compensation programs, contract management services, and private pay sources. We believe that our services are attractive to healthcare payors who are seeking to provide high-quality and cost-effective care to their enrollees. The balance of our reimbursement is derived from Medicare and other government sponsored programs.

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

**Outpatient Rehabilitation Strategy**

The key elements of our outpatient rehabilitation strategy are to:

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

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

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

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

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

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

**Other**

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

**Our Competitive Strengths**

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

*Leading Operator in Distinct but Complementary Lines of Business.* We believe that we are a leading operator in our business segments based on number of facilities in the United States. Our leadership position and reputation as a high-quality, cost-effective healthcare provider in each of our business segments allows us to attract patients and employees, aids us in our marketing efforts to referral sources, and helps us negotiate payor contracts. In our critical illness recovery hospital segment, we operated 104 critical illness recovery hospitals in 29 states as of December 31, 2024. In our rehabilitation hospital segment, we operated 35 rehabilitation hospitals in 14 states as of December 31, 2024. In our outpatient rehabilitation segment, we operated 1,914 outpatient rehabilitation clinics in 39 states and the District of Columbia as of December 31, 2024. 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 2024, we completed a number of significant acquisitions. We believe that we have improved the operating performance of these businesses over time by applying our standard operating practices and by realizing efficiencies from our centralized operations and management.

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

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

*Experienced and Proven Management Team.* The members of our senior management team have extensive experience in the healthcare industry, with an average of almost 25 years in the business. In recent years, we have reorganized our operations to expand executive talent and promote management continuity.

## Sources of Revenue

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

| Revenue by Payor Source | Year Ended December 31, 2022 | 2023 | 2024 |
|---|---|---|---|
| Medicare | 31.4 % | 30.8 % | 28.8 % |
| Commercial insurance[1] | 49.0 % | 49.3 % | 51.3 % |
| Workers' Compensation | 4.8 % | 4.7 % | 4.4 % |
| Private and other[2] | 12.5 % | 12.3 % | 12.5 % |
| Medicaid | 2.3 % | 2.9 % | 3.0 % |
| Total | 100.0 % | 100.0 % | 100.0 % |

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

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

### *Government Sources*

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. As of December 31, 2024, we operated 104 critical illness recovery hospitals, all of which were certified by Medicare as LTCHs. Also as of December 31, 2024, we operated 35 rehabilitation hospitals, 34 of which were certified by Medicare as IRFs. Our outpatient rehabilitation clinics regularly receive Medicare payments for their services. Additionally, many of our critical illness recovery hospitals and rehabilitation hospitals participate in state Medicaid programs. Amounts received under the Medicare and Medicaid programs are generally less than the customary charges for the services provided. In recent years, there have been significant changes made to the Medicare and Medicaid programs. Since a significant portion of our revenues come from patients covered under the Medicare program, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in the Medicare program. See "—Government Regulations—Overview of U.S. and State Government Reimbursements."

### *Non-Government Sources*

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

## Human Capital Management

*Overview*

At December 31, 2024, we had approximately 44,100 employees, including approximately 30,000 full-time and 14,100 part-time and per-diem employees. Our critical illness recovery hospital segment employees totaled approximately 16,500, rehabilitation hospital segment employees totaled approximately 13,700, and outpatient rehabilitation segment employees totaled approximately 11,300. Approximately 2,600 of the remaining employees performed corporate management, administration, and other support services primarily at our Mechanicsburg, Pennsylvania headquarters.

Our workforce is predominantly non-union, with less than 40 employees represented by one labor union. We consider our employee relations to be good and believe that our employees are essential contributors to our success. In some markets, the shortage of clinical personnel is a significant operating issue facing healthcare providers. Shortages of nurses and other clinical personnel, including therapists, may, from time to time, require us to increase use of more costly temporary personnel, which we refer to as "contract labor," and other types of premium pay programs.

Our hospitals are staffed by licensed physicians who are usually not employed by us. Any licensed physician may apply to be accepted to the medical staff of any of our hospitals, but the hospital’s medical staff and the appropriate governing board of the hospital, in accordance with established credentialing criteria, must approve acceptance to the staff. Members of the medical staffs of our hospitals often also serve on the medical staffs of other hospitals and may terminate their affiliation with one of our hospitals at any time. Within our hospital divisions, approximately 17,000 practitioners are credentialed to treat and provide services to our patients. In addition, some physicians or group practices provide administrative and/or clinical services in our hospitals under contracts.

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

Select Medical's Human Capital and Compensation Committee undertakes an annual review of material compensation and human capital risk exposures, and reviews management's efforts to monitor and mitigate such exposures.

*Talent Acquisition*

We have several key strategies to attract and hire top talent across the markets that we serve. These strategies include robust employee referral programs, new hire incentives such as sign-on bonuses and loan repayment assistance, recruitment marketing through social media and our internal campaign technology, promotion of virtual and in-person hiring events and partnering with nursing and therapy schools for clinical rotations and hiring new graduate nursing and therapy clinicians with extended orientation. Our recruitment and selection processes seek to ensure that we hire employees who have the level of education, experience, and professional licensure that align with the organization’s strategic objectives.

*Training and Development*

Our licensed clinicians receive new-hire orientation and training which is commensurate with the experience of the employee. Due to the complex medical conditions of the patients admitted to our hospitals and the specialized nature of their work, our nurses receive more extensive training, which has a duration of up to 13 weeks, prior to assuming patient care responsibilities.

We have also developed several programs to advance technical and clinical skills, enable career growth and improve retention for clinical and operational employees. Using our online learning platform, we have developed an extensive catalog of online learning classes for both instructor-led and asynchronous learning covering technical, professional, and management-related topics. To support mandatory educational requirements for our licensed clinicians, many of our clinical education courses are approved for continuing education units with the respective accrediting bodies.

To develop future leaders at all levels of the organization, we offer online curriculum as well as a variety of in-person workshops and intensives. In addition to internal education opportunities, we provide tuition assistance for employees who pursue relevant degrees and certifications from accredited educational institutions. We also utilize an internal program that encourages and makes it easier for employees to explore possible career growth opportunities within the Company. To promote business continuity, we create specific succession plans for our key operational and support management and executive positions.

*Diversity and Inclusion*

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

*Employee Engagement and Wellness*

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

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

In response to heightened threats of workplace violence faced by healthcare workers, we have formed a dedicated interdisciplinary task force focused on development of robust strategies to enhance workplace safety.

*Workforce Compensation and Pay Equity*

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

*Select Medical Charitable Foundation*

We have operated a private, non-profit charitable foundation known as the Select Medical Charitable Foundation since 2004. The Foundation is funded primarily by donations by our employees. The Foundation provides financial assistance to employees significantly impacted by natural disasters such as hurricanes, tornadoes, and wildfires. Eligibility is application-based with grant distribution determined by the Foundation Review Committee, comprised of colleagues across the organization. In 2024, the Foundation assisted our colleagues impacted by hurricanes Helene, Milton, and Beryl, and tropical storm Francine.

## Competition

### *Critical Illness Recovery Hospitals and Rehabilitation Hospitals*

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

***Outpatient Rehabilitation Clinics***

Our outpatient rehabilitation clinics face a highly fragmented and competitive environment. The primary competitors that provide outpatient rehabilitation services include physician-owned physical therapy clinics, dedicated locally owned and managed outpatient rehabilitation clinics, and hospital or university owned or affiliated ventures, as well as national and regional providers in select areas, including Athletico Physical Therapy, ATI Physical Therapy, U.S. Physical Therapy, and Upstream Rehabilitation. Some of these competing clinics have longer operating histories and greater name recognition in these communities than our clinics, and they may have stronger relationships 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.

## 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) comply with various requirements and standards. These laws and regulations include those relating to the adequacy of medical care, facilities and equipment, personnel, operating policies and procedures, and recordkeeping, as well as standards for reimbursement, fraud and abuse prevention, and health information privacy and security. These laws and regulations are extremely complex, often overlap and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid, and other federal and state healthcare programs.

### *Facility Licensure*

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

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

### *Professional Licensure, Corporate Practice and Fee-Splitting Laws*

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

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

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

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

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

***Medicare Enrollment and Certification***

In order to participate in the Medicare program and receive Medicare reimbursement, each facility must comply with the applicable regulations of the United States Department of Health and Human Services relating to, among other things, the type of facility, its equipment, its personnel, and its standards of medical care, as well as compliance with all applicable state and local laws and regulations. As of December 31, 2024, all of the critical illness recovery hospitals we operated were certified by Medicare as LTCHs. As of December 31, 2024, 22 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.

***Accreditation***

Our critical illness recovery hospitals and our rehabilitation hospitals receive accreditation from TJC, DNV, CIHQ and/or CARF. As of December 31, 2024, all of the 104 critical illness recovery hospitals and all of the 35 rehabilitation hospitals we operated were accredited by TJC, DNV, or CIHQ. In addition, 30 of our rehabilitation hospitals have also received accreditation from CARF.

***Workers’ Compensation***

Workers’ compensation is a state mandated, comprehensive insurance program that requires employers to fund or insure medical expenses, lost wages, and other costs resulting from work related injuries and illnesses. Workers’ compensation benefits and arrangements vary from state to state, and are often highly complex. In some states, payment for services covered by workers’ compensation programs are subject to cost containment features, such as requirements that all workers’ compensation injuries be treated through a managed care program, or the imposition of fee schedules or payment caps for services furnished to injured employees. Some state workers’ compensation laws limit the ability of an employer to select the providers furnishing care to injured employees. Several states require that physicians furnishing non-emergency services to workers’ compensation patients must register with the applicable state agency and undergo special continuing education and training. Workers’ compensation programs may also impose other requirements that affect the operations of our facilities furnishing outpatient services. Revenue generated directly from workers’ compensation programs represented approximately 15% of our revenue from our outpatient rehabilitation segment, 2% of our revenue from our rehabilitation hospital segment, and 1% of our revenue from our critical illness recovery hospital segment for the year ended December 31, 2024.

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

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

***Overview of U.S. and State Government Reimbursements***

*Medicare Program in General*

The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and CMS. The table below shows the percentage of revenue generated directly from the Medicare program for each of our segments and our company as a whole for the fiscal years ended December 31, 2022, 2023, and 2024.

| | Year Ended December 31, | | |
|---|---|---|---|
| **Medicare Revenue by Segment** | **2022** | **2023** | **2024** |
| Critical illness recovery hospital | 38.0 % | 36.5 % | 32.7 % |
| Rehabilitation hospital | 46.2 % | 47.2 % | 45.3 % |
| Outpatient rehabilitation | 15.6 % | 15.3 % | 15.2 % |
| Total Company | 31.4 % | 30.8 % | 28.8 % |

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

***Medicare Reimbursement of LTCH Services***

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

*Standard Federal Rate*

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

*Patient Criteria*

The Bipartisan Budget Act of 2013, enacted December 26, 2013, established a dual-rate LTCH-PPS for Medicare patients discharged from an LTCH. Specifically, for Medicare patients discharged in cost reporting periods beginning on or after October 1, 2015, LTCHs are reimbursed at the LTCH-PPS standard federal payment rate only if, immediately preceding the patient's LTCH admission, the patient was discharged from a "subsection (d) hospital" (generally, a short-term acute care hospital paid under IPPS) and either the patient's stay included at least three days in an intensive care unit or coronary care unit at the subsection (d) hospital, or the patient was assigned to an MS-LTC-DRG for cases receiving at least 96 hours of ventilator services in the LTCH. In addition, to be paid at the LTCH-PPS standard federal payment rate, the patient's discharge from the LTCH may not include a principal diagnosis relating to psychiatric or rehabilitation services. For any Medicare patient who does not meet these criteria, the LTCH will be paid a "site-neutral" payment rate, which will be the lower of: (i) the IPPS comparable per-diem payment rate capped at the MS-DRG payment rate plus any outlier payments; or (ii) 100 percent of the estimated costs for services. For hospital discharges beginning on or after October 1, 2017 through September 30, 2026, the IPPS comparable per diem payment amount (including any applicable outlier payment) used to determine the site neutral payment rate is reduced by 4.6% after any annual payment rate update.

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

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

In response to the COVID-19 outbreak in the United States, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") was enacted on March 27, 2020. The CARES Act provided two temporary waivers regarding the site-neutral payment to LTCHs. The first waived the LTCH discharge payment percentage requirement for the cost reporting periods that included the emergency period. The second waived the application of the site neutral payment rate so that all LTCH cases admitted during the emergency period were paid the LTCH-PPS standard federal rate. These waivers ended when the public health emergency expired on May 11, 2023. See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes" for further description of the CARES Act provisions.

*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-LTC-DRG standard federal payment rate increases and the percentage of the payment based on the IPPS comparable amount decreases.

*Interrupted Stays*

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

*Freestanding, HIH, and Satellite LTCHs*

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

*Facility Certification Criteria*

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

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

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

*Annual Payment Rate Update*

Fiscal Year 2023. On August 10, 2022, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2023 (affecting discharges and cost reporting periods beginning on or after October 1, 2022, through September 30, 2023). Certain errors in the final rule were corrected in documents published November 4, 2022 and December 13, 2022. The standard federal rate for fiscal year 2023 was set at $46,433, an increase from the standard federal rate applicable during fiscal year 2022 of $44,714. The update to the standard federal rate for fiscal year 2023 included a market basket increase of 4.1%, less a productivity adjustment of 0.3%. The standard federal rate also included an area wage budget neutrality factor of 1.0004304. As a result of the CARES Act, LTCH cases were paid at the standard federal rate during the public health emergency. When the public health emergency ended on May 11, 2023, CMS returned to using the site-neutral payment rate for reimbursement of cases that did not meet the LTCH patient criteria. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $38,518, an increase from the fixed-loss amount in the 2022 fiscal year of $33,015. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $38,788, an increase from the fixed-loss amount in the 2022 fiscal year of $30,988.

Fiscal Year 2024. On August 28, 2023, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2024 (affecting discharges and cost reporting periods beginning on or after October 1, 2023, through September 30, 2024). Certain errors in the final rule were corrected in documents published October 4, 2023 and November 9, 2023. The standard federal rate for fiscal year 2024 was set at $48,117, an increase from the standard federal rate applicable during fiscal year 2023 of $46,433. The update to the standard federal rate for fiscal year 2024 includes a market basket increase of 3.5%, less a productivity adjustment of 0.2%. The standard federal rate also includes an area wage budget neutrality factor of 1.0031599. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS is $59,873, an increase from the fixed-loss amount in the 2023 fiscal year of $38,518. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate is $42,750, an increase from the fixed-loss amount in the 2023 fiscal year of $38,788.

Fiscal Year 2025. On August 28, 2024, CMS published a final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2025 (affecting discharges and cost reporting periods beginning on or after October 1, 2024, through September 30, 2025). Certain errors in the final rule were corrected in a document published on October 2, 2024. In an interim final action document published on October 3, 2024, CMS also made modifications to the fiscal year 2025 policies and payment rates as a result of a recent decision issued by the United States Court of Appeals for the District of Columbia Circuit. The standard federal rate for fiscal year 2025 is $49,383, an increase from the standard federal rate applicable during fiscal year 2024 of $48,117. The update to the standard federal rate for fiscal year 2025 includes a market basket increase of 3.5%, less a productivity adjustment of 0.5%. The standard federal rate also includes an area wage budget neutrality factor of 0.9964315. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS is $77,048, an increase from the fixed-loss amount in the 2024 fiscal year of $59,873. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate is $46,217, an increase from the fixed-loss amount in the 2024 fiscal year of $42,750.

***High Cost Outliers and Criteria for Reconciliation of Outlier Payments***

Under the LTCH PPS, CMS makes two types of outlier payments to LTCHs. First, CMS makes additional payments to LTCHs for high cost outlier cases that have extraordinarily high costs relative to the costs of most discharges. For these cases, CMS sets a fixed loss amount each year that represents the maximum loss an LTCH will incur for a case before qualifying for a high cost outlier payment. A high cost outlier threshold equal to the LTCH PPS adjusted Federal payment for the case plus the fixed loss amount determines when Medicare pays a high cost outlier payment. Such payments are based on 80% of the estimated cost of the case above the high cost outlier threshold. Second, CMS reduces payments to LTCHs for patients with a relatively short stay, which is defined as a length of stay less than or equal to five-sixths of the geometric average length of stay for that particular MS-LTC-DRG. Short stay outlier cases are paid using a per diem rate based on 120% of the MS-LTC-DRG specific per diem amount and an IPPS per diem amount.

Outlier payments made to LTCHs during the cost reporting year may be reconciled at cost report settlement by the Medicare Administrative Contractor (“MAC”) if certain criteria are met. According to CMS, the reconciliation of outlier payments is intended to account for the fact that the LTCH’s cost-to-charge ratio (“CCR”) used to pay Medicare claims during the cost reporting year may differ from the LTCH’s final CCR for the year calculated by the MAC at cost report settlement. The outlier reconciliation criteria were: (1) a change in the LTCH’s CCR of 10 percentage points or more when comparing the actual CCR to the CCR used during the cost reporting period to make outlier payments; and (2) the LTCH received at least $500,000 in outlier payments during the cost reporting period. If the criteria for outlier reconciliation are met, the MAC will conduct an outlier reconciliation to determine whether the LTCH was overpaid or underpaid for outlier cases. If the LTCH was overpaid, the LTCH must repay Medicare in the amount of the overpayment plus the time value of money (*i.e.*, interest). If the LTCH was underpaid, Medicare must pay the LTCH in the amount of the underpayment plus the time value of money.

On April 26, 2024, CMS issued new guidance in Transmittal 12594 changing the criteria for LTCH outlier reconciliations. CMS modified the first criterion to a change in the LTCH’s CCR of 20 percent or more from the CCR used to make outlier payments during the cost reporting period. CMS did not change the second criterion for reconciliation that the LTCH must have received at least $500,000 in outlier payments during the cost reporting period. The revised policy is effective for cost reporting periods beginning on or after October 1, 2024. However, CMS notes that MACs would receive the first cost reports subject to the revised policy in March 2026.

Setting the threshold at 20 percent for changes in the hospital’s CCR will result in more outlier reconciliations. This increases the likelihood that LTCHs will have a portion of their outlier payments recouped by the MAC at cost report settlement. Because outlier reconciliations often delay the final settlement of cost reports, and providers cannot appeal disputed reimbursement amounts until the cost report is settled, this new policy will likely delay more reimbursement appeals related to LTCH cost reports.

***Medicare Reimbursement of IRF Services***

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

*Facility Certification Criteria*

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

*Patient Classification Criteria*

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

*Annual Payment Rate Update*

Fiscal Year 2023. On August 1, 2022, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2023 (affecting discharges and cost reporting periods beginning on or after October 1, 2022, through September 30, 2023). The standard payment conversion factor for discharges for fiscal year 2023 was set at $17,878, an increase from the standard payment conversion factor applicable during fiscal year 2022 of $17,240. The update to the standard payment conversion factor for fiscal year 2023 included a market basket increase of 4.2%, less a productivity adjustment of 0.3%. CMS increased the outlier threshold amount for fiscal year 2023 to $12,526 from $9,491 established in the final rule for fiscal year 2022.

Fiscal Year 2024. On August 2, 2023, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2024 (affecting discharges and cost reporting periods beginning on or after October 1, 2023, through September 30, 2024).Certain errors in the final rule were corrected in a document published on October 4, 2023.The standard payment conversion factor for discharges for fiscal year 2024 was set at $18,541, an increase from the standard payment conversion factor applicable during fiscal year 2022 of $17,878. The update to the standard payment conversion factor for fiscal year 2024 included a market basket increase of 3.6%, less a productivity adjustment of 0.2%. CMS decreased the outlier threshold amount for fiscal year 2024 to $10,423 from $12,526 established in the final rule for fiscal year 2023.

Fiscal Year 2025. On August 6, 2024, CMS published the final rule to update policies and payment rates for the IRF-PPS for fiscal year 2025 (affecting discharges and cost reporting periods beginning on or after October 1, 2024, through September 30, 2025). Certain errors in the final rule were corrected in a document published on October 2, 2024. The standard payment conversion factor for discharges for fiscal year 2025 was set at $18,907, an increase from the standard payment conversion factor applicable during fiscal year 2024 of $18,541. The update to the standard payment conversion factor for fiscal year 2025 included a market basket increase of 3.5%, less a productivity adjustment of 0.5%. CMS increased the outlier threshold amount for fiscal year 2025 to $12,043 from $10,423 established in the final rule for fiscal year 2024.

***Medicare Reimbursement of Outpatient Rehabilitation Clinic Services***

The Medicare program reimburses outpatient rehabilitation providers based on the Medicare physician fee schedule (“MPFS”). Outpatient rehabilitation providers may enroll in Medicare as institutional outpatient rehabilitation facilities (i.e., rehab agencies) or individual physical or occupational therapists in private practice. The majority of our providers are reimbursed through enrolled rehab agencies while the remaining balance of our clinicians are enrolled as individual physical or occupational therapists in private practice.

On an annual basis, our provider reimbursement under the MPFS is subject to changes by CMS, which may include adjustments in our reimbursement based on performance under the Merit-based Incentive Payment System (“MIPS”), and additional incentives for participation in alternative payment models (“APMs”). Historically, outpatient rehabilitation providers were not eligible to participate in the MIPS program. In 2019, CMS added physical and occupational therapists in private practice to the list of MIPS eligible clinicians. For enrolled therapists in private practice, payments under the MPFS are subject to adjustment in a later year based on their performance in MIPS according to established performance standards. Calendar year 2021 was the first year that payments were adjusted, based upon the therapist’s performance under MIPS in 2019. Providers in facility-based outpatient therapy settings, including rehab agencies, are excluded from MIPS eligibility and therefore not subject to this payment adjustment.

As required under the Medicare Access and CHIP Reauthorization Act (“MACRA”), a 0.0% percent update will be applied each year to the fee schedule payment rates for therapy services provided in 2020 through 2025, subject to adjustments under MIPS and APMs. In 2026 and subsequent years, eligible professionals participating in APMs who meet certain criteria will receive annual updates of 0.75%, while all other professionals will receive annual updates of 0.25%. Each year from 2019 through 2024 eligible clinicians who receive a significant share of their revenues through an advanced APM (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus. As required under the Consolidated Appropriations Act, 2023, the bonus payment will be 3.5% in 2025. The Consolidated Appropriations Act, 2024 established a 1.88% bonus payment for eligible clinicians in 2026. 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. To date, none of our outpatient rehabilitation providers participate in qualified APMs.

In the calendar year 2023 MPFS final rule, CMS announced that it calculated the payment rates for the MPFS as if the 3% payment increase in calendar year 2022 from the Protecting Medicare and American Farmers from Sequester Cuts Act was never applied. The statute stated that the 3% payment increase for 2022 shall not be taken into account in determining the payment rates for subsequent years. As a result, physician fee schedule payments were expected to decrease 4.5% in 2023. CMS stated in the final rule that it expected that its policies for 2023 would result in a 1% decrease in Medicare payments for the therapy specialty, but this decrease did not account for the effects of the end of the 3% payment increase from 2022. However, Congress passed the Consolidated Appropriations Act, 2023, which required the Secretary to increase 2023 physician fee schedule payments by 2.5% and 2024 payments by 1.25%. As a result, payments under the 2023 MPFS physician fee schedule decreased by 2% in 2023. Medicare payments were also due to decrease by an additional 4% in 2023 due to mandatory cuts required under the PAYGO Act of 2010. The Consolidated Appropriations Act, 2023, further delayed PAYGO until 2025. The calendar year 2023 final rule also included further development of MIPS Value Pathways (“MVPs”) to transition the MIPS program. CMS began the transition to MVPs in 2023 with an initial set of MVPs in which reporting is voluntary. First, CMS revised the first set of seven MVPs that it adopted in the calendar year 2022 final rule. CMS removed certain improvement activities from these seven MVPs and added other quality measures for voluntary reporting by participants in these MVPs. In addition, CMS added five new MVPs that were available for voluntary reporting for the calendar year 2023 performance period.

In the calendar year 2024 MPFS final rule, CMS calculated the payment rates without the 2.5% payment increase to calendar year 2023 rates from the Consolidated Appropriations Act of 2023, but with the 1.25% payment increase to calendar year 2024 rates from that legislation. As a result of the lower statutory payment increase for calendar year 2024 and a negative 2.20% budget neutrality adjustment associated with changes to the relative value units, physician fee schedule payments are expected to decrease in 2024. CMS expected that its final policies for 2024 will result in a 3% decrease in Medicare payments for the therapy specialty. CMS also adopted changes to the quality payment program, including the transition from MIPS to the MVPs. First, CMS revised the existing set of 12 MVPs that it previously adopted in the calendar year 2022 and 2023 final rules. CMS removed certain improvement activities from these MVPs and added other quality measures for MVP participants to choose from for data reporting. CMS also consolidated two of the existing MVPs into a single primary care MVP. Finally, CMS added five new MVPs. According to CMS, the new Rehabilitative Support of Musculoskeletal Care MVP will be most applicable to clinicians who specialize in rehabilitation support for musculoskeletal care, including physical therapists and occupational therapists. These new MVPs are available for voluntary reporting for the calendar year 2024 performance period.

In the calendar year 2025 MPFS final rule, CMS calculated the payment rates without the 1.25% and 2.93% payment increases under the Consolidated Appropriations of 2023 and 2024, respectively. However, CMS expects that its policies for 2025 will not result in any increase or decrease in Medicare payments for the therapy specialty. CMS also continued to expand the MVPs in anticipation of future retirement of traditional MIPS. CMS added six new MVPSs available for reporting in the calendar year 2025 performance period. CMS also made modifications to the quality measures, improvement activities, and cost measures for the previously adopted MVPs, including the Rehabilitative Support for Musculoskeletal Care MVP.

*Therapy Caps*

Outpatient therapy providers reimbursed under the MPFS have historically been subject to annual limits for therapy expenses. The Bipartisan Budget Act of 2018 repealed the annual limits on outpatient therapy, but the law preserves the former therapy cap amounts as thresholds above which claims must include a modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. The threshold is applied to physical therapy and speech therapy services combined and separately applied to occupational therapy. For calendar year 2022, this modifier threshold amount was $2,150. For calendar year 2023, the modifier threshold amount was $2,230. For calendar year 2024, the modifier threshold amount is $2,330. For calendar year 2025, CMS set the modifier threshold amount at $2,410. This amount is indexed annually by the Medicare Economic Index. Claims for services over the modifier threshold amounts without the modifier are denied. Along with the modifier threshold, the Bipartisan Budget Act of 2018 retained the targeted medical review process that was established in the Medicare Access and CHIP Reauthorization Act of 2015. For calendar year 2018 through calendar year 2028, all therapy claims exceeding $3,000 are subject to a targeted manual medical review process. The $3,000 threshold is applied to physical therapy and speech therapy services combined and separately applied to occupational therapy. Beginning in 2028 and in each calendar year thereafter, the threshold amount for claims requiring targeted manual medical review will increase by the percentage increase in the Medicare Economic Index.

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

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

The calendar year 2024 MPFS final rule did not contain any policy changes concerning the modifiers for services provided by physical therapy and occupational therapy assistants. However, the final rule included one change to Medicare policies relating to supervision of services provided by physical therapy assistants and occupational therapy assistants.In the final rule, CMS established a general supervision policy for remote therapeutic monitoring services provided by physical therapy assistants and occupational therapy assistants in private practice settings. In the calendar year 2025 MPFS final rule, CMS modified the supervision requirement for services provided by PTAs and OTAs in private practice settings. CMS previously required that physical therapists and occupational therapists provide direct supervision of PTAs and OTAs in private practice settings. However, starting January 1, 2025, a general supervision requirement will apply in private practice settings. One documentation requirement for Medicare payment of outpatient physical therapy and occupational therapy services is that a physician establish a plan of care prescribing the type, amount, and duration of services. The plan of care can be established by a physician or a qualified physical therapist or occupational therapist, but it must be reviewed periodically by a physician. Medicare requires that a physician certify that the patient needs therapy, a plan of care was established, and the services were furnished under the care of a physician before it will pay for outpatient physical therapy and occupational therapy services. In the calendar year 2025 MPFS final rule, CMS established an exception to the requirement for a physician signature on the certification when there is a written order or referral from the physician or non-physician practitioner in the medical record and there is evidence in the medical record that the therapist delivered the plan of care to the physician or non-physician practitioner within 30 days after the initial evaluation.

*Other Requirements for Payment*

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

***Medicaid Reimbursement of LTCH and IRF Services***

The Medicaid program is designed to provide medical assistance to individuals unable to afford care. The program is governed by the Social Security Act of 1965, funded jointly by each individual state and the federal government and administered by state agencies. Medicaid payments are made under a number of different systems, which include cost based reimbursement, prospective payment systems, or programs that negotiate payment levels with individual hospitals. In addition, Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies, and certain government funding limitations, all of which may increase or decrease the level of program payments to our hospitals. Revenue generated directly from the Medicaid program represented approximately 5% of our critical illness recovery hospital segment revenue and 2% of our rehabilitation hospital segment revenue for the year ended December 31, 2024.

***Other Healthcare Regulations***

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

The Secretary of Health and Human Services (“HHS”) authorized a number of waivers or modifications of certain requirements under Medicare, Medicaid and the Children’s Health Insurance Program (“CHIP”) pursuant to section 1135 of the Social Security Act in response to the COVID-19 outbreak in the United States. However, most of these waivers ended when the COVID-19 public health emergency expired on May 11, 2023. For a description of such waivers and modifications, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes.”

*Medicare Quality Reporting*

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

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

*Medicare Hospital Wage Index Adjustment*

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

*Physician-Owned Hospital Limitations*

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

Under the transparency and program integrity provisions of the Affordable Care Act ("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, 2024, 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. RACs are paid on a contingency fee basis. The contingency fee is a percentage of improper overpayment recoveries or underpayments identified by the RAC. The RAC must return the contingency fee if an improper payment determination is reversed on appeal. RACs conduct audit activities nationwide in four regions of the country that cover all 50 states on a combined basis. RAC audits of our Medicare reimbursement may lead to assertions that we have been overpaid, require us to incur additional costs to respond to requests for records and pursue the reversal of payment denials through appeals, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict the impact of future RAC reviews on our results of operations or cash flows.

*Fraud and Abuse Enforcement*

Various federal and state laws prohibit the submission of false or fraudulent claims, including claims to obtain payment under Medicare, Medicaid, and other government healthcare programs. Penalties for violation of these laws include civil and criminal fines, imprisonment, and exclusion from participation in federal and state healthcare programs. In recent years, federal and state government agencies have increased the level of enforcement resources and activities targeted at the healthcare industry. In addition, the federal False Claims Act and similar state statutes allow individuals to bring lawsuits on behalf of the government, in what are known as qui tam or "whistleblower" actions, alleging false or fraudulent Medicare or Medicaid claims or other violations of the statute. The use of these private enforcement actions against healthcare providers has increased dramatically in recent years, in part because the individual filing the initial complaint is entitled to share in a portion of any settlement or judgment. Revisions to the False Claims Act enacted in 2009 expanded significantly the scope of liability, provided for new investigative tools, and made it easier for whistleblowers to bring and maintain False Claims Act suits on behalf of the government. See "Item 3. 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 work plan includes (1) a nationwide audit of IRF claims, (2) a review to determine whether recipients of Provider Relief Fund payments complied with Federal requirements and the terms and conditions for reporting and spending such payments, (3) an audit to determine whether hospital price transparency information required by CMS is readily available, and (4) a review to determine whether hospitals are correctly billing for sepsis patients. We monitor government publications applicable to us to supplement and enhance our compliance efforts.

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

*Remuneration and Fraud Measures*

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

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

*Provider-Based Status*

The designation “provider-based” refers to circumstances in which a subordinate facility (such as a separately certified Medicare provider, a department of a provider, or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included on the “main” provider’s cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. As of December 31, 2024, we operated 18 critical illness recovery hospitals and nine rehabilitation hospitals that were treated as provider-based satellites of certain of our other facilities. In addition, 285 of the outpatient rehabilitation clinics we operated were provider-based and operated as departments of the rehabilitation hospitals we operated. We also provide rehabilitation management and staffing services to hospital rehabilitation departments that may be treated as provider-based. These facilities are required to satisfy certain operational standards in order to retain their provider-based status.

*Health Information Practices*

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

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

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

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

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

During the COVID-19 public health emergency, the Department of Health and Human Services issued four Notifications of Enforcement Discretion announcing that HIPAA rules would not be applied to certain activities related to the response to COVID-19. For example, one of the Notifications of Enforcement Discretion promoted the use of telehealth by waiving HIPAA penalties for providers that used telehealth in good faith during the public health emergency. However, these Notifications of Enforcement Discretion related to HIPAA ended on May 11, 2023, when the public health emergency expired.

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

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

*IMPACT Act*

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

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

In addition to the new reporting requirements, the IMPACT Act outlined a process for the potential development of a unified PAC PPS. The IMPACT Act does not require CMS to adopt a unified PAC PPS, nor does it provide CMS with specific authority to implement a new payment system. However, the IMPACT Act required HHS and MedPAC to submit a series of reports to Congress with recommendations and a technical prototype for a PAC PPS. These recommendations and prototypes could become the basis of future legislation that would create a unified PAC PPS to replace some or all of the existing Medicare payment systems for LTCHs, IRFs, SNFs, and HHAs. MedPAC submitted the first report to Congress in June 2016. The report included recommended features for a unified PAC payment system based on the Post-Acute Payment Reform Demonstration (“PAC-PRD”). In July 2022, HHS submitted its report to Congress with a technical prototype for a united PAC PPS developed around criteria stated in the IMPACT Act. Under this payment system prototype, a Medicare beneficiary would be assigned to one of 32 Unified PAC Clinical Groups (“UPCGs”) and to a PAC Case-Mix Group (“P-CMG”) specific to the UPCG. The combination of the assigned UPCG and P-CMG would determine the base payment weight, which is then adjusted according to certain factors, including beneficiary comorbidities and provider type. There are three general categories of UPCGs in the prototype which are intended to represent the patient’s primary reason for needing PAC care: (1) Rehabilitation and Therapy-Focused, (2) Medical and Diagnosis-Focused, and (3) Medication Management, Teaching and Assessment. Each UPCG has its own P-CMGs to differentiate patients based on their clinical characteristics and relative costliness. The report states that universal implementation of a unified PAC PPS cannot be accomplished under CMS’s existing statutory authority. By June 30, 2023, MedPAC was required to submit an additional report to Congress with recommendations and a technical prototype for a new PAC payment system that would satisfy the same criteria HHS was directed to use. MedPAC issued a report in June 2023 with its final analysis and recommendations on the design of a unified PAC PPS. MedPAC concluded that a unified PAC PPS is feasible, but would disproportionately impact payments for certain PAC provider types, particularly LTCHs. MedPAC believes designing a unified PAC PPS would be relatively straightforward, but it would be more complicated to develop and implement such a payment system. According to MedPAC, a unified PAC PPS would also require companion policies, including changes to cost sharing requirements, a value-based incentive program, and uniform Medicare conditions of participation.

*Price Transparency*

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

CMS revised the price transparency regulations in the calendar year 2024 Outpatient Prospective Payment System final rule. Effective January 1, 2024, hospitals are required to display pricing information in a standardized format that conforms to a CMS template, data specifications, and data dictionary. Other changes are intended to improve the accessibility of the pricing data. Hospitals are also required to provide an affirmation statement confirming that the pricing information is up-to-date and accurate. In addition, CMS expanded its price transparency enforcement tools, including a required acknowledgement by hospitals of any notice of violations of the price transparency rules, the ability for CMS to notify health system leadership of provider violations, and the potential for CMS to publish on its website information regarding hospital violations of the price transparency rules. Beginning January 1, 2025, hospitals must display additional data elements, including an estimated allowed amount for standard charges, drug unit and type of measurement, and modifiers that could change the standard charge.

*Surprise Billing*

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

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

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

The Texas Medical Association filed four lawsuits against HHS challenging certain provisions in the IDR rules. The court agreed with several of the legal claims asserted by the Texas Medical Association and vacated portions of the HHS rules and guidance. As a result, HHS issued new rules and guidance for the IDR process, including updates to the process for the batching of claims for IDR and removal of the rebuttable presumption that the QPA is the appropriate payment amount.

HHS appealed the district court's decision in the second Texas Medical Association case to the United States Court of Appeals for Fifth Circuit. In this case, the Texas Medical Association argued that the HHS continued to improperly use the QPA as the benchmark rate. On August 2, 2024, the Fifth Circuit issued a decision affirming the district court's decision in favor of Texas Medical Association which vacated HHS' rules making the QPA a de facto benchmark in the IDR process. The Texas Medical Association and HHS also appealed the district court's decision in the third case to the Fifth Circuit. The Texas Medical Association argued in this case that HHS' rules artificially deflated the amount used in arbitration to decide the appropriate out-of-network rate and therefore violated the plain text of the law. On October 30, 2024, the Fifth Circuit partially reversed the district court's decision. The Fifth Circuit rejected the Texas Medical Association's argument that HHS' use of "ghost rates" (*i.e.*, rates that technically exist, but are not actually billed by providers) in the QPA violates the No Surprises Act. Additionally, the Fifth Circuit held that HHS had the authority to exclude case-specific payment agreements and bonus payments from the QPA. The Fifth Circuit also affirmed the district court's decision vacating HHS' implementation of the 30-calendar day deadline for insurers to provide an initial payment or notice of denial. Finally, the Fifth Circuit affirmed the district court's holding that plans do not have to disclose additional information regarding QPA calculations. HHS says that it is reviewing the Fifth Circuit's decision and intends to issue further guidance in the near future.

## Compliance Program

### *Our Compliance Program*

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

### *Compliance and Audit Committee*

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

### *Operating Our Compliance Program*

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

### *Compliance Issue Reporting*

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

### *Compliance Monitoring and Auditing / Comprehensive Training and Education*

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

### *Policies and Procedures Reflecting Compliance Focus Areas*

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

### *Internal Audit*

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

## Available Information

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

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

### Executive Officers of the Registrant

The following table sets forth the names, ages and titles, as well as a brief account of the business experience, of each person who was an executive officer of the Company as of February 20, 2025:

| Name | Age | Position |
|---|---|---|
| Robert A. Ortenzio | 67 | Executive Chairman and Co-Founder |
| David S. Chernow | 67 | Chief Executive Officer |
| Martin F. Jackson | 70 | Senior Executive Vice President, Strategic Finance and Operations |
| Michael F. Malatesta | 55 | Executive Vice President and Chief Financial Officer |
| John A. Saich | 56 | President |
| Thomas P. Mullin | 41 | President |
| Michael E. Tarvin | 64 | Senior Executive Vice President, General Counsel and Secretary |
| Brian R. Rusignuolo | 49 | Executive Vice President and Chief Information Officer |
| Christopher S. Weigl | 41 | Senior Vice President, Controller and Chief Accounting Officer |
| Robert G. Breighner, Jr. | 55 | Senior Vice President, Compliance and Audit |

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

*David S. Chernow* serves as our Chief Executive Officer. Previously, he served as President and Chief Executive Officer from January 2014 to October 2023 and as President from September 2010 to January 2014. 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 Senior Executive Vice President of Strategic Finance and Operations since October 2023. Previously, he was Executive Vice President and Chief Financial Officer from February 2007 to October 2023, and 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.

*Michael F. Malatesta* has served as our Executive Vice President and Chief Financial Officer since October 2023. Previously, he was Senior Vice President of Finance from November 2013 to October 2023. Before that, Mr. Malatesta held the positions of Vice President of Outpatient Finance from October 2010 to November 2013, Outpatient Controller from 2002 to 2010, and Director of Outpatient Revenue Accounting from 2000 to 2002. He began his career at the Company in 1999 as an Accounting Manager for NovaCare Rehabilitation. Prior to joining the Company, Mr. Malatesta held financial roles at Tenet Healthcare, Health Partners Insurance of Philadelphia and the Graduate Health System. He is a certified public accountant and began his career in public accounting at Deloitte & Touche LLP.

*John A. Saich* has served as our President since October 2023. Previously, he held the positions of Executive Vice President and Chief Administrative Officer from October 2018 to October 2023, and 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.

*Thomas P. Mullin* has served as President since October 2023. Previously, he was our Executive Vice President of Hospital Operations from August 2020 to October 2023, President of the Specialty Hospital Divisions from November 2018 to August 2020, and Chief Operating Officer of Specialty Hospitals from January 2018 to November 2018. He served as Chief Operating Officer of our CIRH Division from October 2016 to January 2018. Mr. Mullin served as Senior Vice President, Business and Market Development in our CIRH Division from July 2015 to September 2016. He served as Regional Vice President in our CIRH Division from September 2014 to July 2015. He held other positions in our CIRH Division from June 2008 to September 2014.

*Michael E. Tarvin* has served as our Senior Executive Vice President, General Counsel and Secretary since October 2023. Previously, he was Executive Vice President, General Counsel and Secretary from February 2007 to October 2023. Mr. Tarvin held the positions of Senior Vice President, General Counsel and Secretary from November 1999 to February 2007, and 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.

*Brian R. Rusignuolo* has served as our Executive Vice President and Chief Information Officer since January 2021. Previously, he was Senior Vice President and Chief Information Officer from December 2012 to January 2021. Mr. Rusignuolo held the positions of Senior Vice President, Information Security from October 2011 to December 2012, and Vice President, Information Security from January 2010 to October 2011. Prior to becoming an officer of the Company, he held a variety of leadership positions in the Company's Information Systems Department beginning in January 2001. Earlier in his career, he was an Environmental Scientist for DynCorp and a Park Ranger for the National Park Service. Mr. Rusignuolo is committed to serving others as a member and leader of professional and community organizations including, the Technology Council of Central Pennsylvania, the IT Board of Advisors of Harrisburg University of Science and Technology, and the Penn State Harrisburg IT Advisory Board.

*Christopher S. Weigl* is a certified public accountant who has served as our Senior Vice President, Controller & Chief Accounting Officer since March 2023. Prior to that, he served as our Senior Vice President of Corporate Accounting Services from August 2022 through February 2023. He served as the Vice President of Finance and Accounting Operations of MedStar Health Inc. from June 2016 to July 2022. Prior to that, he was employed by PricewaterhouseCoopers LLP from September 2005 to June 2016, most recently in the role of Assurance Senior Manager.

*Robert G. Breighner, Jr.* has served as our Senior Vice President of Compliance and Audit since October 2023. Previously, he was Vice President, Compliance and Audit Services from August 2003 to October 2023, and Director of Internal Audit from November 2001 to August 2003. Before joining the Company, Mr. Breighner was with Susquehanna Pfaltzgraff Co. where he held a variety of leadership roles, including Director of Internal Audit.

**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 Medicare reimbursements for our services, our revenue and profitability could decline.***

Revenues from providing services to patients covered under the Medicare program represented approximately 31%, 31%, and 29% of our revenue for the years ended December 31, 2022, 2023, and 2024, respectively.

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

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

***Adverse economic conditions including an inflationary economic environment in the U.S. or globally could adversely affect us.***

Our business is exposed to fluctuating market conditions, including rising interest rates. A continued economic downturn or recession, or slowing or stalled recovery therefrom, may have a material adverse effect on our business, financial condition or results of operations, as it could negatively impact our current and prospective patients, adversely affect the financial ability of health insurers to pay claims, adversely impact our ability to pay our expenses, and limit our ability to obtain financing for our operations.

Healthcare spending in the U.S. could be negatively affected in the event of a downturn in economic conditions. For example, patients who have lost their jobs or healthcare coverage may no longer be covered by an employer-sponsored health insurance plan and patients reducing their overall spending may elect to decrease the frequency of visits to our facilities or forgo elective treatments or procedures, thereby reducing demand for our services.

Inflation has increased throughout the U.S. economy. In an inflationary environment, we may continue to experience increases in the prices of labor and other costs of doing business. Cost increases may outpace our expectations, causing us to use our cash and other liquid assets faster than forecasted. If we are unable to successfully manage the effects of inflation, our business, operating results, cash flows and financial condition may be adversely affected.

***Labor shortages, increased employee turnover, increases in employee-related costs, and union activity could have adverse effects including significant increases in our operating costs.***

We have experienced and may continue to experience decreased profitability due to increased employee-related costs. A number of factors contribute to increased labor costs, such as constrained staffing due to a shortage of healthcare workers, increased dependence on contract clinical workers, the cost of recruiting and training new employees, the cost of retaining existing staff, and other government regulations, which include laws and regulations related to workers’ health and safety.

Our critical illness recovery hospitals and our rehabilitation hospitals are highly dependent on nurses and our outpatient rehabilitation division is highly dependent on therapists for patient care. The market for qualified healthcare professionals is highly competitive. Difficulties in attracting and retaining qualified healthcare personnel can limit our ability to staff our facilities. It has also led us to use agency clinical staff in our facilities, which can increase our costs and lower our margins. Additionally, the cost of attracting, training, and retaining qualified healthcare personnel may be higher than historical trends and, as a result, our profitability could decline.

While we have historically experienced some level of ordinary course employee turnover, the continuing impact of the COVID-19 pandemic and its aftermath have exacerbated labor shortages and increased employee turnover. Increased employee turnover rates within our employee base can lead to decreased efficiency and increased costs, such as increased overtime to meet demand, increased compensation and bonuses to attract and retain employees, and incremental training costs.

An overall or prolonged labor shortage, lack of skilled labor, increased employee turnover or continued increase in the cost of recruiting and retaining employees could have a material adverse impact on our operations, results of operations, liquidity or cash flows.

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

***Public health threats such as a global pandemic, or widespread outbreak of infectious disease, similar to the COVID-19 pandemic, may create uncertainties about our future operating results and financial conditions.***

Public health threats, such as COVID-19 or any other pandemic, may have an impact on our business and results of operations, financial position, and cash flows. Prolonged volatility or significant disruption of global financial markets due in part to a public health threat could have a negative impact on our business and overall financial position. Other factors and uncertainties include, but are not limited to, adverse impacts on patient volumes and revenue, increased operational costs associated with operating during and after a pandemic; evolving macroeconomic factors, including general economic uncertainty, increased labor costs, and recessionary pressures; capital and other resources needed to respond to a pandemic; along with the severity and duration of a pandemic. These risks and their impacts are difficult to predict and could continue to otherwise disrupt and adversely affect our operations and our financial performance.

***Unfavorable global economic conditions brought about by material global crises, military conflicts or war, geopolitical and trade disputes or other factors, may adversely affect our business and financial results.***

Our business may be sensitive to global economic conditions, which can be adversely affected by political and military conflict, trade and other international disputes, significant natural disasters (including as a result of climate change) or other events that disrupt macroeconomic conditions.

For example, trade policies and geopolitical disputes (including as a result of China-Taiwan relations) and other international conflicts can result in tariffs, sanctions and other measures that restrict international trade, and may adversely affect our business. Countries may also adopt other measures, such as controls on imports or exports of goods, technology or data, that could adversely impact our operations.

Further, military conflicts or wars (such as the ongoing conflicts between Russia and Ukraine and Israel and Palestine) can cause exacerbated volatility and disruptions to various aspects of the global economy. The uncertain nature, magnitude, and duration of hostilities stemming from such conflicts, including the potential effects of sanctions and counter-sanctions, or retaliatory cyber-attacks on the world economy and markets, have contributed to increased market volatility and uncertainty, which could have an adverse impact on macroeconomic factors that affect our business and operations, such as worldwide supply chain issues. It is not possible to predict the short and long-term implications of military conflicts or wars or geopolitical tensions which could include further sanctions, uncertainty about economic and political stability, increases in inflation rate and energy prices, cyber-attacks, supply chain challenges and adverse effects on currency exchange rates and financial markets.

***CMS finalized record increases to the high cost outlier fixed loss amount for LTCH-PPS standard Federal payment rate cases in FY 2024 and FY 2025 and, unless there are significant reforms, the fixed loss amount will likely increase again in FY 2026, which will result in fewer cases qualifying for high cost outlier payments and often lower payments for the cases that do qualify.***

Under the LTCH-PPS, CMS makes additional payments to LTCHs for high cost outlier cases that have extraordinarily high costs relative to the costs of most discharges. Each year, CMS sets a fixed loss amount that represents the maximum loss an LTCH will incur for a case before qualifying for a high cost outlier payment. For each case, CMS determines the high cost outlier threshold, which is an amount equal to the LTCH-PPS adjusted Federal payment for the case, plus the fixed loss amount. Payments for qualifying high cost outlier cases are based on 80% of the estimated cost of the case above the high cost outlier threshold. When CMS increases the fixed loss amount, our LTCHs have fewer cases that qualify for outlier payments and often lower payments for the cases that do qualify. In the FY 2024 IPPS/LTCH-PPS Proposed Rule, CMS proposed an unprecedented increase to the fixed loss amount, from $38,518 to $94,378. In the FY 2024 IPPS/LTCH-PPS Final Rule, CMS set the fixed loss amount at $59,873 after considering comments and making some methodological changes. Although this was a lower fixed loss amount than initially proposed, it was still the largest one-year increase to the fixed loss amount for the LTCH-PPS. In the FY

2025 IPPS/LTCH-PPS Proposed Rule, CMS proposed another significant increase to the fixed loss amount, to $90,921. However, after incorporating more recent data, CMS set the fixed-loss amount at $77,048 in the FY 2025 IPPS/LTCH-PPS Final Rule. There are several factors that have likely caused the recent increases to the fixed loss amount, including the COVID-19 pandemic, the LTCH-PPS dual payment rate structure with the site neutral payment rate, and inflation. These factors may continue to impact the LTCH-PPS rate setting in future years, including the upcoming FY 2026 rate setting for the Federal fiscal year that begins on October 1, 2025. As a result, there is a risk that CMS will continue to increase the fixed loss amount, which would reduce the Medicare payment for many of the most costly patients treated at our LTCHs.

The effects of the COVID-19 pandemic on the dataset CMS uses for rate setting is one factor that is contributing to the recent increases to the LTCH-PPS high cost outlier fixed loss amount for standard Federal payment rate cases. The standard methodology CMS uses to calculate the fixed loss amount is based on claims data that are two years old and cost report data that are three years old. Therefore, even though the COVID-19 public health emergency ended on May 11, 2023, the cost report data used to calculate the fixed-loss amount will continue to be affected by abnormal LTCH utilization and case-mix that occurred during the COVID-19 pandemic until June 2026. As long as CMS uses data impacted by the COVID-19 public health emergency and associated waivers, the fixed loss amount will reflect increased costs and utilization patterns that were unique to the pandemic.

Another contributing factor to the recent increases to the fixed loss amount is the dual payment rate structure of the LTCH-PPS. CMS has not accounted for the effects of the dual payment rate structure on high cost outliers. The site neutral payment rate has significantly reduced the number of standard Federal payment rate cases in the dataset used for setting the fixed loss amount and has caused some operators to close LTCHs, which further reduces the dataset. The site neutral payment rate also has led to more concentration of patients assigned to DRGs likely to meet the patient criteria. Despite these changes to the LTCH-PPS, CMS has not modified its high cost outlier rate setting process to account for their effects.

Finally, recent increases to the fixed loss amount may be attributable to rising inflation in the United States, and in the healthcare sector specifically. LTCHs have been subject to relatively large increases in labor, supply, and drug costs in recent years. for example, the American Hospital Association found that the growth in hospital labor costs from 2014 to 2023 significantly outpaced economy-wide inflation over the same period. However, CMS has not directly accounted for these cost increases when calculating the fixed loss amount. If CMS does not address these factors, it is likely that the fixed loss amount for FY 2026 will increase further, which will reduce the Medicare payment for high cost outlier cases.

***CMS changed the criteria for reconciliation of outlier payments, which could lead to more recoupments of Medicare outlier payments from our LTCHs.***

Our LTCHs receive two types of outlier payments from Medicare: (1) high cost outlier payments, and (2) short stay outlier payments. If specific criteria are met, LTCH outlier payments may be subject to reconciliation by the MAC at the time of cost report settlement. The MAC will conduct the outlier reconciliation when the criteria are met and will determine if Medicare underpaid or overpaid the LTCH for outlier payments during the LTCH’s cost reporting period. If Medicare overpaid the LTCH for outlier payments, then the LTCH must repay Medicare the amount of the overpayment, plus an additional payment for the time value of money (i.e., interest).

Our LTCH cost reports have been subject to outlier reconciliations in the past and the LTCHs have had to repay significant amounts to the Medicare program. For cost reports that started prior to October 1, 2024, the criteria for an outlier reconciliation were: (1) a change in the LTCH’s CCR of 10 percentage points or more when comparing the actual CCR to the CCR used during the cost reporting period to make outlier payments; and (2) the LTCH received at least $500,000 in outlier payments during the cost reporting period.

CMS recently modified the first criterion for identifying cost reports subject to outlier reconciliation. Beginning with cost reporting periods starting on or after October 1, 2024, the first criterion now specifies that the LTCH is subject to reconciliation if the actual CCR is found to be plus or minus 20 percent or more from the CCR used during the cost reporting period to make outlier payments. CMS did not change the second criterion regarding the outlier payments exceeding $500,000.

CMS’s change to the first criterion will likely result in the MACs conducting more outlier reconciliations when settling our LTCH cost reports. These outlier reconciliations could lead to the MACs recouping payments from our LTCHs if the MACs find that the Medicare program overpaid the LTCH for outlier payments during the cost reporting period. Outlier reconciliations also delay final settlement of the cost report, which prevents the LTCH from pursuing a reimbursement appeal related to its cost report.

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

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

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

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

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

As of December 31, 2024, we operated 104 critical illness recovery hospitals, all of which are currently certified by Medicare as LTCHs. LTCHs must meet certain conditions of participation to enroll in, and seek payment from, the Medicare program as an LTCH, including, among other things, maintaining an average length of stay for Medicare patients in excess of 25 days. An LTCH that fails to maintain this average length of stay for Medicare patients in excess of 25 days during a single cost reporting period is generally allowed an opportunity to show that it meets the length of stay criteria during a subsequent cure period. If the LTCH can show that it meets the length of stay criteria during this cure period, it will continue to be paid under the LTCH-PPS. If the LTCH again fails to meet the average length of stay criteria during the cure period, it will be paid under the general acute care hospital IPPS at rates generally lower than the rates under the LTCH-PPS.

CMS issued temporary waivers that exempted LTCHs from the 25 day average length of stay requirement for all cost reporting periods that included the COVID-19 pandemic public health emergency. Medicare cost reporting periods for our LTCHs that began after May 11, 2023, are again required to comply with this rule. See “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes.”

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

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

Our outpatient rehabilitation clinics receive payments from the Medicare program under the Medicare physician fee schedule. In the calendar year 2024 physician fee schedule final rule, CMS announced that Medicare payments for the therapy specialty are expected to decrease 3% in 2024. Congress passed the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, which provided a one-time 2.5% increase in payments in calendar year 2023 to offset some of the 4.5% cut to payments for therapy and other services paid under the physician fee schedule that otherwise would have occurred in calendar year 2023, and a one-time 1.25% increase in payments in calendar year 2024. However, these one-time increases have only partially offset CMS's cuts to the physician fee schedule conversion factor. Even with the statutory 1.25% increase, the calendar year 2024 conversion factor was still 3.4% less than the calendar year 2023 conversion factor. In the Consolidated Appropriations Act, 2024, Congress replaced the 1.25% increase in payments for calendar year 2024 with a 2.93% increase that applied starting on March 9, 2024. For calendar year 2025, CMS calculated the physician fee schedule conversion factor without the 1.25% and 2.93% statutory increases. CMS does not expect its policies for 2025 will result in any increase or decrease in Medicare payments for the therapy specialty. However, without any further Congressional action, the calendar year 2025 conversion factor will be 2.83% less than the calendar year 2024 conversion factor.

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 requires that payments under the physician fee schedule be adjusted starting in 2019 based on performance in a MIPS and additional incentives for participation in APMs. The specifics of the MIPS and incentives for participation in APMs will be subject to future notice and comment rule-making. In 2019, CMS added physical and occupational therapists to the list of MIPS eligible clinicians. For these therapists in private practice, payments under the fee schedule are subject to adjustment in a later year based on their performance in MIPS according to established performance standards. Calendar year 2021 was the first year that payments were adjusted, based upon the therapist's performance under MIPS in 2019. Each year from 2019 through 2024 eligible clinicians who receive a significant share of their revenues through an advanced APM (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus. As required under the Consolidated Appropriations Act, 2023, the bonus payment will be 3.5% in 2025. The Consolidated Appropriations Act, 2024 established a 1.88% bonus payment for eligible clinicians in 2026. The bonus payment for APM participation is intended to encourage participation and testing of new APMs and to promote the alignment of incentives across payors. Providers in facility-based outpatient therapy settings are excluded from MIPS eligibility and therefore not subject to this payment adjustment. It is unclear what impact, if any, the MIPS and incentives for participation in alternative payment models will have on our business and operating results, but any resulting administrative burden or decrease in payment may reduce our future revenue and profitability.

In the calendar year 2022 physician fee schedule final rule, CMS also adopted its plan to transition the MIPS program to MVPs. CMS began the transition to MVPs in 2023 with an initial set of MVPs in which reporting is voluntary. In the calendar year 2023 physician fee schedule final rule, CMS revised the initial set of MVPs and added five new MVPs. In the same final rule, CMS added five new MVPs including the Rehabilitative Support of Musculoskeletal Care MVP that will be applicable to physical therapists and occupational therapists. Beginning in 2026, multispecialty groups must form subgroups to report MVPs. CMS plans to develop more MVPs from 2024 to 2027 and is considering that MVP reporting could become mandatory in 2029. Each MVP includes population health claims-based measures and requires clinicians to report on the Promoting Interoperability performance category measures. In addition, MVP participants select certain quality measures and improvement activities and then report data for such measures and activities. At this time, the impact that the transition to MVPs will have on our business and operating results is unclear, however, any resulting administrative burden or decrease in reimbursement rates may reduce our future revenue and profitability.

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

As of December 31, 2024, we operated 35 rehabilitation hospitals, 34 of which were certified by Medicare as IRFs. Our rehabilitation hospitals must meet certain conditions of participation to enroll in, and seek payment from, the Medicare program as an IRF. Among other things, at least 60% of the IRF's total inpatient population must require treatment for one or more of 13 conditions specified by regulation. This requirement is now commonly referred to as the "60% Rule." Compliance with the 60% Rule is demonstrated through a two-step process. The first step is the "presumptive" method, in which patient diagnosis codes are compared to a "presumptive compliance" list. IRFs that fail to demonstrate compliance with the 60% Rule using this presumptive test may demonstrate compliance through a second step involving an audit of the facility's medical records to assess compliance.

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

CMS issued temporary waivers in response to the COVID-19 pandemic that allowed IRFs, IRF units and hospitals and units applying to be classified as IRFs to exclude patients admitted solely to respond to the public health emergency from the 60% Rule. These waivers expired on May 11, 2023, when the COVID-19 public health emergency ended and admissions to our IRFs are once again counted for purposes of the 60% Rule. See "Management's Discussion and Analysis of Financial Condition and Results of Operations—Regulatory Changes."

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

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

Beginning August 21, 2023, CMS implemented a five-year review choice demonstration ("RCD") for IRF services in Alabama. On March 1, 2024, CMS expanded RCD to IRFs in Pennsylvania. CMS plans to further expand RCD to Texas and California, but the timing of this expansion is not known. We operate inpatient rehabilitation hospitals in Pennsylvania, Texas and California. CMS has announced it will expand RCD to include additional IRFs based on the Medicare Administrative Contractor to which those IRFs submit claims. Under RCD, participating IRFs have an initial choice between pre-claim or post-payment review of 100% of claims submitted to demonstrate compliance with applicable Medicare coverage and clinical documentation requirements. If a certain percentage of the claims reviewed are found to be valid, the IRF may then opt out of the 100% review. That percentage will initially be 80% or greater and eventually increase to 90% or greater in subsequent review cycles. In opting out, the IRF may elect spot prepayment reviews of samples consisting of 5% of total claims or selective post-payment review of a statistically valid random sample. RCD does not create new documentation requirements. We cannot predict the impact, if any, the RCD may have on the collectability of our Medicare claims over its five-year term and ultimately our financial position, results of operations, and cash flows.

On September 15, 2022, the HHS-OIG updated its work plan to conduct a nationwide audit of IRF claims in order to determine the extent to which CMS could clarify the Medicare IRF claim payment criteria. The HHS-OIG expects to issue a report on this audit. An HHS-OIG work plan, audit or similar future efforts could result in proposed changes to the payment systems for providers or increased denials of Medicare claims for patients notwithstanding the referring physicians' judgment that treatment is appropriate.

CMS has also instructed Medicare Administrative Contractors to conduct targeted probe and educate reviews of providers, in which the contractors select providers for up to three rounds of claim reviews. The contractor provides education to the provider after each round of review regarding any identified issues. These reviews can be conducted post-payment, but the contractors can also subject providers to pre-payment review of claims. In addition to the additional costs and burdens discussed above, providers can be further subject to withholding of Medicare payments during this review process.

***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 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 $71,162 per violation with a maximum of $2.1 million in a calendar year for violations of the same requirement.

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

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

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

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

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

Furthermore, while our information technology systems are maintained with safeguards protecting against cyber attacks, including intrusion protection, firewalls, and malware detection, 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 with training at least annually on important measures they can take to prevent breaches and other cyber threats. We routinely identify attempts to gain unauthorized access to our systems. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and security measures or other controls will detect, prevent, or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. For example, it has been widely reported that many well-organized international interests, in certain cases with the backing of sovereign governments, are targeting the theft of patient information through the use of advance persistent threats. Similarly, in recent years, several hospitals have reported being the victim of ransomware attacks in which they lost access to their systems, including clinical systems, during the course of the attacks. While we are not aware of having experienced a material cyber breach or attack to date, we are likely to face attempted attacks in the future. Accordingly, we may be vulnerable to losses associated with the improper functioning, security breach, or unavailability of our information systems as well as any systems used in acquired operations.

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

***Quality reporting requirements may negatively impact Medicare reimbursement.***

The IMPACT Act requires the submission of standardized data by certain healthcare providers. Specifically, the IMPACT Act requires, among other significant activities, that LTCHs, IRFs, SNFs, and HHAs report standardized patient assessment data to CMS for cross-setting quality measures, resource use measures, and standardized patient assessment data elements. To the extent that such reporting requirements have been incorporated into the Medicare quality reporting programs, failure to report such data as required will subject providers to a 2% reduction to their annual payment update for the fiscal year that follows the reporting period. As CMS adds new measures to the Medicare quality reporting programs to implement the IMPACT Act, the burden to report data increases. Moreover, when CMS adds other measures to the quality reporting programs, provider reporting obligations become more burdensome. For example, CMS recently added a COVID-19 Vaccination Coverage Among Healthcare Personnel measure to the LTCH, IRF, and SNF quality reporting programs. The adoption of 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. This includes the additional burden from the fiscal year 2023 IRF-PPS final rule to require IRFs, starting with discharges after October 1, 2024, to collect data using the IRF Patient Assessment Instrument for all IRF patients, regardless of payer. Currently, CMS only requires IRFs to complete the IRF Patient Assessment Instrument for Medicare beneficiaries (Part A and Part C).

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

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

CMS has increased several quality reporting program data completion thresholds for certain provider types. Failure to meet a quality program data completion threshold may result in CMS reducing the provider's Medicare payments by 2%. The FY 2024 SNF PPS Final Rule increased the SNF QRP data completion threshold from 80% to 90% for Minimum Data Set data items beginning with the CY 2024 data collection period. The FY 2024 IPPS/LTCH Final Rule similarly increased the LTCH QRP data completion threshold for LTCH Continuity Assessment Record and Evaluation Data Set submissions from 80% to 85% effective for the CY 2024 data collection period. Increasing the data completion thresholds reduces the margin for error when submitting quality reporting program data and increases the risk of CMS applying a 2% penalty to our facilities' Medicare payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Significant legal actions could subject us to substantial uninsured liabilities.***

Physicians, hospitals, and other healthcare providers have become subject to an increasing number of legal actions and claims alleging professional malpractice, general liability for property damage, personal and bodily injury, violations of federal and state employment laws, often in the form of wage and hour class action lawsuits, and liability for data breaches. Many of these actions involve large claims and significant defense costs and sometimes, as in the case of wage and hour class actions, are not covered by insurance. 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 "Item 3. Legal Proceedings." and Note 20 – Commitments and Contingencies in our audited consolidated financial statements.

We currently maintain professional malpractice liability insurance and general liability insurance coverages through a number of different programs that are dependent upon such factors as the state where we are operating and whether the operations are wholly owned or are operated through a joint venture. For our wholly owned hospital and outpatient clinic operations, we currently maintain insurance coverages under a combination of policies with a total annual aggregate limit of up to $42.0 million for professional malpractice liability insurance and $45.0 million for general liability insurance. Our insurance for the professional liability coverage is written on a "claims-made" basis, and our commercial general liability coverage is maintained on an "occurrence" basis. These coverages apply after a self-insured retention limit is exceeded. For our joint venture operations, we have designed a separate insurance program that responds to the risks of specific joint ventures. Most of our joint ventures are insured under a master program with an annual aggregate limit of up to $80.0 million, subject to a sublimit aggregate ranging from $23.0 million to $33.0 million for most joint ventures. The policies are generally written on a "claims-made" basis. Each of these programs has either a deductible or self-insured retention limit. In addition, the Company purchases additional primary care limits in certain patient compensation fund states, including Indiana, Kansas, Pennsylvania and Wisconsin. We also maintain additional types of liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by the applicable professional malpractice and general liability insurance policies, including workers compensation, property and casualty, directors and officers, cyber liability insurance, and employment practices liability insurance coverages. Our insurance policies generally are silent with respect to punitive damages so coverage is available to the extent insurance under the law of any applicable jurisdiction and are subject to various deductibles and policy limits. We review our insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. See "Business—Government Regulations—Other Healthcare Regulations"

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

Our executives and directors, beneficially own, in the aggregate, approximately 11.56% of Holdings' outstanding common stock as of February 1, 2025. 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.

***If there is later a determination that certain steps of the Separation or the Distribution are taxable because the facts, assumptions, representations or undertakings underlying the IRS private letter ruling or any tax opinions are incorrect or for any other reason, then the Company and our stockholders could incur significant U.S. federal income tax liabilities and Concentra could incur significant liabilities through its indemnification obligations under the Tax Matters Agreement.***

We received a private letter ruling from the IRS substantially to the effect that, among other things, certain steps of the Separation together with the Distribution will qualify as a transaction that is tax-free for U.S. federal income tax purposes under Section 355 of the U.S. Internal Revenue Code of 1986, as amended (the “Code”). The Distribution was conditioned on, among other things, the continuing effectiveness and validity of our private letter ruling from the IRS and the receipt of favorable opinions of our U.S. tax advisors. The private letter ruling and the tax opinions relied on certain facts, assumptions, representations and undertakings from us and Concentra regarding the past and future conduct of the companies’ respective businesses and other matters. If any of these facts, assumptions, representations or undertakings are incorrect or not otherwise satisfied, the Company and our stockholders may not be able to rely on the ruling or the opinions of tax advisors and could be subject to significant tax liabilities. Notwithstanding the private letter ruling and opinions of tax advisors, the IRS could determine on audit that certain steps of the Separation or the Distribution are taxable if it determines that any of these facts, assumptions, representations or undertakings are not correct or have been violated or if it disagrees with the conclusions in the opinions that are not covered by the private letter ruling, or for other reasons, including as a result of certain significant changes in our stock ownership or the stock ownership of Concentra following the completion of the Distribution.

If certain steps of the Separation or the Distribution are determined to be taxable for U.S. federal income tax purposes, then the Company or our stockholders could incur significant U.S. federal income tax liabilities and Concentra could also incur significant liabilities under the Tax Matters Agreement. Under the Tax Matters Agreement, Concentra will generally be required to indemnify us against taxes incurred by the Company arising from any breach of representations made by Concentra (including those provided in connection with the private letter ruling from the IRS and opinions from tax advisors) or from certain other acts or omissions, in each case that result in certain steps of the Separation or the Distribution failing to meet the requirements under Section 355 of the Code. See “Certain Relationships and Related Person Transactions — Agreements Entered into in Connection with the Separation — Tax Matters Agreement.”

***In connection with the Separation, Concentra agreed to indemnify us for certain liabilities. However, we cannot assure you that the indemnity will be sufficient to protect us against the full amount of such liabilities or that Concentra’s ability to satisfy its indemnification obligation will not be impaired in the future.***

Pursuant to the Separation Agreement and certain other agreements we have entered into with Concentra in connection with the Separation, Concentra agreed to indemnify us for certain liabilities. However, third parties could also seek to hold us responsible for any of the liabilities that Concentra has agreed to retain and we cannot assure you that the indemnity from Concentra will be sufficient to protect us against the full amount of such liabilities, or that Concentra will be able to fully satisfy its indemnification obligations. In addition, pursuant to the Separation Agreement, Concentra’s self-funded insurance policies are not available to us, and Concentra’s third-party insurance policies may not be available to us, for liabilities associated with occurrences of indemnified liabilities prior to the Separation, and in any event Concentra’s insurers may deny coverage to us for liabilities associated with certain occurrences of indemnified liabilities prior to the Separation. Moreover, even if we ultimately succeed in recovering from Concentra or its insurance providers any amounts for which we are held liable, we may be temporarily required to bear these losses. The occurrence of any of these events could adversely affect our business, results of operations or financial condition.

***Our Separation from Concentra and the distribution of Concentra shares to our stockholders may not achieve some or all of the anticipated benefits and may adversely affect our business.***

On January 3, 2024, we announced that our Board of Directors had unanimously approved the pursuit of the Separation, to be effected by way of IPO and spin-off. On July 26, 2024, Concentra completed its IPO and generated proceeds of approximately $499.7 million, net of underwriting discounts and commissions. In addition, the underwriters exercised the option to purchase an additional 750,000 shares of Concentra’s common stock for proceeds of $16.7 million, net of underwriting discounts and commissions. Upon completion of the IPO, we held 104,093,503 shares of Concentra common stock, representing approximately 81.74% of the outstanding shares of Concentra common stock. On November 25, 2024, we completed the distribution of these 104,093,503 shares to our stockholders, and we no longer own any shares of Concentra common stock after the Distribution.

There is a risk that we may not be able to achieve the full strategic, operational and financial benefits to us that were anticipated to result from the Separation. In fact, the Distribution may adversely affect our business. Following the Distribution, we are a smaller company with a less diversified product portfolio and a narrower business focus. As a result, we may be more vulnerable to changing market conditions, which could materially and adversely affect our business, financial condition and results of operations. Although Select and Concentra are now two independent companies, our long joint history may cause consumers and investors to continue to associate the companies with each other, either positively or negatively. Separating the businesses may also eliminate or reduce synergies or economies of scale that existed prior to the Distribution, which could harm our business.

***We may be exposed to claims and liabilities as a result of the Distribution.***

We entered into a separation agreement and various other agreements with Concentra to govern the Distribution and the relationship of the two companies going forward. These agreements provide for specific indemnity and liability obligations and could lead to disputes between us and Concentra. The indemnity rights we have against Concentra under the agreements may not be sufficient to protect us, for example, if our losses exceeded our indemnity rights or if Concentra did not have the financial resources to meet its indemnity obligations. In addition, our indemnity obligations to Concentra may be significant, and these risks could negatively affect our results of operations and financial condition.

## Risks Related to Our Capital Structure

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

We have a substantial amount of indebtedness. As of December 31, 2024, we had approximately $1,711.8 million of total indebtedness. Our indebtedness could have important consequences to you. For example, it:

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

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

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

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

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

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

As of December 31, 2024, we were required to maintain our leverage ratio (the ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters) at less than 7.00 to 1.00. At December 31, 2024, our leverage ratio was 3.18 to 1.00.

Our indenture, dated December 3, 2024, by and among Select, the guarantors named therein and U.S. Bank National Association, as trustee (the “Indenture”), contains covenants that, among other things, limit our ability and the ability of certain of our subsidiaries, which unconditionally guarantee on a joint and several basis the senior notes under the Indenture, to (i) grant liens on its assets, (ii) make dividend payments, other distributions or other restricted payments, (iii) incur restrictions on the ability of Select’s restricted subsidiaries to pay dividends or make other payments, (iv) enter into sale and leaseback transactions, (v) merge, consolidate, transfer or dispose of substantially all of their assets, (vi) incur additional indebtedness, (vii) make investments, (viii) sell assets, including capital stock of subsidiaries, (ix) use the proceeds from sales of assets, including capital stock of restricted subsidiaries, and (x) enter into transactions with affiliates. In addition, the Indenture requires us, among other things, to provide financial and current reports to holders of the notes or file such reports electronically with the SEC.

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

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

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

***Despite our substantial level of indebtedness, we and our subsidiaries may be able to incur additional indebtedness. This could further exacerbate the risks described above, especially in the current rising interest rate environment.***

We and our subsidiaries may be able to incur additional indebtedness in the future. Although our credit facilities and the Indenture contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. Also, these restrictions do not prevent us or our subsidiaries from incurring obligations that do not constitute indebtedness. As of December 31, 2024, we had $453.3 million of availability under our revolving facility (as defined below) (after giving effect to $105.0 million of outstanding borrowings and $41.7 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.

Changing interest rates may have unpredictable effects on markets, may result in heightened market volatility and may detract from our performance to the extent we are exposed to such interest rates and/or volatility. In periods of rising interest rates, such as the current interest rate environment, to the extent we borrow money subject to a floating interest rate, our operating costs would increase, which could reduce our net income.

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

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

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

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

None.

**Item 1C. *Cybersecurity.***

The proper confidentiality, integrity, and availability of the Company’s information systems are critical to the business. Securing the Company’s business information, customer, patient and employee data, and technology systems is essential for the continuity of its businesses, meeting applicable regulatory requirements, and maintaining the trust of its stakeholders. As part of its enterprise risk management program, the Company has processes in place to assess, identify, and manage material business, operational and legal risks from cybersecurity threats. Such risks include business disruption, fraud, extortion, reputational harm, violations of laws and regulations, litigation, and harm to employees, patients, customers and business partners.

**Cybersecurity Program Overview**

The Company’s cybersecurity program is structured around the cybersecurity framework (“Cybersecurity Framework”) of the National Institute of Standards and Technology (“NIST”), an agency of the U.S. Department of Commerce. The Cybersecurity Framework provides best practices to prevent, detect, identify, respond to, and recover from cyber-attacks. The Company’s cybersecurity program involves establishing information security policies, procedures and standards, investing in and implementing information protection processes, security measures and technologies, ongoing monitoring of systems and networks on which the Company relies, cybersecurity training and collaborating with public and private organizations on cyber threat information and best practices. We also assess and identify potential cyber and information security risks relating to third-party technology providers. These efforts may include due diligence to assess the party’s cybersecurity practices, controls, and compliance with relevant statutes and regulations; the use of contractual agreements that outline certain cybersecurity requirements; and using outside services to perform ongoing monitoring of select suppliers and third-party service providers. We may also collaborate with third-party suppliers to develop and align incident response plans. The Company actively monitors the current threat landscape in an effort to identify material risks arising from new and evolving cybersecurity threats. The Company engages an external third-party cybersecurity assessor to perform an annual assessment or validation of the cybersecurity program in accordance with the Cybersecurity Framework and the HIPAA Security Risk Assessment Tool of the U.S. Health and Human Services Office for Civil Rights.

**Board Oversight of Cybersecurity Risks**

The Board of Directors of the Company provides strategic oversight on cybersecurity matters, including risks associated with cybersecurity threats. The Company’s Chief Information Officer (“CIO”) and Chief Information Security Officer (“CISO”) provide annual written reports and quarterly briefings on the Company’s cybersecurity program to the Board of Directors. They also provide quarterly cybersecurity updates to the Audit and Compliance Committee. The reports to the Board of Directors include details and metrics on, among other things, the Company’s quarterly Cybersecurity Framework assessment updates, internal and external threat intelligence, quarterly information security program progress, business associate risk assessments and ongoing monitoring, company-wide awareness training, device security compliance, routine resilience efforts including disaster recovery exercises, tabletop security incident response exercises, and cyber penetration tests.

**Management's Role in Cybersecurity Risk Management**

The Company’s management, including the Company’s CIO and CISO, is responsible for assessing and managing material risks from cybersecurity threats. The Company’s CIO and CISO each have more than 20 years of experience in cybersecurity. The Company provides formalized cybersecurity training for newly-hired employees and annually for existing employees. In addition, the Company provides cybersecurity awareness training and education throughout the year. The annual cybersecurity training curriculum includes modules on information security, the employee’s role in protecting Company information, recognizing different cybersecurity incidents, identifying phishing emails, understanding the appropriate personnel to approach with information or questions, and acceptance of the Company’s Information Security Policy. The Company’s management is informed of cybersecurity incidents through ongoing monitoring and, in some cases, through receipt of notifications from third-party service providers. The CISO maintains and annually updates a Cybersecurity Incident Response Plan, which is a guide for the Company’s cybersecurity team to respond effectively to cybersecurity incidents in a coordinated manner in the interest of minimizing the risk of harm. The team works with colleagues in various departments throughout the Company, including Information Technology, Human Resources, Legal, Risk Management and Compliance, to prevent, mitigate and remediate cybersecurity incidents impacting the Company.

**Assessment of Cybersecurity Risk**

Management continuously assesses the potential impact of risks from cybersecurity threats on the Company, and regularly evaluates how such risks could materially affect the Company’s business strategy, operational results, and financial condition. As noted above, an assessment of the cybersecurity program leveraging the Cybersecurity Framework is completed annually by an independent and qualified external third-party cybersecurity assessor. The Company has not experienced a cybersecurity breach or information security breach during the past four fiscal years. The Company, from time to time, has been notified of third-party information cybersecurity breaches, but none of them has had a material impact on the Company's operations or financial results. The Company annually purchases a cybersecurity risk insurance policy to help defray the costs associated with any covered cybersecurity incident. Although the Company did not experience a material cybersecurity incident during the year ended December 31, 2024, the scope and impact of any future incident cannot be predicted.

**Item 2. *Properties.***

We currently lease most of our consolidated facilities, including critical illness recovery hospitals, rehabilitation hospitals, outpatient rehabilitation clinics, and our corporate headquarters. We own 21 of our critical illness recovery hospitals, nine of our rehabilitation hospitals, and one of our outpatient rehabilitation clinics throughout the United States. As of December 31, 2024, we leased 83 of our critical illness recovery hospitals, 14 of our rehabilitation hospitals, and 1,616 of our outpatient rehabilitation clinics.

We lease our corporate headquarters from companies owned by a related party affiliated with us through common ownership or management. As of December 31, 2024, our corporate headquarters is approximately 292,173 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, 2024.

| | Critical Illness Recovery Hospitals[1] | Rehabilitation Hospitals[1] | Outpatient Rehabilitation Clinics[1] | Total Facilities |
|---|---|---|---|---|
| Alabama | 1 | — | 15 | 16 |
| Alaska | — | — | 12 | 12 |
| Arizona | 4 | 4 | 60 | 68 |
| Arkansas | 1 | — | 1 | 2 |
| California | 1 | 1 | 92 | 94 |
| Colorado | — | — | 50 | 50 |
| Connecticut | — | — | 62 | 62 |
| Delaware | 1 | — | 13 | 14 |
| District of Columbia | — | — | 3 | 3 |
| Florida | 12 | 3 | 132 | 147 |
| Georgia | 4 | 1 | 70 | 75 |
| Illinois | 1 | — | 87 | 88 |
| Indiana | 3 | 1 | 43 | 47 |
| Iowa | 2 | — | 26 | 28 |
| Kansas | 2 | — | 16 | 18 |
| Kentucky | 2 | — | 71 | 73 |
| Louisiana | — | 2 | 2 | 4 |
| Maine | — | — | 34 | 34 |
| Maryland | — | — | 60 | 60 |
| Massachusetts | — | — | 19 | 19 |
| Michigan | 10 | — | 38 | 48 |
| Minnesota | 1 | — | 27 | 28 |
| Mississippi | 4 | — | 1 | 5 |
| Missouri | 3 | 3 | 111 | 117 |
| Nebraska | 1 | — | 1 | 2 |
| Nevada | — | 1 | 20 | 21 |
| New Hampshire | — | — | 7 | 7 |
| New Jersey | 3 | 4 | 168 | 175 |
| North Carolina | 2 | — | 45 | 47 |
| Ohio | 13 | 6 | 107 | 126 |
| Oklahoma | 2 | 1 | 30 | 33 |
| Oregon | — | — | 4 | 4 |
| Pennsylvania | 9 | 2 | 219 | 230 |
| South Carolina | 2 | — | 25 | 27 |
| South Dakota | 1 | — | — | 1 |
| Tennessee | 7 | — | 20 | 27 |
| Texas | 2 | 5 | 155 | 162 |
| Virginia | 3 | 1 | 43 | 47 |
| Washington | — | — | 13 | 13 |
| West Virginia | 4 | — | 6 | 10 |
| Wisconsin | 3 | — | 6 | 9 |
| Total Company | 104 | 35 | 1,914 | 2,053 |

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

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

Refer to the "Litigation" section contained within Note 20 – Commitments and Contingencies of the notes to our consolidated financial statements included herein.

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

None.

# PART II

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

### Market Information

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

### Holders

At the close of business on February 1, 2025, Holdings had 128,962,850 shares of common stock issued and outstanding. As of that date, there were 133 registered holders of record. This does not reflect beneficial stockholders who hold their stock in nominee or "street" name through brokerage firms.

### Dividend Policy

Holdings' Board of Directors declared the following dividends during the year ended December 31, 2024:

| Declaration Date | Record Date | Payment Date | Dividend Per Share | Amount (in thousands) |
| --- | --- | --- | --- | --- |
| February 13, 2024 | March 1, 2024 | March 13, 2024 | $ 0.125 | $ 16,045 |
| May 1, 2024 | May 16, 2024 | May 30, 2024 | $ 0.125 | $ 16,254 |
| July 31, 2024 | August 14, 2024 | August 30, 2024 | $ 0.125 | $ 16,194 |
| October 30, 2024 | November 15, 2024 | November 26, 2024 | $ 0.125 | $ 16,124 |

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

### Securities Authorized For Issuance Under Equity Compensation Plans

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

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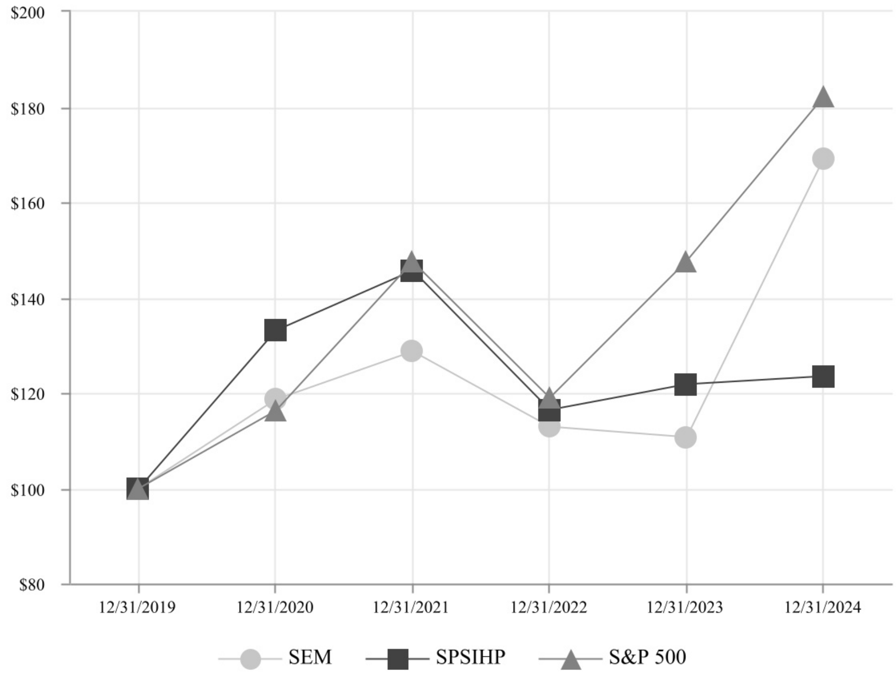
**Stock Performance Graph**

The graph below compares the cumulative total stockholder return on $100 invested at the close of the market on December 31, 2019, with dividends being reinvested on the date paid through and including the market close on December 31, 2024, 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.




| | 12/31/2019 | 12/31/2020 | 12/31/2021 | 12/31/2022 | 12/31/2023 | 12/31/2024 |
|---|---|---|---|---|---|---|
| Select Medical Holdings Corporation (SEM) | $ 100.00 | $ 118.51 | $ 128.59 | $ 112.79 | $ 110.62 | $ 169.23 |
| S&P Health Care Services Select Industry Index (SPSIHP) | $ 100.00 | $ 133.00 | $ 145.57 | $ 116.36 | $ 121.70 | $ 123.45 |
| S&P 500 | $ 100.00 | $ 116.26 | $ 147.52 | $ 118.84 | $ 147.64 | $ 182.05 |

### Purchases of Equity Securities by the Issuer and Affiliated Purchasers

Holdings' Board of Directors authorized a common stock repurchase program to repurchase up to $1.0 billion worth of shares of its common stock. The program will remain in effect until December 31, 2025, 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. On August 16, 2022, Congress passed the Inflation Reduction Act of 2022, which enacted a 1% excise tax on stock repurchases that exceed $1.0 million, effective January 1, 2023.

The following table provides information regarding repurchases of our common stock during the three months ended December 31, 2024.

| | Total Number of Shares Purchased | Average Price Paid Per Share | Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs | Approximate Dollar Value of Shares that May Yet Be Purchased Under Plans or Programs |
|---|---|---|---|---|
| October 1 – October 31, 2024[(1)] | 73,877 | $ 31.74 | — | $ 399,677,961 |
| November 1 – November 31, 2024[(1)] | 474,083 | 37.20 | — | 399,677,961 |
| December 1 – December 31, 2024 | — | — | — | 399,677,961 |
| Total | 547,960 | $ 35.68 | — | $ 399,677,961 |

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

**Item 6. [Reserved]**

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

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

### Overview

We began operations in 1997 and, based on number of facilities, are one of the largest operators of critical illness recovery hospitals, rehabilitation hospitals, and outpatient rehabilitation clinics in the United States. As of December 31, 2024, we had operations in 40 states and the District of Columbia. We operated 104 critical illness recovery hospitals in 29 states, 35 rehabilitation hospitals in 14 states, and 1,914 outpatient rehabilitation clinics in 39 states and the District of Columbia as of December 31, 2024.

On July 26, 2024, Concentra Group Holdings Parent (“Concentra”), a then wholly-owned subsidiary of Select, completed an IPO of 22,500,000 shares of its common stock, par value $0.01 per share, at an initial public offering price of $23.50 per share for net proceeds of $499.7 million after deducting underwriting discounts and commission of $29.1 million. In addition, the underwriters exercised the option to purchase an additional 750,000 shares of Concentra’s common stock for net proceeds of $16.7 million after deducting discounts and commission of $1.0 million. Concentra shares began trading on the New York Stock Exchange under the symbol “CON” on July 25, 2024.

After the closing of the IPO and underwriters option, Select owned 81.74% of the total outstanding shares of Concentra common stock. On November 25, 2024, Select completed a tax-free distribution of 104,093,503 shares of common stock of Concentra to its stockholders. Holders of the Company’s common stock received 0.806971 shares of Concentra common stock for each outstanding share of the Company’s common stock they owned as of the Record Date. Following the completion of the distribution, the Company no longer owns any shares of Concentra common stock. The historical results of Concentra (which previously represented the Concentra business segment) are reflected as discontinued operations in the Company’s Consolidated Financial Statements through the date of the distribution.

Our reportable segments include the critical illness recovery hospital segment, the rehabilitation hospital segment, and the outpatient rehabilitation segment. We had revenue of $5,187.1 million for the year ended December 31, 2024. Of this total, we earned approximately 47% of our revenue from our critical illness recovery hospital segment, approximately 21% from our rehabilitation hospital segment, and approximately 24% from our outpatient rehabilitation 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.

#### *Impact of the Change Healthcare Cybersecurity Incident*

On February 22, 2024, UnitedHealth Group Incorporated indicated in a Form 8-K filing, that a cyber security threat actor had gained access to some of its Change Healthcare information technology systems. Upon receiving notification of the incident, we severed connectivity with all Change Healthcare-related systems and we are not aware of any impact on our own information technology systems. However, as a result of the incident, certain of our patient billing and collections processes were disrupted and alternative platforms needed to be enabled to resume normal patient billing and collections operations. As of and for the year ended December 31, 2024, the incident did not have a material impact on our financial condition or operations.

### Non-GAAP Measure

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

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

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Income from continuing operations, net of tax | $ 18,545 | $ 110,471 | $ 129,987 |
| Income tax expense from continuing operations | 16,723 | 29,253 | 44,782 |
| Interest expense | 137,470 | 154,165 | 128,605 |
| Equity in earnings of unconsolidated subsidiaries | (27,984) | (41,339) | (63,904) |
| Loss on early retirement of debt | — | 14,692 | 28,845 |
| Income from continuing operations before other income and expense | 144,754 | 267,242 | 268,315 |
| Stock compensation expense: | | | |
| Included in general and administrative | 30,555 | 36,041 | 79,931 |
| Included in cost of services | 5,059 | 7,117 | 19,283 |
| Depreciation and amortization | 132,158 | 135,691 | 142,866 |
| Adjusted EBITDA | $ 312,526 | $ 446,091 | $ 510,395 |

### Summary Financial Results

Income from continuing operations, net of tax, was $130.0 million, $110.5 million, and $18.5 million for the years ended December 31, 2024, 2023, and 2022, respectively. Income from continuing operations, net of tax, included losses on early retirement of debt of $28.8 million and $14.7 million during the years ended December 31, 2024 and 2023, respectively.

The following tables reconcile our segment performance measures to our consolidated operating results for the years ended December 31, 2024, 2023, and 2022:

| | For the Year Ended December 31, 2024 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Revenue | $ 2,444,196 | $ 1,110,592 | $ 1,250,294 | $ 382,023 | $ 5,187,105 |
| Operating expenses | (2,145,595) | (864,844) | (1,141,715) | (627,176) | (4,779,330) |
| Depreciation and amortization | (69,842) | (28,442) | (36,579) | (8,003) | (142,866) |
| Other operating income | 3,033 | — | (2) | 375 | 3,406 |
| Income from continuing operations before other income and expense | 231,792 | 217,306 | 71,998 | (252,781) | 268,315 |
| Depreciation and amortization | 69,842 | 28,442 | 36,579 | 8,003 | 142,866 |
| Stock compensation expense | — | — | — | 99,214 | 99,214 |
| Adjusted EBITDA | $ 301,634 | $ 245,748 | $ 108,577 | $ (145,564) | $ 510,395 |
| Adjusted EBITDA margin | 12.3 % | 22.1 % | 8.7 % | N/M | 9.8 % |

| | For the Year Ended December 31, 2023 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Revenue | $ 2,299,773 | $ 979,585 | $ 1,188,914 | $ 357,705 | $ 4,825,977 |
| Operating expenses | (2,053,758) | (758,466) | (1,077,322) | (535,016) | (4,424,562) |
| Depreciation and amortization | (63,865) | (28,055) | (35,210) | (8,561) | (135,691) |
| Other operating income | — | 756 | 276 | 486 | 1,518 |
| Income from continuing operations before other income and expense | 182,150 | 193,820 | 76,658 | (185,386) | 267,242 |
| Depreciation and amortization | 63,865 | 28,055 | 35,210 | 8,561 | 135,691 |
| Stock compensation expense | — | — | — | 43,158 | 43,158 |
| Adjusted EBITDA | $ 246,015 | $ 221,875 | $ 111,868 | $ (133,667) | $ 446,091 |
| Adjusted EBITDA margin | 10.7 % | 22.6 % | 9.4 % | N/M | 9.2 % |

| | For the Year Ended December 31, 2022 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Revenue | $ 2,234,132 | $ 916,763 | $ 1,125,282 | $ 333,002 | $ 4,609,179 |
| Operating expenses | (2,127,233) | (718,970) | (1,023,422) | (491,096) | (4,360,721) |
| Depreciation and amortization | (61,565) | (27,814) | (32,663) | (10,116) | (132,158) |
| Other operating income | 4,445 | 241 | — | 23,768 | 28,454 |
| Income from continuing operations before other income and expense | 49,779 | 170,220 | 69,197 | (144,442) | 144,754 |
| Depreciation and amortization | 61,565 | 27,814 | 32,663 | 10,116 | 132,158 |
| Stock compensation expense | — | — | — | 35,614 | 35,614 |
| Adjusted EBITDA | $ 111,344 | $ 198,034 | $ 101,860 | $ (98,712) | $ 312,526 |
| Adjusted EBITDA margin | 5.0 % | 21.6 % | 9.1 % | N/M | 6.8 % |

The following tables summarize the changes in our segment performance measures for the year-to-date periods specified below.

| | 2024 Compared to 2023 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| Change in revenue | 6.3 % | 13.4 % | 5.2 % | 6.8 % | 7.5 % |
| Change in income from continuing operations before other income and expense | 27.3 % | 12.1 % | (6.1) % | N/M | 0.4 % |
| Change in Adjusted EBITDA | 22.6 % | 10.8 % | (2.9) % | N/M | 14.4 % |

| | 2023 Compared to 2022 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| Change in revenue | 2.9 % | 6.9 % | 5.7 % | 7.4 % | 4.7 % |
| Change in income from continuing operations before other income and expense | 265.9 % | 13.9 % | 10.8 % | N/M | 84.6 % |
| Change in Adjusted EBITDA | 121.0 % | 12.0 % | 9.8 % | N/M | 42.7 % |

N/M Not meaningful.

## Regulatory Changes

The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and CMS. Revenues from providing services to patients covered under the Medicare program represented approximately 31%, 31%, and 29% of our revenue for the years ended December 31, 2022, 2023, and 2024, respectively.

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

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

On January 31, 2020, HHS declared a public health emergency under section 319 of the Public Health Service Act, 42 U.S.C. § 247d, in response to the COVID-19 outbreak in the United States. The HHS Secretary subsequently renewed the public health emergency determination for 90-day periods through May 11, 2023, the end of the public health emergency.

On March 13, 2020, President Trump declared a national emergency due to the COVID-19 pandemic and the HHS Secretary authorized the waiver or modification of certain requirements under Medicare, Medicaid, and the CHIP program pursuant to section 1135 of the Social Security Act. Under this authority, CMS issued a number of blanket waivers that excused health care providers and suppliers from specific program requirements. Our Annual Report on Form 10-K for the year ended December 31, 2023 contains a detailed discussion of blanket waivers and other actions by CMS in response to the COVID-19 pandemic that affected our operations in Part II — Management’s Discussion and Analysis of Financial Condition and Results of Operations — Regulatory Changes.

One of the blanket waivers expanded the types of health care professionals who could furnish telehealth services to include all those who are eligible to bill Medicare for their professional services. This allowed health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services. Pursuant to the Coronavirus Preparedness and Response Supplemental Appropriations Act, Public Law 116-123, CMS also waived Medicare telehealth payment requirements during the emergency so that beneficiaries in all areas of the country (not just rural areas) could receive telehealth services, including in their homes. In the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, Congress extended to December 31, 2024 several telehealth flexibilities that were scheduled to expire 151 days after the end of the COVID-19 public health emergency, including the expansion of permitted originating sites for telehealth, expansion of eligible practitioners for furnishing telehealth, and coverage of audio-only telehealth services. CMS issued additional waivers to permit more than 150 additional services to be furnished by telehealth, allow physicians to monitor patient services remotely, and fulfill face-to-face requirements in IRFs. In the calendar year 2025 MPFS final rule, CMS extended some of the telehealth flexibilities through December 31, 2025, including regulations that allow (1) the use of real-time audio and visual interactive telecommunications for compliance with the direct supervision requirement, and (2) a distant site practitioner to provide telehealth services from their home using their currently enrolled practice location. CMS also made a permanent change to the telehealth rules in the calendar year 2025 MPFS final rule to allow telehealth to be provided for any service using an audio-only communication technology in certain situations when the patient is not able to use video technology.

Pursuant to the Coronavirus Preparedness and Response Supplemental Appropriations Act, Public Law 116-123, CMS also waived Medicare telehealth payment requirements during the emergency so that beneficiaries in all areas of the country (not just rural areas) could receive telehealth services, including in their homes. In the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, Congress extended to December 31, 2024 several telehealth flexibilities that were scheduled to expire 151 days after the end of the COVID-19 public health emergency, including the expansion of permitted originating sites for telehealth, expansion of eligible practitioners for furnishing telehealth, and coverage of audio-only telehealth services. CMS issued additional waivers to permit more than 150 additional services to be furnished by telehealth, allow physicians to monitor patient services remotely, and fulfill face-to-face requirements in IRFs. In the calendar year 2025 MPFS final rule, CMS extended some of the telehealth flexibilities through December 31, 2025, including regulations that allow (1) the use of real-time audio and visual interactive telecommunications for compliance with the direct supervision requirement, and (2) a distant site practitioner to provide telehealth services from their home using their currently enrolled practice location. CMS also made a permanent change to the telehealth rules in the calendar year 2025 MPFS final rule to allow telehealth to be provided for any service using an audio-only communication technology in certain situations when the patient is not able to use video technology.

***Medicare Reimbursement of LTCH Services***

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

Fiscal Year 2023. On August 10, 2022, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2023 (affecting discharges and cost reporting periods beginning on or after October 1, 2022, through September 30, 2023). Certain errors in the final rule were corrected in documents published November 4, 2022, and December 13, 2022. The standard federal rate for fiscal year 2023 was set at $46,433, an increase from the standard federal rate applicable during fiscal year 2022 of $44,714. The update to the standard federal rate for fiscal year 2023 included a market basket increase of 4.1%, less a productivity adjustment of 0.3%. The standard federal rate also included an area wage budget neutrality factor of 1.0004304. As a result of the CARES Act, LTCH cases were paid at the standard federal rate during the public health emergency. When the public health emergency ended on May 11, 2023, CMS returned to using the site-neutral payment rate for reimbursement of cases that did not meet the LTCH patient criteria. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $38,518, an increase from the fixed-loss amount in the 2022 fiscal year of $33,015. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $38,788, an increase from the fixed-loss amount in the 2022 fiscal year of $30,988.

Fiscal Year 2024. On August 28, 2023, CMS published the final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2024 (affecting discharges and cost reporting periods beginning on or after October 1, 2023, through September 30, 2024). Certain errors in the final rule were corrected in documents published October 4, 2023 and November 9, 2023. The standard federal rate for fiscal year 2024 was set at $48,117, an increase from the standard federal rate applicable during fiscal year 2023 of $46,433. The update to the standard federal rate for fiscal year 2024 included a market basket increase of 3.5%, less a productivity adjustment of 0.2%. The standard federal rate also included an area wage budget neutrality factor of 1.0031599. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS was set at $59,873, an increase from the fixed-loss amount in the 2023 fiscal year of $38,518. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate was set at $42,750, an increase from the fixed-loss amount in the 2023 fiscal year of $38,788.

Fiscal Year 2025. On August 28, 2024, CMS published a final rule updating policies and payment rates for the LTCH-PPS for fiscal year 2025 (affecting discharges and cost reporting periods beginning on or after October 1, 2024, through September 30, 2025). Certain errors in the final rule were corrected in a document published on October 2, 2024. In an interim final action document published on October 3, 2024, CMS also made modifications to the fiscal year 2025 policies and payment rates as a result of a recent decision issued by the United States Court of Appeals for the District of Columbia Circuit. The standard federal rate for fiscal year 2025 is $49,383, an increase from the standard federal rate applicable during fiscal year 2024 of $48,117. The update to the standard federal rate for fiscal year 2025 includes a market basket increase of 3.5%, less a productivity adjustment of 0.5%. The standard federal rate also includes an area wage budget neutrality factor of 0.9964315. The fixed-loss amount for high cost outlier cases paid under LTCH-PPS is $77,048, an increase from the fixed-loss amount in the 2024 fiscal year of $59,873. The fixed-loss amount for high cost outlier cases paid under the site-neutral payment rate is $46,217, an increase from the fixed-loss amount in the 2024 fiscal year of $42,750. See high cost outlier risk factor within “Item 1A. *Risk Factors*.

***Criteria for Reconciliation of Outlier Payments***

Under the LTCH PPS, CMS makes two types of outlier payments to LTCHs. First, CMS makes additional payments to LTCHs for high cost outlier cases that have extraordinarily high costs relative to the costs of most discharges. For these cases, CMS sets a fixed loss amount each year that represents the maximum loss an LTCH will incur for a case before qualifying for a high cost outlier payment. A high cost outlier threshold equal to the LTCH PPS adjusted Federal payment for the case plus the fixed loss amount determines when Medicare pays a high cost outlier payment. Such payments are based on 80% of the estimated cost of the case above the high cost outlier threshold. Second, CMS reduces payments to LTCHs for patients with a relatively short stay, which is defined as a length of stay less than or equal to five-sixths of the geometric average length of stay for that particular MS-LTC-DRG. Short stay outlier cases are paid using a per diem rate based on 120% of the MS-LTC-DRG specific per diem amount and an IPPS per diem amount.

Outlier payments made to LTCHs during the cost reporting year may be reconciled at cost report settlement by the Medicare Administrative Contractor (“MAC”) if certain criteria are met. According to CMS, the reconciliation of outlier payments is intended to account for the fact that the LTCH’s cost-to-charge ratio (“CCR”) used to pay Medicare claims during the cost reporting year may differ from the LTCH’s final CCR for the year calculated by the MAC at cost report settlement. The outlier reconciliation criteria were: (1) a change in the LTCH’s CCR of 10 percentage points or more when comparing the actual CCR to the CCR used during the cost reporting period to make outlier payments; and (2) the LTCH received at least

$500,000 in outlier payments during the cost reporting period. If the criteria for outlier reconciliation are met, the MAC will conduct an outlier reconciliation to determine whether the LTCH was overpaid or underpaid for outlier cases. If the LTCH was overpaid, the LTCH must repay Medicare in the amount of the overpayment plus the time value of money (*i.e.*, interest). If the LTCH was underpaid, Medicare must pay the LTCH in the amount of the underpayment plus the time value of money.

On April 26, 2024, CMS issued new guidance in Transmittal 12594 changing the criteria for LTCH outlier reconciliations. CMS modified the first criterion to a change in the LTCH’s CCR of 20 percent or more from the CCR used to make outlier payments during the cost reporting period. CMS did not change the second criterion for reconciliation that the LTCH must have received at least $500,000 in outlier payments during the cost reporting period. The revised policy is effective for cost reporting periods beginning on or after October 1, 2024. However, CMS notes that MACs would receive the first cost reports subject to the revised policy in March 2026.

Setting the threshold at 20 percent for changes in the hospital’s CCR will result in more outlier reconciliations. This increases the likelihood that LTCHs will have a portion of their outlier payments recouped by the MAC at cost report settlement. Because outlier reconciliations often delay the final settlement of cost reports, and providers cannot appeal disputed reimbursement amounts until the cost report is settled, this new policy will likely result in additional delays of reimbursement appeals related to LTCH cost reports.

***Medicare Reimbursement of IRF Services***

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

Fiscal Year 2023. On August 1, 2022, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2023 (affecting discharges and cost reporting periods beginning on or after October 1, 2022, through September 30, 2023). The standard payment conversion factor for discharges for fiscal year 2023 was set at $17,878, an increase from the standard payment conversion factor applicable during fiscal year 2022 of $17,240. The update to the standard payment conversion factor for fiscal year 2023 included a market basket increase of 4.2%, less a productivity adjustment of 0.3%. CMS increased the outlier threshold amount for fiscal year 2023 to $12,526 from $9,491 established in the final rule for fiscal year 2022.

Fiscal Year 2024. On August 2, 2023, CMS published the final rule updating policies and payment rates for the IRF-PPS for fiscal year 2024 (affecting discharges and cost reporting periods beginning on or after October 1, 2023, through September 30, 2024). Certain errors in the final rule were corrected in a document published on October 4, 2023. The standard payment conversion factor for discharges for fiscal year 2024 was set at $18,541, an increase from the standard payment conversion factor applicable during fiscal year 2022 of $17,878. The update to the standard payment conversion factor for fiscal year 2024 included a market basket increase of 3.6%, less a productivity adjustment of 0.2%. CMS decreased the outlier threshold amount for fiscal year 2024 to $10,423 from $12,526 established in the final rule for fiscal year 2023.

Fiscal Year 2025. On August 6, 2024, CMS published the final rule to update policies and payment rates for the IRF-PPS for fiscal year 2025 (affecting discharges and cost reporting periods beginning on or after October 1, 2024, through September 30, 2025). Certain errors in the final rule were corrected in a document published on October 2, 2024. The standard payment conversion factor for discharges for fiscal year 2025 was set at $18,907, an increase from the standard payment conversion factor applicable during fiscal year 2024 of $18,541. The update to the standard payment conversion factor for fiscal year 2025 included a market basket increase of 3.5%, less a productivity adjustment of 0.5%. CMS increased the outlier threshold amount for fiscal year 2025 to $12,043 from $10,423 established in the final rule for fiscal year 2024.

***Medicare Reimbursement of Outpatient Rehabilitation Clinic Services***

The Medicare program reimburses outpatient rehabilitation providers based on the MPFS. Outpatient rehabilitation providers may enroll in Medicare as institutional outpatient rehabilitation facilities (i.e., rehab agencies) or individual physical or occupational therapists in private practice. The majority of our providers are reimbursed through enrolled rehab agencies while the remaining balance of our clinicians are enrolled as individual physical or occupational therapists in private practice. The following is a summary of significant regulatory changes which have affected our results of operations as well as the policies and payment rates that may affect our future results of operations.

For calendar years 2021 and 2022, CMS's expected decreases in Medicare reimbursement were mostly offset by one-time increases in payments as a result of other legislation passed by Congress. Payments under the 2023 MPFS physician fee schedule decreased by 2%, and for calendar year 2024, CMS expected that its final policies for 2024 would result in a 3% decrease in Medicare payments for the therapy specialty. In the calendar year 2025 MPFS final rule, CMS calculated the payment rates without the one-time increases provided for in legislation. CMS expects that its policies for 2025 will not result in any increase or decrease in Medicare payments for the therapy specialty. However, the policies CMS announced in the calendar year 2025 MPFS final rule will reduce Medicare payments for the physical and occupational therapy services we provide by approximately 3%.

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

In the final 2020 MPFS rule, CMS clarified that when the physical therapist is involved for the entire duration of the service and the PTA provides skilled therapy alongside the physical therapist, the CQ modifier is not required. Also, when the same service (code) is furnished separately by the physical therapist and PTA, CMS applies the de minimis standard to each 15-minute unit of codes, not on the total physical therapist and PTA time of the service. For dates of service on and after January 1, 2022, CMS pays for physical therapy and occupational therapy services provided by PTAs and OTAs at 85% of the otherwise applicable Part B payment amount. CMS allows a timed service to be billed without the CQ or CO modifier when a PTA or OTA participates in providing care, but the physical therapist or occupational therapist meets the Medicare billing requirements without including the PTA's or OTA's minutes. This occurs when the physical therapist or occupational therapist provides more minutes than the 15-minute midpoint. The calendar year 2025 MPFS final rule did not contain any policy changes concerning the modifiers for services provided by physical therapy and occupational therapy assistants.

## Critical Accounting Estimates

***Revenue Recognition and Accounts Receivable***

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

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

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

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

***Insurance Risk Programs***

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

We monitor these programs quarterly and revise our estimates as necessary to take into account additional information. We recorded a liability of $132.1 million and $141.6 million for our estimated losses under these insurance programs at December 31, 2023 and 2024, respectively. We also recorded insurance proceeds receivable of $8.1 million and $8.5 million, respectively, at December 31, 2023 and 2024, for liabilities which exceed our deductibles and self-insured retention limits and are recoverable through our insurance policies.

***Goodwill***

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

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

As of October 1, 2024, we performed a qualitative impairment assessment for the rehabilitation hospital reporting unit, the critical illness recovery hospital reporting unit, and the former Concentra reporting unit. When performing the qualitative assessment, we apply judgement in determining the events and circumstances that most affect the fair value of the reporting unit and in evaluating the significance of those identified events and circumstances in order to determine whether it is more likely than not that the fair value of the reporting unit is less than its carrying amount. As part of our qualitative assessments, we considered (i) the magnitude of the reporting unit's excess fair value over its carrying amount from the most recent quantitative impairment test, (ii) industry and market conditions, including the impacts of the interest rate environment, (iii) historical financial performance, including our revenue, earnings, and operating cash flow growth trends, (iv) our forecasts of revenue, earnings, and operating cash flows, (v) cost factors, including the effects of inflation and rising prices, (vi) the regulatory environment, including reimbursement and compliance requirements such as those that exist under the Medicare program, (vii) other factors specific to each reporting unit, such as a change in strategy, a change in management, or acquisitions and divestitures affecting the composition of the reporting unit and its future operating results, and (viii) consideration of changes in our market capitalization. Historically, each reporting unit's fair value has significantly exceeded its carrying amount.

We performed a quantitative impairment assessment for the outpatient rehabilitation reporting unit as of October 1, 2024, to assess the impact of the current operating performance as compared to historical operating trends on the estimated fair value of the reporting unit. We used the income approach in determining the fair value of the outpatient rehabilitation reporting unit. Included in the income approach are assumptions regarding revenue growth rates, future Adjusted EBITDA margin estimates, future capital expenditure requirements, the industry's weighted average cost of capital, and industry specific, market observable implied Adjusted EBITDA multiples. We also include estimated residual values at the end of the forecast period. In establishing our assumptions, we consider current industry and market conditions; historical financial performance, including our revenue, earnings, and operating cash flow growth trends; cost factors, including the effects of inflation and rising prices; and the regulatory environment, including reimbursement and compliance requirements such as those that exist under the Medicare program. If any one of the above assumptions or judgments used to estimate the fair value of the reporting unit fails to materialize, the resulting decline in our estimated fair value could result in an impairment charge to the goodwill associated with the outpatient rehabilitation reporting unit.

Our annual assessment did not indicate that goodwill impairment was likely for any of our reporting units. We did not identify any goodwill impairment events during the quarter ended December 31, 2024.

We have recorded total goodwill of $2.3 billion at December 31, 2024, of which $1.2 billion related to our critical illness recovery hospital reporting unit, $497.1 million related to our rehabilitation hospital reporting unit, and $668.9 million related to our outpatient rehabilitation reporting unit.

### Operating Statistics

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| **Critical illness recovery hospital data:** | | | |
| Number of consolidated hospitals—start of period[1] | 104 | 103 | 107 |
| Number of hospitals acquired | 2 | 2 | — |
| Number of hospital start-ups | 1 | 4 | 1 |
| Number of hospitals closed/sold | (4) | (2) | (4) |
| Number of consolidated hospitals—end of period[1] | 103 | 107 | 104 |
| Available licensed beds[3] | 4,386 | 4,538 | 4,450 |
| Admissions[3][4] | 36,594 | 36,225 | 35,784 |
| Patient days[3][5] | 1,127,911 | 1,108,492 | 1,118,757 |
| Average length of stay (days)[3][6] | 31 | 31 | 31 |
| Revenue per patient day[3][7] | $ 1,973 | $ 2,067 | $ 2,177 |
| Occupancy rate[3][8] | 69 % | 68 % | 68 % |
| Percent patient days—Medicare[3][9] | 39 % | 38 % | 35 % |
| **Rehabilitation hospital data:** | | | |
| Number of consolidated hospitals—start of period[1] | 20 | 20 | 21 |
| Number of hospitals acquired | — | 1 | 1 |
| Number of hospital start-ups | — | — | 1 |
| Number of hospitals closed/sold | — | — | — |
| Number of consolidated hospitals—end of period[1] | 20 | 21 | 23 |
| Number of unconsolidated hospitals managed—end of period[2] | 11 | 12 | 12 |
| Total number of hospitals (all)—end of period | 31 | 33 | 35 |
| Available licensed beds[3] | 1,391 | 1,479 | 1,639 |
| Admissions[3][4] | 29,736 | 31,627 | 33,665 |
| Patient days[3][5] | 430,547 | 446,145 | 470,594 |
| Average length of stay (days)[3][6] | 15 | 14 | 14 |
| Revenue per patient day[3][7] | $ 1,953 | $ 2,017 | $ 2,134 |
| Occupancy rate[3][8] | 85 % | 85 % | 84 % |
| Percent patient days—Medicare[3][9] | 48 % | 49 % | 48 % |
| **Outpatient rehabilitation data:** | | | |
| Number of consolidated clinics—start of period | 1,572 | 1,622 | 1,633 |
| Number of clinics acquired | 30 | 16 | 11 |
| Number of clinic start-ups | 44 | 37 | 17 |
| Number of clinics closed/sold | (24) | (42) | (44) |
| Number of consolidated clinics—end of period | 1,622 | 1,633 | 1,617 |
| Number of unconsolidated clinics managed—end of period | 306 | 300 | 297 |
| Total number of clinics (all)—end of period | 1,928 | 1,933 | 1,914 |
| Number of visits[3][10] | 9,573,980 | 10,657,558 | 11,147,920 |
| Revenue per visit[3][11] | $ 103 | $ 100 | $ 101 |

(1) Represents the number of hospitals included in our consolidated financial results at the end of each period presented.

(2) Represents the number of hospitals which are managed by us at the end of each period presented. We have minority ownership interests in these businesses.

(3) Data excludes locations managed by the Company.

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

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

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

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

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

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

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

(11) Represents the average amount of revenue recognized for each patient visit. Revenue per visit is calculated by dividing patient service revenue, excluding revenues from certain other ancillary services, by the total number of visits.

## Results of Operations

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Revenue | 100.0 % | 100.0 % | 100.0 % |
| Costs and expenses: | | | |
| Cost of services, exclusive of depreciation and amortization(1) | 91.3 | 88.2 | 87.8 |
| General and administrative | 3.3 | 3.5 | 4.4 |
| Depreciation and amortization | 2.9 | 2.8 | 2.8 |
| Total costs and expenses | 97.5 | 94.5 | 95.0 |
| Other operating income | 0.6 | — | 0.2 |
| Income from continuing operations before other income and expense | 3.1 | 5.5 | 5.2 |
| Loss on early retirement of debt | — | (0.3) | (0.6) |
| Equity in earnings of unconsolidated subsidiaries | 0.6 | 0.9 | 1.2 |
| Interest expense | (2.9) | (3.2) | (2.4) |
| Income from continuing operations before income taxes | 0.8 | 2.9 | 3.4 |
| Income tax expense from continuing operations | 0.4 | 0.6 | 0.9 |
| Income from continuing operations, net of tax | 0.4 | 2.3 | 2.5 |
| Discontinued operations: | | | |
| Income from discontinued business | 4.9 | 5.0 | 4.3 |
| Income tax expense from discontinued business | 1.0 | 1.1 | 1.1 |
| Income from discontinued operations, net of tax | 3.9 | 3.9 | 3.2 |
| Net income | 4.3 | 6.2 | 5.7 |
| Net income attributable to non-controlling interests | 0.9 | 1.2 | 1.6 |
| Net income attributable to Select Medical Holdings Corporation | 3.4 % | 5.0 % | 4.1 % |

(1) Cost of services includes personnel expense, facilities expense, and other operating costs.

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

| | Year Ended December 31, | | | % Change | % Change |
|---|---|---|---|---|---|
| | 2022 | 2023 | 2024 | 2022 – 2023 | 2023 – 2024 |
| | (in thousands, except percentages) | | | | |
| Revenue: | | | | | |
| Critical illness recovery hospital | $ 2,234,132 | $ 2,299,773 | $ 2,444,196 | 2.9 % | 6.3 % |
| Rehabilitation hospital | 916,763 | 979,585 | 1,110,592 | 6.9 | 13.4 |
| Outpatient rehabilitation | 1,125,282 | 1,188,914 | 1,250,294 | 5.7 | 5.2 |
| Other[1] | 333,002 | 357,705 | 382,023 | 7.4 | 6.8 |
| Total Company | $ 4,609,179 | $ 4,825,977 | $ 5,187,105 | 4.7 % | 7.5 % |
| Income (loss) from continuing operations before other income and expense:[2] | | | | | |
| Critical illness recovery hospital | $ 49,779 | $ 182,150 | $ 231,792 | 265.9 % | 27.3 % |
| Rehabilitation hospital | 170,220 | 193,820 | 217,306 | 13.9 | 12.1 |
| Outpatient rehabilitation | 69,197 | 76,658 | 71,998 | 10.8 | (6.1) |
| Other[1] | (144,442) | (185,386) | (252,781) | N/M | N/M |
| Total Company | $ 144,754 | $ 267,242 | $ 268,315 | 84.6 % | 0.4 % |
| Adjusted EBITDA:[2] | | | | | |
| Critical illness recovery hospital | $ 111,344 | $ 246,015 | $ 301,634 | 121.0 % | 22.6 % |
| Rehabilitation hospital | 198,034 | 221,875 | 245,748 | 12.0 | 10.8 |
| Outpatient rehabilitation | 101,860 | 111,868 | 108,577 | 9.8 | (2.9) |
| Other[1] | (98,712) | (133,667) | (145,564) | N/M | N/M |
| Total Company | $ 312,526 | $ 446,091 | $ 510,395 | 42.7 % | 14.4 % |
| Adjusted EBITDA margins:[2] | | | | | |
| Critical illness recovery hospital | 5.0 % | 10.7 % | 12.3 % | | |
| Rehabilitation hospital | 21.6 | 22.6 | 22.1 | | |
| Outpatient rehabilitation | 9.1 | 9.4 | 8.7 | | |
| Other[1] | N/M | N/M | N/M | | |
| Total Company | 6.8 % | 9.2 % | 9.8 % | | |
| Total assets: | | | | | |
| Critical illness recovery hospital | $ 2,484,542 | $ 2,496,886 | $ 2,654,474 | | |
| Rehabilitation hospital | 1,200,767 | 1,233,888 | 1,366,922 | | |
| Outpatient rehabilitation | 1,371,123 | 1,380,447 | 1,404,379 | | |
| Other[1] | 327,214 | 248,204 | 182,176 | | |
| Total Company | $ 5,383,646 | $ 5,359,425 | $ 5,607,951 | | |
| Purchases of property, equipment and other assets: | | | | | |
| Critical illness recovery hospital | $ 79,524 | $ 93,036 | $ 65,861 | | |
| Rehabilitation hospital | 14,426 | 21,922 | 53,620 | | |
| Outpatient rehabilitation | 40,677 | 38,776 | 36,142 | | |
| Other[1] | 9,762 | 6,126 | 3,285 | | |
| Total Company | $ 144,389 | $ 159,860 | $ 158,908 | | |

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

(2) For the years ended December 31, 2024, 2023, and 2022, we recognized other operating income of $3.4 million, $1.5 million, and $28.5 million, respectively. The impact of this income on the operating results of our segments and other activities is outlined within the tables presented under "*Summary Financial Results.*"

N/M Not meaningful.

***Year Ended December 31, 2024 Compared to Year Ended December 31, 2023***

For the year ended December 31, 2024, we had revenue of $5,187.1 million and income from continuing operations before other income and expense of $268.3 million, as compared to revenue of $4,826.0 million and income from continuing operations before other income and expense of $267.2 million for the year ended December 31, 2023. For the year ended December 31, 2024, Adjusted EBITDA was $510.4 million, with an Adjusted EBITDA margin of 9.8%, as compared to Adjusted EBITDA of $446.1 million and an Adjusted EBITDA margin of 9.2% in the prior year.

The improvement in our financial performance for the year ended December 31, 2024, as compared to the year ended December 31, 2023, was principally attributable to the increase in revenue in our Critical Illness Recovery Hospital and Rehabilitation Hospital segments, as discussed below under "*Revenue.*"

***Revenue***

*Critical Illness Recovery Hospital Segment.* Revenue increased 6.3% to $2,444.2 million for the year ended December 31, 2024, compared to $2,299.8 million for the year ended December 31, 2023. The increase was attributable to revenue per patient day, which increased 5.3% to $2,177 for the year ended December 31, 2024, compared to $2,067 for the year ended December 31, 2023. Our patient days increased 0.9% to 1,118,757 for the year ended December 31, 2024, compared to 1,108,492 patient days for the year ended December 31, 2023. Occupancy in our critical illness recovery hospitals was 68% for the years ended December 31, 2024 and 2023.

*Rehabilitation Hospital Segment.* Revenue increased 13.4% to $1,110.6 million for the year ended December 31, 2024, compared to $979.6 million for the year ended December 31, 2023. Our revenue per patient day increased 5.8% to $2,134 for the year ended December 31, 2024, compared to $2,017 for the year ended December 31, 2023. Our patient days increased 5.5% to 470,594 days for the year ended December 31, 2024, compared to 446,145 days for the year ended December 31, 2023. Occupancy in our rehabilitation hospitals was 84% for the year ended December 31, 2024, compared to 85% for the year ended December 31, 2023.

*Outpatient Rehabilitation Segment.* Revenue increased 5.2% to $1,250.3 million for the year ended December 31, 2024, compared to $1,188.9 million for the year ended December 31, 2023. The increase was principally attributable to patient visits, which increased 4.6% to 11,147,920 for the year ended December 31, 2024, compared to 10,657,558 visits for the year ended December 31, 2023. Our revenue per visit increased 1.0% to $101 for the year ended December 31, 2024, compared to $100 for the year ended December 31, 2023.

***Operating Expenses***

Our operating expenses consist principally of cost of services and general and administrative expenses. Our operating expenses were $4,779.3 million, or 92.2% of revenue, for the year ended December 31, 2024, compared to $4,424.6 million, or 91.7% of revenue, for the year ended December 31, 2023. Our cost of services, a major component of which is labor expense, was $4,553.5 million, or 87.8% of revenue, for the year ended December 31, 2024, compared to $4,254.4 million, or 88.2% of revenue, for the year ended December 31, 2023. General and administrative expenses were $225.9 million, or 4.4% of revenue, for the year ended December 31, 2024, compared to $170.2 million, or 3.5% of revenue, for the year ended December 31, 2023. The increase in general and administrative expenses relative to our revenue was principally attributable to the accelerated recognition of $33.4 million of stock compensation expense recognized as a result of modifications to the restricted stock awards, as described in *Note 17 - Stock-based Compensation.*

***Other Operating Income***

For the year ended December 31, 2024, we had other operating income of $3.4 million, compared to $1.5 million for the year ended December 31, 2023.

***Adjusted EBITDA***

*Critical Illness Recovery Hospital Segment.* Adjusted EBITDA increased 22.6% to $301.6 million for the year ended December 31, 2024, compared to $246.0 million for the year ended December 31, 2023. Our Adjusted EBITDA margin for the critical illness recovery hospital segment was 12.3% for the year ended December 31, 2024, compared to 10.7% for the year ended December 31, 2023. The increases in our Adjusted EBITDA and Adjusted EBITDA margin during the year ended December 31, 2024, as compared to the year ended December 31, 2023, were principally attributable an increase in net revenue.

*Rehabilitation Hospital Segment.* Adjusted EBITDA increased 10.8% to $245.7 million for the year ended December 31, 2024, compared to $221.9 million for the year ended December 31, 2023. Our Adjusted EBITDA margin for the rehabilitation hospital segment was 22.1% for the year ended December 31, 2024, compared to 22.6% for the year ended December 31, 2023. The increase in Adjusted EBITDA was principally due to an increase in revenue.

*Outpatient Rehabilitation Segment.* Adjusted EBITDA was $108.6 million for the year ended December 31, 2024, compared to $111.9 million for the year ended December 31, 2023. Our Adjusted EBITDA margin for the outpatient rehabilitation segment was 8.7% for the year ended December 31, 2024, compared to 9.4% for the year ended December 31, 2023. The decreases in our Adjusted EBITDA and Adjusted EBITDA margin for the year ended December 31, 2024, as compared to the year ended December 31, 2023, were principally attributable to higher labor costs, partially offset by an increase in revenue.

***Depreciation and Amortization***

Depreciation and amortization expense was $142.9 million for the year ended December 31, 2024, compared to $135.7 million for the year ended December 31, 2023.

***Income from Continuing Operations before Other Income and Expense***

For the year ended December 31, 2024, we had income from operations from continuing operations before other income and expense of $268.3 million, compared to $267.2 million for the year ended December 31, 2023.

***Loss on Early Retirement of Debt***

For the year ended December 31, 2024, we had a loss on early retirement of debt of $28.8 million related to the prepayment on our term loan, the amendments to the Select credit agreement, and the refinancing of our senior notes, as described in *Note 12 - Long-Term Debt and Notes Payable*. For the year ended December 31, 2023, we had a loss on early retirement of debt of $14.7 million related to an amendment to the Select credit agreement.

***Equity in Earnings of Unconsolidated Subsidiaries***

For the year ended December 31, 2024, we had equity in earnings of unconsolidated subsidiaries of $63.9 million, compared to $41.3 million for the year ended December 31, 2023. The increase in equity in earnings of unconsolidated subsidiaries is principally due to a gain of $14.6 million recognized upon gaining a controlling financial interest in a previously unconsolidated entity. Additionally, we had improved operating performance of our rehabilitation businesses in which we are a minority owner.

***Interest***

Interest expense was $128.6 million for the year ended December 31, 2024, compared to $154.2 million for the year ended December 31, 2023. The decrease in interest expense was principally due to the reduction in total debt as a result of the financing transactions, as described in *Note 12. Long-Term Debt and Notes Payable*.

***Income Tax Expense from Continuing Operations***

We recorded income tax expense of $44.8 million for the year ended December 31, 2024, which represented an effective tax rate of 25.6%. We recorded income tax expense of $29.3 million for the year ended December 31, 2023, which represented an effective tax rate of 20.9%. For the year ended December 31, 2024, the higher effective tax rate primarily resulted from a limitation on deductibility of officer's compensation associated with the restricted stock award modifications as described in *Note 17 - Stock-based Compensation*. Additionally, our effective tax rate for the year ended December 31, 2023 was lower partially due to a reduction in the state tax rates used in evaluating our net deferred tax liabilities.

Refer to *Note 18 – Income Taxes* of the notes to our consolidated financial statements included herein for the reconciliations of the statutory federal income tax rate to our effective income rate for the years ended December 31, 2024 and 2023.

***Income from Discontinued Operations, Net of Tax***

For the year ended December 31, 2024, we had income from discontinued operations, net of tax, of $166.7 million, compared to $189.3 million for the year ended December 31, 2023. Discontinued operations for both periods represent the operations of Concentra. The common stock of Concentra was distributed to Select stockholders on November 25, 2024, as discussed in "*Overview*." The decrease in income from discontinued operations, net of tax, was primarily due to the $16.3 million of transaction costs included within discontinued operations, as discussed in *Note 2 - Acquisitions and Dispositions.*

***Year Ended December 31, 2023 Compared to Year Ended December 31, 2022***

For the year ended December 31, 2023, we had revenue of $4,826.0 million and income from continuing operations before other income and expense of $267.2 million, as compared to revenue of $4,609.2 million and income from continuing operations before other income and expense of $144.8 million for the year ended December 31, 2022. For the year ended December 31, 2023, Adjusted EBITDA was $446.1 million, with an Adjusted EBITDA margin of 9.2%, as compared to Adjusted EBITDA of $312.5 million and an Adjusted EBITDA margin of 6.8% in the prior year.

A significant contributor to the improvement in our financial performance for the year ended December 31, 2023, as compared to the year ended December 31, 2022, was a decrease in labor costs and an increase in revenue in our critical illness recovery hospital segment, as the investments we made in recruitment, hiring, and retention of full-time staff in 2022 resulted in a significant decrease in contract labor utilization in 2023. Additionally, reduced demand in the marketplace resulted in lower contract labor rates, which further contributed to the decrease in total contract labor costs. We believe the ratio of personnel expense to net revenue for the critical illness recovery hospital segment for the year ended December 31, 2023, is indicative of a more stabilized labor environment. Revenue, Adjusted EBITDA, and Adjusted EBITDA margin increased for the year ended December 31, 2023, as compared to the year ended December 31, 2022, in each of our other operating segments. Other operating income during the year ended December 31, 2023, was $1.5 million. Other operating income during the year ended December 31, 2022, was $28.5 million, principally related to the recognition of payments received under the Provider Relief Fund for health care related expenses and lost revenues attributable to COVID-19.

***Revenue***

*Critical Illness Recovery Hospital Segment.* Revenue increased 2.9% to $2,299.8 million for the year ended December 31, 2023, compared to $2,234.1 million for the year ended December 31, 2022. The increase was attributable to revenue per patient day, which increased 4.8% to $2,067 for the year ended December 31, 2023, compared to $1,973 for the year ended December 31, 2022. Our patient days were 1,108,492 for the year ended December 31, 2023, compared to 1,127,911 patient days for the year ended December 31, 2022. Occupancy in our critical illness recovery hospitals was 68% for the year ended December 31, 2023, compared to 69% for the year ended December 31, 2022.

*Rehabilitation Hospital Segment.* Revenue increased 6.9% to $979.6 million for the year ended December 31, 2023, compared to $916.8 million for the year ended December 31, 2022. Our revenue per patient day increased 3.3% to $2,017 for the year ended December 31, 2023, compared to $1,953 for the year ended December 31, 2022. Our patient days increased 3.6% to 446,145 days for the year ended December 31, 2023, compared to 430,547 days for the year ended December 31, 2022. Occupancy in our rehabilitation hospitals was 85% for the years ended December 31, 2023 and 2022.

*Outpatient Rehabilitation Segment.* Revenue increased 5.7% to $1,188.9 million for the year ended December 31, 2023, compared to $1,125.3 million for the year ended December 31, 2022. The increase was attributable to patient visits, which increased 11.3% to 10,657,558 for the year ended December 31, 2023, compared to 9,573,980 visits for the year ended December 31, 2022. Our revenue per visit was $100 for the year ended December 31, 2023, compared to $103 for the year ended December 31, 2022, principally attributable to a decrease in Medicare reimbursement, changes in payor mix, and an increase in variable discounts.

***Operating Expenses***

Our operating expenses consist principally of cost of services and general and administrative expenses. Our operating expenses were $4,424.6 million, or 91.7% of revenue, for the year ended December 31, 2023, compared to $4,360.7 million, or 94.6% of revenue, for the year ended December 31, 2022. Our cost of services, a major component of which is labor expense, was $4,254.4 million, or 88.2% of revenue, for the year ended December 31, 2023, compared to $4,207.7 million, or 91.3% of revenue, for the year ended December 31, 2022. The decrease in our operating expenses relative to our revenue was principally attributable to the decreased labor costs within our critical illness recovery hospital segment, as explained further within the "*Adjusted EBITDA*" discussion. General and administrative expenses were $170.2 million, or 3.5% of revenue, for the year ended December 31, 2023, compared to $153.0 million, or 3.3% of revenue, for the year ended December 31, 2022.

***Other Operating Income***

For the year ended December 31, 2023, we had other operating income of $1.5 million, compared to $28.5 million for the year ended December 31, 2022. The other operating income for the year ended December 31, 2022, is included within the operating results of our other activities, and is principally related to the recognition of payments received under the Provider Relief Fund for health care related expenses and lost revenues attributable to COVID-19.

***Adjusted EBITDA***

*Critical Illness Recovery Hospital Segment.* Adjusted EBITDA increased 121.0% to $246.0 million for the year ended December 31, 2023, compared to $111.3 million for the year ended December 31, 2022. Our Adjusted EBITDA margin for the critical illness recovery hospital segment was 10.7% for the year ended December 31, 2023, compared to 5.0% for the year ended December 31, 2022. The increases in our Adjusted EBITDA and Adjusted EBITDA margin during the year ended December 31, 2023, as compared to the year ended December 31, 2022, were attributable to lower labor costs as well as an increase in net revenue. The decrease in labor costs resulted from our efforts in 2022 to hire additional full-time nursing staff, improve retention among our employees, and decrease our reliance on contract labor, as well as the lower contract labor rates attributable to reduced demand in the marketplace. Our total contract labor costs decreased by approximately 62% during the year ended December 31, 2023, as compared to the year ended December 31, 2022, which was driven by an approximate 41% decrease in utilization of contract registered nurses and an approximate 32% decrease in the rate per hour for contract registered nurses.

*Rehabilitation Hospital Segment.* Adjusted EBITDA increased 12.0% to $221.9 million for the year ended December 31, 2023, compared to $198.0 million for the year ended December 31, 2022. Our Adjusted EBITDA margin for the rehabilitation hospital segment was 22.6% for the year ended December 31, 2023, compared to 21.6% for the year ended December 31, 2022. The increases in Adjusted EBITDA and Adjusted EBITDA margin were principally attributable to an increase in revenue.

*Outpatient Rehabilitation Segment.* Adjusted EBITDA increased 9.8% to $111.9 million for the year ended December 31, 2023, compared to $101.9 million for the year ended December 31, 2022. Our Adjusted EBITDA margin for the outpatient rehabilitation segment was 9.4% for the year ended December 31, 2023, compared to 9.1% for the year ended December 31, 2022. The increases in Adjusted EBITDA and Adjusted EBITDA margin were principally attributable to an increase in revenue.

***Depreciation and Amortization***

Depreciation and amortization expense was $135.7 million for the year ended December 31, 2023, compared to $132.2 million for the year ended December 31, 2022.

***Income from Continuing Operations before Other Income and Expense***

For the year ended December 31, 2023, we had income from operations of $267.2 million, compared to $144.8 million for the year ended December 31, 2022. The decline in labor costs and increase in revenue experienced within our critical illness recovery hospital segment was the primary cause of the increase in income from operations, as discussed above under "*Adjusted EBITDA.*" We recognized other operating income of $1.5 million during the year ended December 31, 2023, compared to $28.5 million for the year ended December 31, 2022, as described further under "*Other Operating Income.*"

***Loss on Early Retirement of Debt***

For the year ended December 31, 2023, we had a loss on early retirement of debt of $14.7 million related to an amendment to the Select credit agreement, as described in *Note 12. Long-Term Debt and Notes Payable*.

***Equity in Earnings of Unconsolidated Subsidiaries***

For the year ended December 31, 2023, we had equity in earnings of unconsolidated subsidiaries of $41.3 million, compared to $28.0 million for the year ended December 31, 2022. The increase in equity in earnings is principally attributable to the improved operating performance of our rehabilitation businesses in which we are a minority owner.

***Interest***

Our term loan was subject to an interest rate cap, which limited the variable interest rate index to 1.0% on $2.0 billion of principal outstanding under the term loan. The Term SOFR rate was 5.35% at December 31, 2023, compared to the one-month LIBOR rate of 4.39% at December 31, 2022. The one-month LIBOR rate first exceeded 1.0% in June 2022 and the interest rate cap mitigated our exposure to increases in the one-month LIBOR and Term SOFR rates on the term loan. Interest expense was $154.2 million for the year ended December 31, 2023, compared to $137.5 million for the year ended December 31, 2022. The increase was attributable to higher average outstanding borrowings under our revolving facility during the year ended December 31, 2023, as well as an increase in the variable interest rate to the extent not mitigated by the interest rate cap.

***Income Tax Expense from Continuing Operations***

We recorded income tax expense of $29.3 million for the year ended December 31, 2023, which represented an effective tax rate of 20.9%. We recorded income tax expense of $16.7 million for the year ended December 31, 2022, which represented an effective tax rate of 47.4%. For the year ended December 31, 2023, the decrease in our effective tax rate was partially due to a reduction in the state tax rates used in evaluating our net deferred tax liabilities. Additionally, our effective tax rate for the year ended December 31, 2022 was higher due to our lower income from continuing operations, the mix of states in which the income was earned, valuation allowances recorded as a result of an inability to recognize net operating losses in future periods and the effect of permanent tax differences.

Refer to *Note 18. Income Taxes* of the notes to our consolidated financial statements included herein for the reconciliations of the statutory federal income tax rate to our effective income rate for the years ended December 31, 2023 and 2022.

***Income from Discontinued Operations, Net of Tax***

For the year ended December 31, 2023, we had income from discontinued operations, net of tax, of $189.3 million, compared to $179.5 million for the year ended December 31, 2022. Discontinued operations for both periods represent the operations of Concentra. The common stock of Concentra was distributed to Select stockholders on November 25, 2024, as discussed in "*Overview*." The increase in income from discontinued operations, net of tax, was principally attributable to an increase in revenue for Concentra.

## Liquidity and Capital Resources

***Cash Flows for the Years Ended December 31, 2022, 2023, and 2024***

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Cash flows provided by operating activities | $ 284,825 | $ 582,058 | $ 517,864 |
| Cash flows used in investing activities | (226,339) | (268,477) | (231,011) |
| Cash flows used in financing activities | (34,890) | (327,481) | (311,165) |
| Net increase (decrease) in cash and cash equivalents | 23,596 | (13,900) | (24,312) |
| Cash and cash equivalents at beginning of period | 74,310 | 97,906 | 84,006 |
| Cash and cash equivalents at end of period [1] | $ 97,906 | $ 84,006 | $ 59,694 |

(1) The Company had and $37.7 million and $31.4 million of cash and cash equivalents from discontinued operations at December 31, 2022 and 2023, respectively.

Operating activities provided $517.9 million, $582.1 million, and $284.8 million of cash flows during the years ended December 31, 2024, 2023, and 2022, respectively. The decrease in cash flows from operating activities for the year ended December 31, 2024, as compared to the year ended December 31, 2023, was principally due to a increase in accounts receivable, which was principally driven by an increase in revenue and an increase in days sales outstanding, and partially offset by an increase in cash flows from operating performance. The increase in cash flows from operating activities for the year ended December 31, 2023, as compared to the year ended December 31, 2022, was principally due to a increase in our operating income and routine changes in net working capital.

Our days sales outstanding was 58 days at December 31, 2024, 60 days at September 30, 2024, 55 days at December 31, 2023, and 58 days at December 31, 2022. Our days sales outstanding will fluctuate based upon variability in our collection cycles and patient volumes.

Investing activities used $231.0 million, $268.5 million, and $226.3 million of cash flows for the years ended December 31, 2024, 2023, and 2022, respectively. For the year ended December 31, 2024, the principal uses of cash were $222.2 million for purchases of property, equipment, and other assets, and $13.1 million for investments in and acquisitions of businesses. For the year ended December 31, 2023, the principal uses of cash were $229.2 million for purchases of property and equipment, and other assets, and $39.4 million for investments in and acquisitions of businesses. For the year ended December 31, 2022, the principal uses of cash were $190.4 million for purchases of property, equipment, and other assets, and $44.3 million for investments in and acquisitions of businesses. The cash outflows were offset in part by proceeds received from the sale of assets and business of $8.3 million.

Financing activities used $311.2 million of cash flows for the year ended December 31, 2024. The principal uses of cash were net payments of $212.4 million on our term loans, $182.1 million of cash transferred to Concentra upon separation, net payments of $175.0 million under our revolving facility, $64.6 million of dividend payments to common stockholders, $61.2 million of net payments as a result of the payoff of our 6.250% senior notes due 2026, and subsequent issuance of our 6.250% senior notes due 2032, and $60.0 million for distributions to and purchases of non-controlling interests. The cash outflows were partially offset by proceeds from the Concentra IPO of $511.2 million.

Financing activities used $327.5 million of cash flows for the year ended December 31, 2023. The principal use of cash were net payments of $165.0 million under our revolving facility, $63.9 million of dividend payments to common stockholders, and $63.5 million for distributions to and purchases of non-controlling interests.

Financing activities used $34.9 million of cash flows for the year ended December 31, 2022. The principal use of cash were $195.5 million for repurchases of common stock, $64.6 million of dividend payments to common stockholders, and $43.1 million for distributions to and purchases of non-controlling interests. We had net borrowings of $285.0 million under our revolving facility.

***Capital Resources***

*Working capital.* We had net working capital of $42.1 million at December 31, 2024, compared to a net working capital of $9.2 million at December 31, 2023. The change in net working capital was primarily due to an increase in accounts receivable, partially offset by the decrease in net working capital as a result of the distribution of our ownership interest in Concentra.

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

*Credit facilities.* On July 26, 2024, the Company entered into Amendment No. 10 to the credit agreement. Amendment No. 10 reduced the revolving credit facility commitments available under the credit agreement from $770.0 million to $550.0 million. Select also made a voluntary prepayment of $1,640.4 million on its term loan and a $300.0 million repayment on its revolving credit facility using the proceeds derived from the Concentra IPO and related debt transactions.

On December 3, 2024, the Company entered into Amendment No. 11 to the credit agreement. Amendment No. 11 established a new incremental term loan in the aggregate amount of $1,050.0 million to replace the existing term loans. The maturity date of the term loan is December 3, 2031. In addition, Amendment No. 11 extended the maturity date of the revolving credit facility to December 3, 2029 and increased the revolving credit facility commitments from $550.0 million to $600.0 million.

At December 31, 2024, Select had outstanding borrowings under its credit facilities consisting of a $1,050.0 million term loan (excluding unamortized original issue discounts and debt issuance costs of $8.3 million) and borrowings of $105.0 million under its revolving facility. At December 31, 2024, Select had $453.3 million of availability under its revolving facility after giving effect to $105.0 million of outstanding borrowings and $41.7 million of outstanding letters of credit.

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

As of December 31, 2024, Select’s leverage ratio (its ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters), which is required to be maintained at less than 7.00 to 1.00 under the terms of the revolving facility, was 3.18 to 1.00.

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

*6.250% senior notes.* On December 3, 2024, Select issued and sold $550.0 million aggregate principal amount of 6.250% senior notes due December 1, 2032. Select used the net proceeds of the 6.250% senior notes due 2032, together with the proceeds from the incremental term loan borrowings (as described above) and cash on hand, to redeem in full the $1,225.0 million of senior notes due 2026 and pay related fees and expenses associated with the financing.

At December 31, 2024, Select had $550.0 million of 6.250% senior notes outstanding (excluding debt issuance costs of $10.6 million).

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

*Stock Repurchase Program.* Holdings' Board of Directors has authorized a common stock repurchase program to repurchase up to $1.0 billion worth of shares of its common stock. The common stock repurchase program will remain in effect until December 31, 2025, unless further extended or earlier terminated by the Board of Directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate. Holdings funds this program with cash on hand and borrowings under its revolving facility. During the year ended December 31, 2024, Holdings did not repurchase shares under the program. Since the inception of the program through December 31, 2024, Holdings has repurchased 48,234,823 shares at a cost of approximately $600.3 million, or $12.45 per share, which includes transaction costs. On August 16, 2022, Congress passed the Inflation Reduction Act of 2022, which enacted a 1% excise tax on stock repurchases that exceed $1.0 million, effective January 1, 2023.

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

***Liquidity***

We believe our internally generated cash flows and borrowing capacity under our revolving facility will allow us to finance our operations in both the short and long term. As of December 31, 2024, we had cash and cash equivalents of $59.7 million and $453.3 million of availability under our revolving facility, after giving effect to $105.0 million of outstanding borrowings and $41.7 million of outstanding letters of credit.

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

i. *Debt payments, including finance lease payments* – Our expected principal payments total $1,731.3 million, with $20.3 million payable within the next twelve months. Refer to *Note 12 – Long-Term Debt and Notes Payable* of the notes to our consolidated financial statements included herein for additional information.

ii. *Interest payments* – Our expected interest payments on the 6.250% senior notes, term loan, and revolving facility total $763.7 million, with $111.6 million payable within the next twelve months. Interest payments for the 6.250% senior notes were calculated using the stated interest rate. Interest payments for the term loan and revolving facility were calculated using interest rates of 6.5% and 8.7%, respectively.

iii. *Operating lease payments* – Our expected operating lease payments total $1,374.2 million, with $235.5 million payable within the next twelve months. Refer to Note 4 – Leases of the notes to our consolidated financial statements included herein for additional information.

iv. *Purchase, construction, and other commitments* – Our expected payments related to purchase, construction, and other obligations total $282.8 million, with $237.7 million payable within the next twelve months. Our purchase obligations primarily relate to software licensing and support agreements which specify all significant contractual terms and are legally binding and enforceable. Our construction commitments are described further in Note 20 – Commitments and Contingencies.

v. *Insurance liabilities* – Our expected payments related to our insurance liabilities, including those for workers' compensation and professional malpractice liabilities, total $141.6 million, with $69.3 million payable within the next twelve months. The amounts payable within the next twelve months are recorded in accrued other in the consolidated balance sheet as of December 31, 2024. The remaining amounts are recorded in other non-current liabilities.

vi. Other current liabilities recorded in the consolidated balance sheet as of December 31, 2024, such as accounts payable and accrued expenses, which are not specifically identified above.

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

***Dividend***

On February 13, 2024, May 1, 2024, July 31, 2024, and October 30, 2024, our Board of Directors declared a cash dividend of $0.125 per share. On March 13, 2024, May 30, 2024, August 30, 2024, and November 26, 2024, cash dividends totaling $16.0 million, $16.3 million, $16.2 million, and $16.1 million were paid.

On February 13, 2025, our Board of Directors declared a cash dividend of $0.0625 per share. The dividend will be payable on or about March 13, 2025, to stockholders of record as of the close of business on March 3, 2025.

**Effects of Inflation**

The healthcare industry is labor intensive and our largest expenses are labor related costs. Wage and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. We have recently experienced higher labor costs related to the current inflationary environment and competitive labor market. In addition, suppliers have passed along rising costs to us in the form of higher prices. We cannot predict our ability to pass along cost increases to our customers.

**Recent Accounting Pronouncements**

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

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

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

As of December 31, 2024, Select had outstanding borrowings under its credit facilities consisting of a $1,050.0 million term loan (excluding unamortized original issue discount and debt issuance costs of $8.3 million) and $105.0 million of borrowings under its revolving facility. As of December 31, 2024, a 0.25% change in market interest rates would impact the interest expense on our variable rate debt by approximately $2.9 million per year.

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

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

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

None.

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

**Evaluation of Disclosure Controls and Procedures**

We carried out an evaluation, under the supervision and with the participation of our principal executive officer and principal financial officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rule 13a-15(e) of the Securities Exchange Act of 1934) as of the end of the period covered in this report. Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures, including the accumulation and communication of disclosure to our principal executive officer and principal financial officer as appropriate to allow timely decisions regarding disclosure, are effective as of December 31, 2024, to provide reasonable assurance that material information required to be included in our periodic SEC reports is recorded, processed, summarized, and reported within the time periods specified in the relevant SEC rules and forms.

**Changes in Internal Control over Financial Reporting**

There was no change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Securities Exchange Act of 1934) identified in connection with the evaluation required by Rule 13a-15(d) of the Securities Exchange Act of 1934 that occurred during the fourth quarter of the year ended December 31, 2024, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**Inherent Limitations on Effectiveness of Controls**

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

**Management's Report on Internal Control over Financial Reporting**

Management is responsible for establishing and maintaining an adequate system of internal control over our financial reporting. In order to evaluate the effectiveness of internal control over financial reporting, as required by Section 404 of the Sarbanes-Oxley Act, management has conducted an assessment, including testing, using the criteria of "Internal Control—Integrated Framework (2013)" issued by the Committee of Sponsoring Organizations of the Treadway Commission, or "COSO," as of December 31, 2024. Our system of internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation and fair presentation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

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

Management assessed the effectiveness of the Company’s internal control over financial reporting as of December 31, 2024. This assessment was based on criteria for effective internal control over financial reporting described in “Internal Control—Integrated Framework (2013)” issued by COSO. Based on this assessment, management concludes that, as of December 31, 2024, internal control over financial reporting was effective to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements in accordance with U.S. generally accepted accounting principles. The effectiveness of the Company’s internal control over financial reporting as of December 31, 2024, has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm as stated in their report which appears herein.

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

***Rule 10b5-1 Trading Plans***

On December 4, 2024, David Chernow, the Company’s Chief Executive Officer, entered into a trading plan intended to satisfy the affirmative defense conditions of Rule 10b5-1(c) under the Exchange Act. The plan provides for the sale, subject to certain price limits, of up to 225,000 shares of common stock. Mr. Chernow’s plan will expire on December 31, 2025, subject to early termination in accordance with the terms of the plan.

On December 5, 2024, Robert Ortenzio, the Company’s Executive Chairman and Co-Founder, and Robert A Ortenzio Descendants Trust DTD 12/23/2002, entered into a trading plan intended to satisfy the affirmative defense conditions of Rule 10b5-1(c) under the Exchange Act. The plan provides for the sale, subject to certain price limits, of up to 600,000 shares of common stock for Robert Ortenzio, and of up to 125,000 shares for Robert A. Ortenzio Descendants Trust DTD 12/23/2002. Mr. Ortenzio’s plan will expire on March 14, 2026, subject to early termination in accordance with the terms of the plan.

**Item 9C.** ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.***

None.

# PART III

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

The Company has an insider trading policy governing the purchase, sale and other dispositions of the Company's securities that applies to all Company personnel, including directors, officers, employees, and other covered persons. The Company also follows procedures for the repurchase of its securities. The Company believes that its insider trading policy and repurchase procedures are reasonably designed to promote compliance with insider trading laws, rules and regulations, and listing standards applicable to the Company. A copy of the Company's insider trading policy is filed as Exhibit 19.1 to this Form 10-K.

The information regarding directors and nominees for directors of the Company, including identification of the audit committee and audit committee financial expert, and Compliance with Section 16(a) of the Exchange Act is presented under the headings "Corporate Governance—Committees of the Board of Directors" and "Election of Directors—Directors and Nominees" in the Company's definitive proxy statement for use in connection with the 2025 Annual Meeting of Stockholders (the "Proxy Statement") to be filed within 120 days after the end of the Company's fiscal year ended December 31, 2024. The information contained under these headings is incorporated herein by reference. Information regarding the executive officers of the Company is included in this annual report on Form 10-K under Item 1 of Part I as permitted by the Instruction to Item 401 of Regulation S-K.

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

## Item 11. *Executive Compensation.*

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

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

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

### *Equity Compensation Plan Information*

Set forth in the table below is a list of all of our equity compensation plans and the number of securities to be issued on exercise of equity rights, average exercise price, and number of securities that would remain available under each plan if outstanding equity rights were exercised as of December 31, 2024.

| Plan Category | Number of securities to be issued upon exercise of outstanding options, warrants and rights (a) | Weighted-average exercise price of outstanding options, warrants and rights (b) | Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))(c) |
|---|---|---|---|
| Equity compensation plans approved by security holders: | | | |
| Select Medical Holdings Corporation 2020 Equity Incentive Plan | — | — | 4,266,900 |
| Equity compensation plans not approved by security holders | — | — | — |

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

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

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

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

## PART IV

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

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

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

ii. Financial Statement Schedule: See Schedule II—Valuation and Qualifying Accounts appearing on page F-41 of this report.

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

| Number | Description |
|---|---|
| 3.1 | Amended and Restated Certificate of Incorporation of Select Medical Corporation, incorporated by reference to Exhibit 3.1 of Select Medical Corporation's Form S-4 filed June 15, 2005 (Reg. No. 001-31441). |
| 3.2 | Form of Restated Certificate of Incorporation of Select Medical Holdings Corporation, incorporated by reference to Exhibit 3.3 of Select Medical Holdings Corporation's Form S-1/A filed September 21, 2009 (Reg. No. 333-152514). |
| 3.3 | Amended and Restated Bylaws of Select Medical Corporation, incorporated herein by reference to Exhibit 3.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed on October 30, 2014 (Reg. Nos. 001-34465 and 001-31441). |
| 3.4 | Amended and Restated Bylaws of Select Medical Holdings Corporation, as amended, incorporated herein by reference to Exhibit 3.4 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2016 (Reg. Nos. 001-34465 and 001-31441). |
| 4.1 | Description of Registrant's Securities, incorporated herein by reference to Exhibit 4.3 of Select Medical Holdings Corporation's Annual Report on Form 10-K for the fiscal year December 31, 2019, filed on February 20, 2020 (Reg. No. 001-34465). |
| 4.2 | Indenture, dated as of December 3, 2024, by and among Select Medical Corporation, the guarantors named therein and U.S.Bank Trust Company, National Association, as trustee, incorporated herein by reference to Exhibit 4.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation on December 4, 2024 (Reg. No. 001-34465). |
| 4.3 | Forms of 6.250% Senior Notes due 2032, incorporated herein by reference to Exhibit 4.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation on December 4, 2024 (Reg. No. 001-34465). |
| 10.1 | Employment Agreement, dated as of March 1, 2000, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.14 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856). |
| 10.2 | Amendment No. 1 to Employment Agreement, dated as of August 8, 2000, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.15 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856). |
| 10.3 | Amendment No. 2 to Employment Agreement, dated as of February 23, 2001, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.48 of Select Medical Corporation's Registration Statement on Form S-1 filed March 30, 2001 (Reg. No. 333-48856). |
| 10.4 | Amendment No. 3 to Employment Agreement, dated as of September 17, 2001, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.53 of Select Medical Corporation's Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (Reg. No. 000-32499). |
| 10.5 | Amendment No. 4 to Employment Agreement, dated as of December 10, 2004, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 99.3 of Select Medical Corporation's Current Report on Form 8-K filed December 16, 2004 (Reg. No. 001-31441). |
| 10.6 | Amendment No. 5 to Employment Agreement, dated as of February 24, 2005, between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.16 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846). |
| 10.7 | Change of Control Agreement, dated as of March 1, 2000, between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.11 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856). |
| 10.8 | Amendment to Change of Control Agreement, dated as of February 23, 2001, between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.52 of Select Medical Corporation's Registration Statement on Form S-1 filed March 30, 2001 (Reg. No. 333-48856). |
| 10.9 | Second Amendment to Change of Control Agreement, dated as of February 24, 2005, between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.24 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846). |
| 10.10 | Change of Control Agreement, dated as of March 1, 2000, between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.22 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856). |

| Number | Description |
| --- | --- |
| 10.11 | Amendment to Change of Control Agreement, dated as of February 23, 2001, between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.54 of Select Medical Corporation's Registration Statement on Form S-1 filed March 30, 2001 (Reg. No. 333-48856). |
| 10.12 | Second Amendment to Change of Control Agreement, dated as of February 24, 2005, between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.39 of Select Medical Corporation's Form S-4 filed June 16, 2005 (Reg. No. 333-125846). |
| 10.13 | Office Lease Agreement, dated as of June 17, 1999, between Select Medical Corporation and Old Gettysburg Associates III, incorporated by reference to Exhibit 10.27 of Select Medical Corporation's Registration Statement on Form S-1 filed October 27, 2000 (Reg. No. 333-48856). |
| 10.14 | First Addendum to Lease Agreement, dated as of April 25, 2008, between Old Gettysburg Associates III and Select Medical Corporation, incorporated by reference to Exhibit 10.65 of Select Medical Holdings Corporation's Form S-1 filed July 24, 2008 (Reg. No. 333-152514). |
| 10.15 | Second Addendum to Lease Agreement, dated as of November 1, 2012, between Old Gettysburg Associates III LP and Select Medical Corporation, incorporated by reference to Exhibit 10.37 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441). |
| 10.16 | Office Lease Agreement, dated August 25, 2006, between Old Gettysburg Associates IV, L.P. and Select Medical Corporation, incorporated by reference to Exhibit 10.1 of Select Medical Corporation's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006 (Reg. No. 001-31441). |
| 10.17 | First Addendum to Lease Agreement, dated as of November 1, 2012, between Old Gettysburg Associates IV LP and Select Medical Corporation, incorporated by reference to Exhibit 10.39 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441). |
| 10.18 | Office Lease Agreement, dated November 1, 2012, by and between Select Medical Corporation and Old Gettysburg Associates, incorporated by reference to Exhibit 10.40 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441). |
| 10.19 | Office Lease Agreement, dated November 1, 2012, by and between Select Medical Corporation and Old Gettysburg Associates II, LP, incorporated by reference to Exhibit 10.41 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 26, 2013 (Reg. Nos. 001-34465 and 001-31441). |
| 10.20 | Amendment No. 6 to Employment Agreement between Select Medical Corporation and Robert A. Ortenzio, incorporated by reference to Exhibit 10.96 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514). |
| 10.21 | Third Amendment to Change of Control Agreement between Select Medical Corporation and Michael E. Tarvin, incorporated by reference to Exhibit 10.100 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514). |
| 10.22 | Third Amendment to Change of Control Agreement between Select Medical Corporation and Martin F. Jackson, incorporated by reference to Exhibit 10.103 of Select Medical Holdings Corporation's Form S-1/A filed June 18, 2009 (Reg. No. 333-152514). |
| 10.23 | Employment Agreement, dated September 13, 2010, by and between Select Medical Corporation and David S. Chernow, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed on September 15, 2010. (Reg. Nos. 001-34465 and 001-31441). |
| 10.24 | Amendment No. 1 to Employment Agreement, dated March 21, 2011, between Select Medical Corporation and David S. Chernow, incorporated herein by reference to Exhibit 10.8 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed on May 5, 2011. (Reg. Nos. 001-34465 and 001-31441). |
| 10.25 | Amendment No. 7 to Employment Agreement, dated November 10, 2010, by and between Select Medical Corporation and Robert A. Ortenzio, incorporated herein by reference to Exhibit 10.2 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select filed on November 15, 2010. (Reg. Nos. 001-34465 and 001-31441). |
| 10.26 | Fourth Amendment to Change of Control Agreement, dated March 8, 2011, between Select Medical Corporation and Martin F. Jackson, incorporated herein by reference to Exhibit 10.111 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441). |
| 10.27 | Amendment No. 8 to Employment Agreement, dated March 8, 2011, between Select Medical Corporation and Robert A. Ortenzio, incorporated herein by reference to Exhibit 10.112 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441). |

| Number | Description |
|---|---|
| 10.28 | Fourth Amendment to Change of Control Agreement, dated March 8, 2011, between Select Medical Corporation and Michael E. Tarvin, incorporated herein by reference to Exhibit 10.117 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 9, 2011 (Reg. Nos. 001-34465 and 001-31441). |
| 10.29 | Office Lease Agreement, dated October 30, 2014, between Century Park Investments, L.P. and Select Medical Corporation, incorporated herein by reference to Exhibit 10.80 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 25, 2015 (Reg. Nos. 001-34465 and 001-31441). |
| 10.30 | First Amendment to Lease Agreement, dated February 24, 2016, between Old Gettysburg II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.82 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 26, 2016 (Reg. Nos. 001-34465 and 001-31441). |
| 10.31 | Second Amendment to the Lease Agreement, dated June 1, 2016, between Old Gettysburg II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed August 4, 2016 (Reg. Nos. 001-34465 and 001-31441). |
| 10.32 | Third Amendment to the Lease Agreement, dated September 19, 2016, between Old Gettysburg II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed November 3, 2016 (Reg. Nos. 001-34465 and 001-31441). |
| 10.33 | Office Lease Agreement, dated October 28, 2016, between Select Medical Corporation and Old Gettysburg Associates V, L.P., incorporated herein by reference to Exhibit 10.3 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed November 3, 2016 (Reg. Nos. 001-34465 and 001-31441). |
| 10.34 | First Amendment to the Lease Agreement, dated November 15, 2016, between Old Gettysburg Associates and Select Medical Corporation, incorporated herein by reference to Exhibit 10.75 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 23, 2017 (Reg. Nos. 001-34465 and 001-31441). |
| 10.35 | Select Medical Holdings Corporation 2016 Equity Incentive Plan, incorporated herein by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A of Select Medical Holdings Corporation filed March 3, 2016 (Reg. No. 001-34465). |
| 10.36 | Form of Restricted Stock Award Agreement under the Select Medical Holdings Corporation 2016 Equity Incentive Plan, incorporated herein by reference to Exhibit 10.77 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed February 23, 2017 (Reg. Nos. 001-34465 and 001-31441). |
| 10.37 | Credit Agreement, dated as of March 6, 2017, among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative and Collateral Agent, Wells Fargo Securities, LLC and Deutsche Bank Securities Inc., as CoSyndication Agents and RBC Capital Markets, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Goldman Sachs Bank USA, PNC Bank, National Association and Morgan Stanley Senior Funding, Inc., as Co-Documentation Agents and the other lenders and issuing banks party thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed on March 7, 2017 (Reg. Nos. 001- 34465 and 001-31441). |
| 10.38 | Change of Control Agreement, dated February 16, 2017, between Select Medical Corporation and John A. Saich, incorporated herein by reference to Exhibit 10.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed May 4, 2017 (Reg. Nos. 001- 34465 and 001-31441). |
| 10.39 | Second Amendment to Lease Agreement, dated as of May 30, 2017, between Old Gettysburg Associates and Select Medical Corporation, incorporated by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation and Select Medical Corporation filed August 3, 2017 (Reg. Nos. 001-34465 and 001-31441). |
| 10.40 | Amendment No. 1, dated March 22, 2018, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed March 23, 2018 (Reg. Nos. 001-34465 and 001-31441). |
| 10.41 | Amendment No. 2, dated October 26, 2018, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, incorporated herein by reference to Exhibit 10.1 of Current Report on Form 8-K of Select Medical Holdings Corporation and Select Medical Corporation filed October 31, 2018 (Reg. Nos. 001-34465 and 001-31441). |

| Number | Description |
|---|---|
| 10.42 | Office Lease Agreement, dated as of October 24, 2018, between 207 Associates and Independence Avenue Investments, LLC and Select Medical Corporation, incorporated herein by reference to Exhibit 10.71 of the Annual Report on Form 10-K of Select Medical Holdings Corporation and Select Medical Corporation filed on February 21, 2019 (Reg. Nos. 001-34465 and 001-31441). |
| 10.43 | Amendment No. 3, dated August 1, 2019, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, and Amendment No. 2, dated as of October 26, 2018, incorporated herein by reference to Exhibit 10.1 of the Current Report on Form 8-K of Select Medical Holdings Corporation filed August 1, 2019 (Reg. No. 001-34465). |
| 10.44 | First Lien Term Loan Credit Agreement, dated December 10, 2019, by and among Select Medical Corporation, Concentra Inc. and Concentra Holdings, Inc., incorporated herein by reference to Exhibit 10.2 of the Current Report on Form 8-K of Select Medical Holdings Corporation filed December 11, 2019 (Reg. No. 001-34465). |
| 10.45 | Select Medical Holdings Corporation 2020 Equity Incentive Plan, incorporated herein by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A of Select Medical Holdings Corporation filed March 4, 2020 (Reg. No. 001-34465). |
| 10.46 | Form of Restricted Stock Award Agreement under the Select Medical Holdings Corporation 2020 Equity Incentive Plan, incorporated herein by reference to Exhibit 10.71 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 25, 2021 (Reg. No. 001-34465). |
| 10.47 | First Amendment to Lease Agreement, dated as of April 24, 2020, between 225 Grandview Investors, LLC and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on July 30, 2020 (Reg. No. 001-34465). |
| 10.48 | Third Addendum to Lease Agreement, dated as of May 5, 2020, between Old Gettysburg Associates III, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on July 30, 2020 (Reg. No. 001-34465). |
| 10.49 | Change of Control Agreement, dated February 18, 2021, between Select Medical Corporation and Thomas P. Mullin, incorporated herein by reference to Exhibit 10.75 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 25, 2021 (Reg. No. 001-34465). |
| 10.50 | Amendment No. 5, dated June 2, 2021, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2, dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019 and Amendment No. 4, dated as of December 10, 2019, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on June 4, 2021 (Reg. No. 001-34465). |
| 10.51 | First Addendum to Lease Agreement, dated as of July 21, 2021, between Old Gettysburg Associates V, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.1 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on November 4, 2021 (Reg. No. 001-34465). |
| 10.52 | Letter Agreement, dated August 6, 2021, between Robert A. Ortenzio and Select Medical Corporation, incorporated herein by reference to Exhibit 10.2 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on November 4, 2021 (Reg. No. 001-34465). |
| 10.53 | First Amendment to Lease Agreement, dated as of August 9, 2021, between Century Park Investments, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.3 of the Quarterly Report on Form 10-Q of Select Medical Holdings Corporation filed on November 4, 2021 (Reg. No. 001-34465). |
| 10.54 | Fourth Amendment to Lease Agreement, dated as of December 28, 2021, between Old Gettysburg Associates II, LP and Select Medical Corporation incorporated herein by reference to Exhibit 10.81 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 24, 2022 (Reg. No. 001-34465). |
| 10.55 | Second Addendum to Lease Agreement, dated as of December 1, 2022, between Old Gettysburg Associates IV LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.69 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 23, 2023 (Reg No. 001-34465). |
| 10.56 | Third Amendment to Lease Agreement, dated as of December 1, 2022, between Old Gettysburg Associates and Select Medical Corporation, incorporated herein by reference to Exhibit 10.70 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 23, 2023 (Reg No. 001-34465). |
| 10.57 | Fifth Amendment to Lease Agreement, dated as of December 1, 2022, between Old Gettysburg Associates II, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.71 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 23, 2023 (Reg No. 001-34465). |
| 10.58 | Fourth Addendum to Lease Agreement, dated as of December 1, 2022, between Old Gettysburg Associates III, LP and Select Medical Corporation, incorporated herein by reference to Exhibit 10.72 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 23, 2023 (Reg No. 001-34465). |

| Number | Description |
| --- | --- |
| 10.59 | Amendment No. 6, dated February 21, 2023, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2 dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019, Amendment No. 4, dated as of December 10, 2019 and Amendment No. 5, dated as of June 2, 2021, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on February 22, 2023 (Reg. No. 001-34465). |
| 10.60 | Amendment No. 7, dated May 31, 2023, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2 dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019, Amendment No. 4, dated as of December 10, 2019, Amendment No. 5, dated as of June 2, 2021 and Amendment No. 6, dated as of February 21, 2023, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on June 6, 2023 (Reg. No. 001-34465). |
| 10.61 | Amendment No. 8, dated July 31, 2023, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2 dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019, Amendment No. 4, dated as of December 10, 2019, Amendment No. 5, dated as of June 2, 2021, Amendment No. 6, dated as of February 21, 2023 and Amendment No. 7, dated as of May 31, 2023, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on August 1, 2023 (Reg. No. 001-34465). |
| 10.62 | Amendment No. 9, dated August 31, 2023, to the Credit Agreement, dated March 6, 2017, by and among Select Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2 dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019, Amendment No. 4, dated as of December 10, 2019, Amendment No. 5, dated as of June 2, 2021, Amendment No. 6, dated as of February 21, 2023, Amendment No. 7, dated as of May 31, 2023 and Amendment No. 8, dated as of July 31, 2023, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on September 1, 2023 (Reg. No. 001-34465). |
| 10.63 | Offer Letter, by and between Select and Christopher S. Weigl, dated April 22, 2022, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on March 1, 2023 (Reg. No. 001-34465). |
| 10.64 | Change of Control Agreement, dated as of November 6, 2023, between Select Medical Corporation and Michael F. Malatesta, incorporated herein by reference to Exhibit 10.73 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 22, 2024 (Reg No. 001-34465). |
| 10.65 | Amendment No. 1, dated April 25, 2024, to the Select Medical Holdings Corporation 2020 Equity Incentive Plan, incorporated herein by reference to Appendix A of the Definitive Proxy Statement on Schedule 14A of Select Medical Holdings Corporation filed March 4, 2020 (Reg. No. 001-34465). |
| 10.66 | Separation Agreement, dated July 26, 2024, by and between Select Medical Corporation and Concentra Group Holdings Parent, Inc., incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on August 1, 2024 (Reg. No. 001-34465). |
| 10.67 | Tax Matters Agreement, dated July 26, 2024, by and between Select Medical Holdings Corporation and Concentra Group Holdings Parent, Inc., incorporated by reference to Exhibit 10.2 of the Current Report on Form 8-K, filed on August 1, 2024 (Reg. No. 001-34465). |
| 10.68 | Employee Matters Agreement, dated July 26, 2024, by and between Select Medical Corporation and Concentra Group Holdings Parent, Inc., incorporated by reference to Exhibit 10.3 of the Current Report on Form 8-K, filed on August 1, 2024 (Reg. No. 001-34465). |
| 10.69 | Transition Services Agreement, dated July 26, 2024, by and between Select Medical Corporation and Concentra Group Holdings Parent, Inc., incorporated by reference to Exhibit 10.4 of the Current Report on Form 8-K, filed on August 1, 2024 (Reg. No. 001-34465). |
| 10.70 | Amendment No, 10, dated July 26, 2024, to the Credit Agreement, dated March 6, 2017, by and among Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2 dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019, Amendment No. 4, dated as of December 10, 2019, Amendment No. 5, dated as of June 2, 2021, Amendment No. 6, dated as of February 21, 2023, Amendment No. 7, dated as of May 31, 2023 and Amendment No. 8, dated as of July 31, 2023, and Amendment No. 9, dated as of August 31, 2023 incorporated by reference to Exhibit 10.5 of the Current Report on Form 8-K, filed on August 1, 2024 (Reg. No. 001-34465). |

| Number | Description |
|---|---|
| 10.71 | Amendment No, 11, dated December 3, 2024, to the Credit Agreement, dated March 6, 2017, by and among Medical Holdings Corporation, Select Medical Corporation, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, and the other lenders and issuing banks party thereto, as amended by Amendment No. 1, dated as of March 22, 2018, Amendment No. 2 dated as of October 26, 2018, Amendment No. 3, dated as of August 1, 2019, Amendment No. 4, dated as of December 10, 2019, Amendment No. 5, dated as of June 2, 2021, Amendment No. 6, dated as of February 21, 2023, Amendment No. 7, dated as of May 31, 2023 and Amendment No. 8, dated as of July 31, 2023, and Amendment No. 9, dated as of August 31, 2023 and Amendment No. 10, dated as of July 26, 2024, incorporated by reference to Exhibit 10.1 of the Current Report on Form 8-K, filed on August 1, 2024 (Reg. No. 001-34465). |
| 19.1 | Select Medical Holdings Corporation Insider Trading Policy |
| 21.1 | Subsidiaries of Select Medical Holdings Corporation. |
| 23 | Consent of PricewaterhouseCoopers LLP. |
| 31.1 | Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. |
| 31.2 | Certification of Executive Vice President and Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. |
| 32.1 | Certification of Chief Executive Officer, and Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350 as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |
| 97 | Select Medical Holdings Corporation Compensation Recovery Policy, incorporated by reference to Exhibit 97 of the Annual Report on Form 10-K of Select Medical Holdings Corporation filed on February 22, 2024 (Reg No. 001-34465). |
| 101.INS | XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document. |
| 101.SCH | Inline XBRL Taxonomy Extension Schema Document. |
| 101.CAL | Inline XBRL Taxonomy Extension Calculation Linkbase Document. |
| 101.DEF | Inline XBRL Taxonomy Extension Definition Linkbase Document. |
| 101.LAB | Inline XBRL Taxonomy Extension Label Linkbase Document. |
| 101.PRE | Inline XBRL Taxonomy Extension Presentation Linkbase Document. |

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

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

None.

**Signatures**

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

SELECT MEDICAL HOLDINGS CORPORATION

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

Date: February 20, 2025

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated as of February 20, 2025.

| | |
|---|---|
| /s/ ROBERT A. ORTENZIO<br>Robert A. Ortenzio<br>*Director, Executive Chairman and Co-Founder* | /s/ DAVID S. CHERNOW<br>David S. Chernow<br>*Director, Chief Executive Officer*<br>*(principal executive officer)* |
| /s/ MICHAEL F. MALATESTA<br>Michael F. Malatesta<br>*Executive Vice President, Chief Financial Officer*<br>*(principal financial officer)* | /s/ CHRISTOPHER S. WEIGL<br>Christopher S. Weigl<br>*Senior Vice President, Controller & Chief Accounting Officer*<br>*(principal accounting officer)* |
| /s/ RUSSELL L. CARSON<br>Russell L. Carson<br>*Director* | /s/ WILLIAM H. FRIST, M.D.<br>William H. Frist, M.D.<br>*Director* |
| /s/ JAMES S. ELY III<br>James S. Ely III<br>*Director* | /s/ DANIEL J. THOMAS<br>Daniel J. Thomas<br>*Director* |
| /s/ THOMAS A. SCULLY<br>Thomas A. Scully<br>*Director* | /s/ KATHERINE R. DAVISSON<br>Katherine R. Davisson<br>*Director* |
| /s/ MARILYN B. TAVENNER<br>Marilyn B. Tavenner<br>*Director* | /s/ PARVINDERJIT S. KHANUJA<br>Parvinderjit S. Khanuja<br>*Director* |

**SELECT MEDICAL HOLDINGS CORPORATION**

**INDEX TO FINANCIAL STATEMENTS**

## Report of Independent Registered Public Accounting Firm

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

### *Opinions on the Financial Statements and Internal Control over Financial Reporting*

We have audited the accompanying consolidated balance sheets of Select Medical Holdings Corporation and its subsidiaries (the “Company”) as of December 31, 2024 and 2023, and the related consolidated statements of operations, of comprehensive income, of changes in equity and income and of cash flows for each of the three years in the period ended December 31, 2024, including the related notes and financial statement schedule listed in the index appearing under Item 15(a)(ii) (collectively referred to as the “consolidated financial statements”). We also have audited the Company's internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2024 and 2023, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2024 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

### *Basis for Opinions*

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

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

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

### *Definition and Limitations of Internal Control over Financial Reporting*

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

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

***Critical Audit Matters***

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

*Valuation of patient accounts receivable*

As described in Note 1 to the consolidated financial statements, substantially all of the Company's accounts receivable is related to providing healthcare services to patients. These services are paid for primarily by federal and state governmental authorities, managed care health plans, commercial insurance companies, workers' compensation programs, and employer-directed programs. As of December 31, 2024, accounts receivable of the Company totaled approximately $821.4 million. As disclosed by management, accounts receivable is reported at an amount equal to the amount management expects to collect for providing healthcare services to its patients. This amount is inclusive of management's estimate of factors such as implicit discounts and other adjustments, which are estimated using historical experience.

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

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's valuation of patient accounts receivable, including controls over management's valuation approach, assumptions and data used to estimate patient accounts receivable. These procedures also included, among others: (i) evaluating management's process for developing its estimate of patient accounts receivable; (ii) testing the completeness, accuracy, and relevance of the underlying data used to estimate patient accounts receivable, including historical billing and reimbursement data; (iii) evaluating the historical accuracy of management's process for developing the estimate of the amount which management expects to collect by comparing actual cash receipts related to patient accounts receivable balances which existed as of the prior period balance sheet date; and (iv) for the Outpatient Rehabilitation segment, developing an independent expectation of the net accounts receivable balance. Developing an independent expectation involved calculating the percentage of cash collections as compared to the corresponding revenue transactions either throughout the year or as of the end of the prior year, applying those calculated percentages to the recorded accounts receivable balance as of December 31, 2024, and comparing the calculated balance to management's estimate of the Outpatient Rehabilitation net accounts receivable balance.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 20, 2025

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

## PART I FINANCIAL INFORMATION

## ITEM 1. CONSOLIDATED FINANCIAL STATEMENTS

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

| | December 31, 2023 | December 31, 2024 |
|---|---|---|
| **ASSETS** | | |
| Current Assets: | | |
| Cash and cash equivalents | $ 52,632 | $ 59,694 |
| Accounts receivable | 724,141 | 821,385 |
| Prepaid income taxes | 14,747 | 26,601 |
| Current portion of interest rate cap contract | 58,962 | — |
| Current assets of discontinued operations | 291,064 | — |
| Other current assets | 116,100 | 112,097 |
| Total Current Assets | 1,257,646 | 1,019,777 |
| Operating lease right-of-use assets | 790,764 | 908,095 |
| Property and equipment, net | 845,191 | 872,185 |
| Goodwill | 2,283,425 | 2,331,898 |
| Identifiable intangible assets, net | 105,147 | 103,183 |
| Non-current assets of discontinued operations | 2,039,142 | — |
| Other assets | 368,316 | 372,813 |
| **Total Assets** | $ 7,689,631 | $ 5,607,951 |
| **LIABILITIES AND EQUITY** | | |
| Current Liabilities: | | |
| Overdrafts | $ 30,274 | $ 25,803 |
| Current operating lease liabilities | 172,454 | 179,601 |
| Current portion of long-term debt and notes payable | 68,874 | 20,269 |
| Accounts payable | 153,899 | 142,157 |
| Accrued and other liabilities | 551,684 | 609,821 |
| Current liabilities of discontinued operations | 271,280 | — |
| Total Current Liabilities | 1,248,465 | 977,651 |
| Non-current operating lease liabilities | 668,557 | 787,124 |
| Long-term debt, net of current portion | 3,584,384 | 1,691,546 |
| Non-current deferred tax liability | 119,942 | 81,497 |
| Non-current liabilities of discontinued operations | 411,487 | — |
| Other non-current liabilities | 82,781 | 73,038 |
| Total Liabilities | 6,115,616 | 3,610,856 |
| Commitments and contingencies (Note 20) | | |
| Redeemable non-controlling interests | 26,297 | 10,167 |
| Stockholders' Equity: | | |
| Common stock, $0.001 par value, 700,000,000 shares authorized, 128,369,492 and 128,962,850 shares issued and outstanding at 2023 and 2024, respectively | 128 | 129 |
| Capital in excess of par | 493,413 | 911,080 |
| Retained earnings | 751,856 | 770,146 |
| Accumulated other comprehensive income | 42,907 | — |
| Total Stockholders' Equity | 1,288,304 | 1,681,355 |
| Non-controlling interests | 259,414 | 305,573 |
| Total Equity | 1,547,718 | 1,986,928 |
| **Total Liabilities and Equity** | $ 7,689,631 | $ 5,607,951 |

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

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Revenue | $ 4,609,179 | $ 4,825,977 | $ 5,187,105 |
| Costs and expenses: | | | |
| Cost of services, exclusive of depreciation and amortization | 4,207,686 | 4,254,369 | 4,553,461 |
| General and administrative | 153,035 | 170,193 | 225,869 |
| Depreciation and amortization | 132,158 | 135,691 | 142,866 |
| Total costs and expenses | 4,492,879 | 4,560,253 | 4,922,196 |
| Other operating income | 28,454 | 1,518 | 3,406 |
| Income from continuing operations before other income and expense | 144,754 | 267,242 | 268,315 |
| Other income and expense: | | | |
| Loss on early retirement of debt | — | (14,692) | (28,845) |
| Equity in earnings of unconsolidated subsidiaries | 27,984 | 41,339 | 63,904 |
| Interest expense | (137,470) | (154,165) | (128,605) |
| Income from continuing operations before income taxes | 35,268 | 139,724 | 174,769 |
| Income tax expense from continuing operations | 16,723 | 29,253 | 44,782 |
| Income from continuing operations, net of tax | 18,545 | 110,471 | 129,987 |
| Discontinued operations: | | | |
| Income from discontinued business | 225,311 | 242,632 | 223,414 |
| Income tax expense from discontinued business | 45,830 | 53,372 | 56,697 |
| Income from discontinued operations, net of tax | 179,481 | 189,260 | 166,717 |
| Net income | 198,026 | 299,731 | 296,704 |
| Less: Net income attributable to non-controlling interests | 39,032 | 56,240 | 82,666 |
| Net income attributable to Select Medical Holdings Corporation | $ 158,994 | $ 243,491 | $ 214,038 |
| Net income attributable to Select Medical Holdings Corporation’s common stockholders: | | | |
| Income (loss) from continuing operations, net of tax | $ (14,971) | $ 59,027 | $ 65,473 |
| Income from discontinued operations, net of tax | 173,965 | 184,464 | 148,565 |
| Net income attributable to Select Medical Holdings Corporation’s common stockholders | $ 158,994 | $ 243,491 | $ 214,038 |
| Earnings (loss) per common share (Note 19): | | | |
| Continuing operations - basic and diluted | $ (0.12) | $ 0.46 | $ 0.51 |
| Discontinued operations - basic and diluted | 1.35 | 1.44 | 1.15 |
| Total earnings per common share - basic and diluted | $ 1.23 | $ 1.91 | (a) $ 1.66 |

(a) Does not total due to rounding.

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

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Net income | $ 198,026 | $ 299,731 | $ 296,704 |
| Other comprehensive income (loss), net of tax: | | | |
| Gain on interest rate cap contract | 90,730 | 15,783 | 5,723 |
| Reclassification adjustment for gains included in net income | (14,410) | (61,478) | (48,630) |
| Net change, net of tax (expense) benefit of $(24,658), $(15,202) and $13,550 | 76,320 | (45,695) | (42,907) |
| Comprehensive income | 274,346 | 254,036 | 253,797 |
| Less: Comprehensive income attributable to non-controlling interests | 39,032 | 56,240 | 82,666 |
| Comprehensive income attributable to Select Medical Holdings Corporation | $ 235,314 | $ 197,796 | $ 171,131 |

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

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

| | | Total Stockholders' Equity | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Common Stock Issued | Common Stock Par Value | Capital in Excess of Par | Retained Earnings | Accumulated Other Comprehensive Income (Loss) | Total Stockholders' Equity | Non-controlling Interests | Total Equity |
| Balance at December 31, 2021 | 133,884 | $ 134 | $ 504,314 | $ 593,251 | $ 12,282 | $ 1,109,981 | $ 215,921 | $ 1,325,902 |
| Net income attributable to Select Medical Holdings Corporation | | | | 158,994 | | 158,994 | | 158,994 |
| Net income attributable to non-controlling interests | | | | | | — | 31,460 | 31,460 |
| Cash dividends declared for common stockholders ($0.50 per share) | | | | (64,589) | | (64,589) | | (64,589) |
| Issuance of restricted stock | 1,642 | 1 | (1) | | | — | | — |
| Forfeitures of unvested restricted stock | (98) | 0 | 0 | 64 | | 64 | | 64 |
| Vesting of restricted stock | | | 35,550 | | | 35,550 | | 35,550 |
| Repurchase of common shares | (8,255) | (8) | (87,838) | (107,682) | | (195,528) | | (195,528) |
| Issuance of non-controlling interests | | | 665 | | | 665 | 9,505 | 10,170 |
| Non-controlling interests acquired in business combination, measurement period adjustment | | | | | | — | 12,463 | 12,463 |
| Distributions to and purchases of non-controlling interests | | | (507) | (2,450) | | (2,957) | (34,707) | (37,664) |
| Redemption value adjustment on non-controlling interests | | | | 3,385 | | 3,385 | | 3,385 |
| Other comprehensive income | | | | | 76,320 | 76,320 | | 76,320 |
| Other | | | | 37 | | 37 | | 37 |
| Balance at December 31, 2022 | 127,173 | $ 127 | $ 452,183 | $ 581,010 | $ 88,602 | $ 1,121,922 | $ 234,642 | $ 1,356,564 |
| Net income attributable to Select Medical Holdings Corporation | | | | 243,491 | | 243,491 | | 243,491 |
| Net income attributable to non-controlling interests | | | | | | — | 48,153 | 48,153 |
| Cash dividends declared for common stockholders ($0.50 per share) | | | | (63,904) | | (63,904) | | (63,904) |
| Issuance of restricted stock | 1,651 | 1 | (1) | | | — | | — |
| Forfeitures of unvested restricted stock | (12) | 0 | 0 | 12 | | 12 | | 12 |
| Vesting of restricted stock | | | 43,619 | | | 43,619 | | 43,619 |
| Repurchase of common shares | (443) | 0 | (5,184) | (7,575) | | (12,759) | | (12,759) |
| Issuance of non-controlling interests | | | 1,870 | | | 1,870 | 21,181 | 23,051 |
| Non-controlling interests acquired in business combination | | | | | | — | 9,007 | 9,007 |
| Distributions to and purchases of non-controlling interests | | | 927 | (2,672) | | (1,745) | (53,569) | (55,314) |
| Redemption value adjustment on non-controlling interests | | | | 1,527 | | 1,527 | | 1,527 |
| Other comprehensive loss | | | | | (45,695) | (45,695) | | (45,695) |
| Other | | | (1) | (33) | | (34) | | (34) |
| Balance at December 31, 2023 | 128,369 | $ 128 | $ 493,413 | $ 751,856 | $ 42,907 | $ 1,288,304 | $ 259,414 | $ 1,547,718 |
| Net income attributable to Select Medical Holdings Corporation | | | | 214,038 | | 214,038 | | 214,038 |
| Net income attributable to non-controlling interests | | | | | | — | 73,264 | 73,264 |
| Cash dividends declared for common stockholders ($0.50 per share) | | | | (64,617) | | (64,617) | | (64,617) |
| Issuance of restricted stock | 1,728 | 2 | (2) | | | — | | — |
| Forfeitures of unvested restricted stock | (69) | 0 | 0 | 71 | | 71 | | 71 |
| Vesting of restricted stock | | | 100,599 | | | 100,599 | | 100,599 |
| Repurchase of common shares | (1,065) | (1) | (18,176) | (19,728) | | (37,905) | | (37,905) |
| Issuance of non-controlling interests | | | | | | — | 27,200 | 27,200 |
| Non-controlling interests acquired in business combination | | | | | | — | 13,009 | 13,009 |
| Distributions to and purchases of non-controlling interests | | | 394 | | | 394 | (50,670) | (50,276) |
| Redemption value adjustment on non-controlling interests | | | | (1,947) | | (1,947) | | (1,947) |
| Concentra Separation and Distribution | | | 334,852 | (109,656) | | 225,196 | (16,644) | 208,552 |
| Other comprehensive loss | | | | | (42,907) | (42,907) | | (42,907) |
| Other | | | | 129 | | 129 | | 129 |
| Balance at December 31, 2024 | 128,963 | $ 129 | $ 911,080 | $ 770,146 | $ — | $ 1,681,355 | $ 305,573 | $ 1,986,928 |

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

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | **2022** | **2023** | **2024** |
| **Operating activities** | | | |
| Net income | $ 198,026 | $ 299,731 | $ 296,704 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | |
| Distributions from unconsolidated subsidiaries | 21,911 | 23,417 | 39,178 |
| Depreciation and amortization | 205,825 | 208,742 | 203,894 |
| Provision for expected credit losses | 174 | 1,030 | 4,279 |
| Equity in earnings of unconsolidated subsidiaries | (26,407) | (40,813) | (60,228) |
| Loss on extinguishment of debt | — | 175 | 19,038 |
| Gain on sale of assets and businesses | (2,714) | (57) | (1,063) |
| Stock compensation expense | 37,755 | 43,809 | 100,670 |
| Amortization of debt discount, premium and issuance costs | 2,272 | 2,647 | 2,963 |
| Deferred income taxes | 7,521 | (16,119) | (32,434) |
| Changes in operating assets and liabilities, net of effects of business combinations: | | | |
| Accounts receivable | (52,183) | 1,156 | (95,845) |
| Other current assets | (4,866) | (29,374) | 18,072 |
| Other assets | 16,491 | 10,031 | 12,933 |
| Accounts payable | (48,042) | (6,412) | (16,789) |
| Accrued expenses | 12,852 | 84,095 | 26,492 |
| Government advances | (83,790) | — | — |
| Net cash provided by operating activities | 284,825 | 582,058 | 517,864 |
| **Investing activities** | | | |
| Business combinations, net of cash acquired | (26,987) | (29,567) | (13,097) |
| Purchases of property, equipment, and other assets | (190,372) | (229,200) | (222,177) |
| Investment in businesses | (17,323) | (9,873) | — |
| Proceeds from sale of assets and businesses | 8,343 | 163 | 4,263 |
| Net cash used in investing activities | (226,339) | (268,477) | (231,011) |
| **Financing activities** | | | |
| Borrowings on revolving facilities | 1,120,000 | 905,000 | 1,240,000 |
| Payments on revolving facilities | (835,000) | (1,070,000) | (1,415,000) |
| Proceeds from term loans, net of issuance costs | — | 2,092,232 | 1,880,052 |
| Payments on term loans | — | (2,113,952) | (2,092,485) |
| Payment on senior notes, including call premium | — | — | (1,237,764) |
| Proceeds from senior notes, net of issuance costs | — | — | 1,176,598 |
| Borrowings of other debt | 25,666 | 31,399 | 24,892 |
| Principal payments on other debt | (35,594) | (46,946) | (65,280) |
| Dividends paid to common stockholders | (64,589) | (63,904) | (64,617) |
| Repurchase of common stock | (195,528) | (12,759) | (37,905) |
| Decrease in overdrafts | (10,392) | (1,687) | (4,471) |
| Proceeds from issuance of non-controlling interests | 9,530 | 22,935 | 15,713 |
| Distributions to and purchases of non-controlling interests | (43,107) | (63,531) | (60,001) |
| Purchase of membership interests of Concentra Group Holdings Parent | (5,876) | (6,268) | — |
| Proceeds from Concentra initial public offering | — | — | 511,198 |
| Cash transferred to Concentra at separation | — | — | (182,095) |
| Net cash used in financing activities | (34,890) | (327,481) | (311,165) |
| Net increase (decrease) in cash and cash equivalents | 23,596 | (13,900) | (24,312) |
| Cash and cash equivalents at beginning of period | 74,310 | 97,906 | 84,006 |
| Cash and cash equivalents at end of period | $ 97,906 | $ 84,006 | $ 59,694 |
| **Supplemental information:** | | | |
| Cash paid for interest, excluding amounts received of $19,584, $82,818, and $68,069 under the interest rate cap contract for the years ended December 31, 2022, 2023 and 2024, respectively. | $ 183,453 | $ 272,261 | $ 256,229 |
| Cash paid for taxes | 32,290 | 88,510 | 133,187 |
| **Non-cash investing and financing activities:** | | | |
| Liabilities for purchases of property and equipment | $ 51,529 | $ 18,403 | $ 21,784 |

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

**SELECT MEDICAL HOLDINGS CORPORATION**
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

## 1. Organization and Significant Accounting Policies

### *Business Description*

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

The Company is, based on number of facilities, one of the largest operators of critical illness recovery hospitals, rehabilitation hospitals, and outpatient rehabilitation clinics in the United States. As of December 31, 2024, the Company had operations in 40 states and the District of Columbia. As of December 31, 2024, the Company operated 104 critical illness recovery hospitals, 35 rehabilitation hospitals, and 1,914 outpatient rehabilitation clinics.

On November 25, 2024, Select completed a tax-free distribution of 104,093,503 shares of common stock of Concentra to its stockholders. Holders of the Company's common stock received 0.806971 shares of Concentra common stock for each outstanding share of the Company's common stock they owned as of November 18, 2024 (the "Record Date"). Following the completion of the distribution, the Company no longer owns any shares of Concentra common stock. The historical results of Concentra (which previously represented the Concentra business segment) are reflected as discontinued operations in the Company's Consolidated Financial Statements through the date of the distribution (see *Note 2, Acquisitions and Dispositions* for additional details). Unless otherwise indicated, the information in the notes to the Consolidated Financial Statements refer only to the Company's continuing operations.

The Company operates through three business segments: the critical illness recovery hospital segment, the rehabilitation hospital segment, and the outpatient rehabilitation segment. The Company's critical illness recovery hospital segment consists of hospitals designed to serve the needs of patients recovering from critical illnesses, often with complex medical needs, and the rehabilitation hospital segment consists of hospitals designed to serve patients that require intensive physical rehabilitation care. Patients are typically admitted to the Company's critical illness recovery hospitals and rehabilitation hospitals from general acute care hospitals. The Company's outpatient rehabilitation segment consists of clinics that provide physical, occupational, and speech rehabilitation services.

### *Recent Accounting Guidance Not Yet Adopted*

*Income Taxes*

In December 2023, FASB issued ASU 2023-09, Income Taxes (Topic 740): Improvements to Income Tax Disclosures, which is intended to improve the transparency and decision usefulness of income tax disclosures. The ASU includes enhanced requirements on the rate reconciliation, including specific categories that must be disclosed, and provides a threshold over which reconciling items must be disclosed. The amendments in the update also require annual disclosure of income taxes paid, disaggregated by federal, state, and foreign taxes, as well as any individual jurisdictions in which income taxes paid is greater than 5% of total income taxes paid.

The Company will adopt ASU 2023-09 beginning with our annual reporting period ending December 31, 2025. The ASU can be applied either prospectively or retrospectively. The Company is currently reviewing ASU 2023-09, but does not expect it to have a significant impact on the disclosures in our consolidated financial statements.

*Expense Disaggregation*

In November 2024, FASB issued ASU 2024-03, *Income Statement - Reporting Comprehensive Income - Expense Disaggregation Disclosures (Subtopic 220-40)*, which is intended to improve the disclosures of expenses by providing more detailed information about the types of expenses in commonly presented expense captions. The ASU requires entities to disclose the amounts of purchases of inventory, employee compensation, depreciation and intangible asset amortization included in each relevant expense caption; as well as a qualitative description of the amounts remaining in relevant expense captions that are not separately disaggregated quantitatively. The amendment also requires disclosure of the total amount of selling expense and, in annual reporting periods, an entity's definition of selling expenses.

**1. Organization and Significant Accounting Policies (Continued)**

The ASU is effective for annual periods beginning after December 15, 2026, and interim periods beginning after December 15, 2027; however early adoption is permitted. The ASU can be applied either prospectively or retrospectively. The Company is currently reviewing the impact that ASU 2024-03 will have on the disclosures in our consolidated financial statements.

***Recently Adopted Accounting Guidance***

*Leases*

In March 2023, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2023-01, *Leases (Topic 842): Common Control Arrangements*, which requires companies to amortize leasehold improvements associated with related party leases under common control over the useful life of the leasehold improvement to the common control group.

The Company adopted this ASU using the prospective method of transition on January 1, 2024. There was not a material impact on the Company's consolidated financial statements upon adoption.

*Segment Reporting*

In November 2023, FASB issued ASU 2023-07, *Segment Reporting (Topic 280): Improvements to Reportable Segment Disclosures*, which is intended to improve disclosure of segment information so that investors can better understand an entity's overall performance. The ASU requires entities to quantitatively disclose significant segment expenses that are regularly provided to the chief operating decision maker for each reportable segment, as well as the amount of other segment items for each reportable segment and a description of what the other segment items are comprised. Disclosure of multiple measures of profit or loss will be permitted by the ASU.

The Company adopted this ASU using the retrospective method of transition in this Form 10-K, resulting in updates to *Note 15. Segment Information.*

***Use of Estimates***

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

***Principles of Consolidation***

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

**1. Organization and Significant Accounting Policies (Continued)**

***Variable Interest Entities***

Certain states prohibit the "corporate practice of medicine," which restricts the Company from owning medical practices which directly employ physicians and from exercising control over medical decisions by physicians. In these states, the Company enters into long-term management agreements with medical practices that are owned by licensed physicians which, in turn, employ or contract with physicians who provide professional medical services in certain of its clinics. The agreements provide for the Company to direct the transfer of ownership of the medical practices to new licensed physicians at any time. Based on the provisions of the management agreements, the medical practices are variable interest entities for which the Company is the primary beneficiary. As of December 31, 2023 and 2024, the net assets of the Company's variable interest entities, excluding intercompany obligations eliminated in consolidation, were $6.2 million and $7.2 million, respectively.

***Non-Controlling Interests***

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

***Earnings per Share***

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

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

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

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

The Company applies the treasury stock method when computing diluted EPS.

***Cash and Cash Equivalents***

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

***Accounts Receivable***

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

**1. Organization and Significant Accounting Policies (Continued)**

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

***Leases***

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

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

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

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

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

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

**1. Organization and Significant Accounting Policies (Continued)**

***Property and Equipment***

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

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

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

***Intangible Assets***

*Goodwill and indefinite-lived identifiable intangible assets*

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

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

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

At December 31, 2024, the Company’s other indefinite-lived intangible assets consist of trademarks, certificates of need, and accreditations. To determine the fair values of its trademarks, the Company uses a relief from royalty income approach. For the Company’s certificates of need and accreditations, the Company performs qualitative assessments. As part of these assessments, the Company evaluates the current business environment, regulatory environment, legal and other company-specific factors. If it is more likely than not that the fair values are less than the carrying values, the Company will then perform a quantitative impairment assessment.

## 1. Organization and Significant Accounting Policies (Continued)

The Company's most recent impairment assessments were completed as of October 1, 2024. The Company did not identify any instances of impairment with respect to goodwill or other indefinite-lived intangible assets.

*Finite-lived intangible assets*

Finite-lived intangible assets are amortized based on the pattern in which the economic benefits are consumed or otherwise depleted. If such a pattern cannot be reliably determined, finite-lived intangible assets are amortized on a straight-line basis over their estimated lives. The Company's finite-lived intangible assets consist of non-compete agreements, which are amortized over the terms specified by the non-compete agreements. The estimated life of the Company's non-compete agreements are 1 – 15 years.

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

***Equity Method Investments***

The Company applies the equity method of accounting for investments in which the Company has the ability to exercise significant influence over the operating and financial policies of the investee, but does not possess a controlling financial interest in the investee. These investments are recorded at their original cost and adjusted periodically to recognize the Company's share of the investees' net income or losses after the date of investment. Generally, the Company will discontinue applying the equity method when its share of net losses from the investee exceed the carrying amount of the Company's investment. In these instances, the Company resumes accounting for the investment under the equity method if the investee subsequently reports net income and the Company's share of that net income exceeds the share of the net losses not recognized during the period the equity method was suspended. The Company evaluates its equity method investments for impairment when events or circumstances suggest that the carrying amount of the investment may not be recoverable. If the Company determines that an equity method investment is other than temporarily impaired, it records an impairment charge equal to the difference between the investment's carrying amount and its fair value.

***Income Taxes***

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

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

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

## 1. Organization and Significant Accounting Policies (Continued)

***Insurance Risk Programs***

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

***Revenue Recognition***

*Patient Service Revenues*

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

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

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

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

## 1. Organization and Significant Accounting Policies (Continued)

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

*Other Revenues*

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

## 2. Acquisitions and Dispositions

***Dispositions***

On July 26, 2024, Concentra Group Holdings Parent ("Concentra"), a then wholly-owned subsidiary of Select, completed an initial public offering ("IPO") of 22,500,000 shares of its common stock, par value $0.01 per share, at an initial public offering price of $23.50 per share for net proceeds of $499.7 million after deducting underwriting discounts and commission of $29.1 million. In addition, the underwriters exercised the option to purchase an additional 750,000 shares of Concentra's common stock for net proceeds of $16.7 million after deducting discounts and commission of $1.0 million. Concentra shares began trading on the New York Stock Exchange under the symbol "CON" on July 25, 2024. In connection with the IPO, Concentra Health Services, Inc. ("CHSI"), a wholly-owned subsidiary of Concentra, entered into a senior secured credit agreement that provides for a $850.0 million term loan and a $400.0 million revolving credit facility. CHSI also issued $650.0 million of 6.875% senior notes.

After the closing of the IPO and underwriters option, Select owned 81.74% of the total outstanding shares of Concentra common stock. On November 25, 2024, Select completed a tax-free distribution of 104,093,503 shares of common stock of Concentra to its stockholders. Following the completion of the distribution, the Company no longer owns any shares of Concentra common stock.

In connection with the separation and distribution, the Company and Concentra also entered into several agreements to govern various interim and ongoing relationships between the Company and Concentra, including a transition services agreement ("TSA"), a tax matters agreement and an employee matters agreement. The services under the TSA generally are a continuation of the support services provided by Select to Concentra prior to the IPO. The support services fees provided to Concentra after the distribution were $1.2 million for the year ended December 31, 2024. The income from the support services fees, as well as the cost to provide these services, are included within General and Administrative expense on the Consolidated Statements of Operations. The services under the TSA are expected to terminate no later than 24 months following the Concentra Distribution.

## 2. Acquisitions and Dispositions (Continued)

Prior to the distribution, Concentra had historically been a separate reportable segment. Concentra’s balance sheet position as of December 31, 2023 is presented as assets of discontinued operations and liabilities of discontinued operations in the Consolidated Balance Sheet, and is summarized as follows:

| | | December 31, 2023 |
|---|---|---|
| **ASSETS** | | |
| Current Assets: | | |
| Cash and cash equivalents | $ | 31,374 |
| Accounts receivable | | 216,194 |
| Prepaid income taxes | | 7,979 |
| Other current assets | | 35,517 |
| Total current assets of discontinued operations | | 291,064 |
| Non-current Assets: | | |
| Operating lease right-of-use assets | | 397,852 |
| Property and equipment, net | | 178,370 |
| Goodwill | | 1,229,745 |
| Identifiable intangible assets, net | | 224,769 |
| Other assets | | 8,406 |
| Total non-current assets of discontinued operations | | 2,039,142 |
| **Total assets of discontinued operations** | $ | 2,330,206 |
| **LIABILITIES** | | |
| Current Liabilities: | | |
| Current operating lease liabilities | | 72,946 |
| Current portion of long-term debt and notes payable | | 1,455 |
| Accounts payable | | 20,413 |
| Accrued and other liabilities | | 176,466 |
| Total current liabilities of discontinued operations | | 271,280 |
| Non-current Liabilities: | | |
| Non-current operating lease liabilities | | 357,310 |
| Long-term debt, net of current portion | | 3,291 |
| Non-current deferred tax liability | | 23,364 |
| Other non-current liabilities | | 27,522 |
| Total non-current liabilities of discontinued operations | | 411,487 |
| **Total liabilities of discontinued operations** | $ | 682,767 |

The results of Concentra are presented as discontinued operations and, as such, have been excluded from both continuing operations and segment results for the years ended December 31, 2022, 2023, and 2024. As a result of the distribution of Concentra, Select recognized transaction related costs of $14.7 million for the year ended December 31, 2024, which are included in Income from discontinued business. Concentra recognized separation transaction costs of $1.6 million for the year ended December 31, 2024, which are included in Income from discontinued business. These costs represent incremental consulting, legal, and audit-related fees incurred in connection with the Company’s separation and distribution of the Concentra segment.

## 2. Acquisitions and Dispositions (Continued)

Certain key selected financial information included in Income from discontinued operations, net of tax, for Concentra is as follows:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Revenue | $ 1,724,359 | $ 1,838,081 | $ 1,738,411 |
| Costs and expenses: | | | |
| Cost of services, exclusive of depreciation and amortization | 1,392,475 | 1,477,648 | 1,374,783 |
| General and administrative | — | — | 1,620 |
| Depreciation and amortization | 73,667 | 73,051 | 61,028 |
| Total costs and expenses | 1,466,142 | 1,550,699 | 1,437,431 |
| Other operating income | 312 | 250 | 284 |
| Income from operations | 258,529 | 287,632 | 301,264 |
| Other income and expense: | | | |
| Equity in earnings of unconsolidated subsidiaries | (1,577) | (526) | (3,676) |
| Interest expense(1) | (31,641) | (44,474) | (59,513) |
| Income from discontinued operations before income taxes | 225,311 | 242,632 | 238,075 |
| Income tax expense | 45,830 | 53,372 | 56,756 |
| Income from discontinued operations, net of tax | 179,481 | 189,260 | 181,319 |
| Less: Net income attributable to non-controlling interests | 5,516 | 4,796 | 18,152 |
| Income from discontinued operations, net of tax, attributable to Select Medical Holdings Corporation's common stockholders | $ 173,965 | $ 184,464 | $ 163,167 |

(1) For the years ended December 31, 2022, 2023, and 2024, interest expense includes allocated interest expense of $31.1 million, $44.3 million, and $22.0 million, respectively. Interest was allocated in accordance with the terms of an intercompany promissory note in place between the Company and Concentra prior to the separation.

The following is selected financial information included on the Consolidated Statements of Cash Flows for Concentra:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Depreciation and amortization | 73,667 | 73,051 | 61,028 |
| Cash flows from investing activities: | | | |
| Purchases of property, equipment, and other assets | $ 45,983 | $ 69,340 | $ 63,269 |

The following table reconciles the cash and cash equivalents balance at December 31, 2023 between cash and cash equivalents from continuing operations and cash and cash equivalents from discontinued operations. Cash and cash equivalents from discontinued operations is included within Current assets of discontinued operations on the Consolidated Balance Sheet.

| | December 31, 2023 |
|---|---|
| Cash and cash equivalents from continuing operations | $ 52,632 |
| Cash and cash equivalents from discontinued operations | 31,374 |
| Cash and cash equivalents | $ 84,006 |

### *Acquisitions*

During the year ended December 31, 2022, the Company made acquisitions consisting of critical illness recovery hospital and outpatient rehabilitation businesses. The consideration given for these acquired businesses consisted principally of $17.3 million of cash. The Company allocated the purchase price of these acquired businesses to assets acquired and liabilities assumed, principally property and equipment and operating lease right-of-use assets and lease liabilities, based on their estimated fair values. The Company recognized goodwill of $6.5 million and $10.9 million in our critical illness recovery hospital and outpatient rehabilitation reporting units, respectively.

## 2. Acquisitions and Dispositions (Continued)

During the year ended December 31, 2023, the Company made acquisitions consisting of critical illness recovery hospital, rehabilitation hospital, and outpatient rehabilitation businesses. The consideration given for these acquired businesses consisted principally of $23.6 million of cash and the issuance of $9.0 million of non-controlling interests. The Company allocated the purchase price of these acquired businesses to assets acquired and liabilities assumed, principally property and equipment and operating lease right-of-use assets and lease liabilities, based on their estimated fair values. The Company recognized goodwill of $6.6 million, $16.2 million, and $2.3 million in our critical illness recovery hospital, rehabilitation hospital, and outpatient rehabilitation reporting units, respectively.

During the year ended December 31, 2024, the Company made acquisitions consisting of critical illness recovery hospital, rehabilitation hospital, and outpatient rehabilitation businesses. The consideration given for these acquired businesses consisted of $12.1 million of cash, $20.3 million of previously held equity interests, and $24.5 million for the issuance of non-controlling interests. The Company allocated the purchase price of these acquired businesses to assets acquired and liabilities assumed, principally property and equipment and operating lease right-of-use assets and lease liabilities, based on their estimated fair values. The Company recognized goodwill of $8.0 million, $38.4 million, and $1.7 million in our critical illness recovery hospital, rehabilitation hospital, and outpatient rehabilitation reporting units, respectively.

## 3. Credit Risk and Payor Concentrations

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

Because of the diversity in the Company’s non-governmental third-party payor base, as well as their geographic dispersion, accounts receivable due from the Medicare program represent the Company’s only significant concentration of credit risk. Approximately 22% and 21% of the Company’s accounts receivable is due from Medicare at December 31, 2023 and 2024, respectively.

Revenues from providing services to patients covered under the Medicare program represented approximately 31%, 31%, and 29% of the Company’s total revenue for the years ended December 31, 2022, 2023, and 2024, respectively. As a provider of services under the Medicare program, the Company is subject to extensive regulations. The inability of any of the Company’s critical illness recovery hospitals, rehabilitation hospitals, or outpatient rehabilitation clinics to comply with Medicare regulations can result in the Company receiving significantly less Medicare payments than the Company currently receives for the services it provides to its patients.

## 4. Leases

The Company has operating and finance leases for its facilities. The Company leases its corporate office space from related parties. The Company's critical illness recovery hospitals and rehabilitation hospitals generally have lease terms of 10 to 20 years with two, five year renewal options. These renewal options vary for hospitals which operate as a hospital within a hospital, or "HIH." The Company's outpatient rehabilitation clinics generally have lease terms of five to 10 years with two, three to five year renewal options.

The Company's total lease cost from continuing operations is as follows:

| | For the Year Ended December 31, | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2022 | | | 2023 | | | 2024 | | |
| | Unrelated Parties | Related Parties | Total | Unrelated Parties | Related Parties | Total | Unrelated Parties | Related Parties | Total |
| | (in thousands) | | | | | | | | |
| Operating lease cost | $ 207,446 | $ 7,245 | $ 214,691 | $ 212,360 | $ 7,335 | $ 219,695 | $ 226,866 | $ 7,335 | $ 234,201 |
| Finance lease cost: | | | | | | | | | |
| Amortization of right-of-use assets | 572 | — | 572 | 572 | — | 572 | 572 | — | 572 |
| Interest on lease liabilities | 1,026 | — | 1,026 | 1,013 | — | 1,013 | 984 | — | 984 |
| Short-term lease cost | 74 | — | 74 | — | — | — | — | — | — |
| Variable lease cost | 38,868 | 462 | 39,330 | 45,086 | 84 | 45,170 | 47,678 | 16 | 47,694 |
| Sublease income | (7,803) | — | (7,803) | (6,725) | — | (6,725) | (6,875) | — | (6,875) |
| Total lease cost from continuing operations | $ 240,183 | $ 7,707 | $ 247,890 | $ 252,306 | $ 7,419 | $ 259,725 | $ 269,225 | $ 7,351 | $ 276,576 |

Supplemental cash flow information related to leases is as follows:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Cash paid for amounts included in the measurement of lease liabilities[(1)]: | | | |
| Operating cash flows for operating leases | $ 308,085 | $ 317,256 | $ 321,271 |
| Operating cash flows for finance leases | 1,335 | 1,239 | 1,104 |
| Financing cash flows for finance leases | 1,472 | 1,617 | 1,347 |
| Right-of-use assets obtained in exchange for lease liabilities: | | | |
| Operating leases | 234,616 | 171,569 | 299,111 |

(1) Cash flows include cash paid for operating and finance leases of discontinued operations.

Supplemental balance sheet information related to leases is as follows:

| | December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2023 | | | 2024 | | |
| | Unrelated Parties | Related Parties | Total | Unrelated Parties | Related Parties | Total |
| **Operating Leases** | (in thousands) | | | | | |
| Operating lease right-of-use assets | $ 761,173 | $ 29,591 | $ 790,764 | $ 885,457 | $ 22,638 | $ 908,095 |
| Current operating lease liabilities | $ 166,861 | $ 5,593 | $ 172,454 | $ 173,189 | $ 6,412 | $ 179,601 |
| Non-current operating lease liabilities | 643,273 | 25,284 | 668,557 | 768,546 | 18,578 | 787,124 |
| Total operating lease liabilities | $ 810,134 | $ 30,877 | $ 841,011 | $ 941,735 | $ 24,990 | $ 966,725 |

## 4. Leases (Continued)

| | December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2023 | | | 2024 | | |
| | Unrelated Parties | Related Parties | Total | Unrelated Parties | Related Parties | Total |
| **Finance Leases** | (in thousands) | | | | | |
| Property and equipment, net | $ 3,922 | $ — | $ 3,922 | $ 3,350 | $ — | $ 3,350 |
| | | | | | | |
| Current portion of long-term debt and notes payable | $ 765 | $ — | $ 765 | $ 798 | $ — | $ 798 |
| Long-term debt, net of current portion | 10,812 | — | 10,812 | 10,014 | — | 10,014 |
| Total finance lease liabilities | $ 11,577 | $ — | $ 11,577 | $ 10,812 | $ — | $ 10,812 |

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

| | December 31, | |
|---|---|---|
| | 2023 | 2024 |
| Weighted average remaining lease term (in years): | | |
| Operating leases | 8.2 | 9.2 |
| Finance leases | 31.9 | 32.8 |
| Weighted average discount rate: | | |
| Operating leases | 6.1 % | 6.6 % |
| Finance leases | 7.2 % | 7.1 % |

As of December 31, 2024, maturities of lease liabilities are approximately as follows:

| | Operating Leases | Finance Leases |
|---|---|---|
| | (in thousands) | |
| 2025 | $ 235,497 | $ 1,551 |
| 2026 | 212,432 | 1,564 |
| 2027 | 173,221 | 1,036 |
| 2028 | 125,025 | 656 |
| 2029 | 94,359 | 656 |
| Thereafter | 533,659 | 22,621 |
| Total undiscounted cash flows | 1,374,193 | 28,084 |
| Less: Imputed interest | 407,468 | 17,272 |
| Total discounted lease liabilities | $ 966,725 | $ 10,812 |

## 5. Property and Equipment

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

| | December 31, 2023 | December 31, 2024 |
|---|---|---|
| | (in thousands) | |
| Land | $ 92,385 | $ 96,255 |
| Leasehold improvements | 538,841 | 565,320 |
| Buildings | 576,765 | 601,615 |
| Furniture and equipment | 649,390 | 686,042 |
| Construction-in-progress | 40,874 | 84,620 |
| Total property and equipment | 1,898,255 | 2,033,852 |
| Accumulated depreciation | (1,053,064) | (1,161,667) |
| Property and equipment, net | $ 845,191 | $ 872,185 |

Depreciation expense was $130.3 million, $134.1 million, and $141.1 million for the years ended December 31, 2022, 2023, and 2024, respectively.

## 6. Intangible Assets

***Goodwill***

The following table shows changes in the carrying amounts of goodwill by reporting unit for the years ended December 31, 2023 and 2024:

| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Total |
|---|---|---|---|---|
| | (in thousands) | | | |
| Balance as of January 1, 2023 | $ 1,151,196 | $ 442,155 | $ 664,978 | $ 2,258,329 |
| Acquisition of businesses | 6,606 | 16,185 | 2,305 | 25,096 |
| Balance as of December 31, 2023 | 1,157,802 | 458,340 | 667,283 | 2,283,425 |
| Acquisition of businesses | 8,000 | 38,367 | 1,666 | 48,033 |
| Measurement period adjustment | — | 440 | — | 440 |
| Balance as of December 31, 2024 | $ 1,165,802 | $ 497,147 | $ 668,949 | $ 2,331,898 |

## 6. Intangible Assets (Continued)

### *Identifiable Intangible Assets*

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

| | December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2023 | | | 2024 | | |
| | Gross Carrying Amount | Accumulated Amortization | Net Carrying Amount | Gross Carrying Amount | Accumulated Amortization | Net Carrying Amount |
| | (in thousands) | | | | | |
| Indefinite-lived intangible assets: | | | | | | |
| Trademarks | $ 61,798 | $ — | $ 61,798 | $ 61,798 | $ — | $ 61,798 |
| Certificates of need | 26,183 | — | 26,183 | 26,393 | — | 26,393 |
| Accreditations | 1,836 | — | 1,836 | 1,775 | — | 1,775 |
| Finite-lived intangible assets: | | | | | | |
| Non-compete agreements | 31,179 | (15,849) | 15,330 | 31,735 | (18,518) | 13,217 |
| Total identifiable intangible assets | $ 120,996 | $ (15,849) | $ 105,147 | $ 121,701 | $ (18,518) | $ 103,183 |

The Company's accreditations and trademarks have renewal terms and the costs to renew these intangible assets are expensed as incurred. At December 31, 2024, the accreditations and trademarks have a weighted average time until next renewal of 1.5 years and 5.8 years, respectively.

The Company's finite-lived intangible assets amortize over their estimated useful lives. Amortization expense was $1.8 million, $1.6 million, and $1.6 million for the years ended December 31, 2022, 2023, and 2024, respectively.

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

| | 2025 | 2026 | 2027 | 2028 | 2029 |
|---|---|---|---|---|---|
| | (in thousands) | | | | |
| Amortization expense | $ 1,613 | $ 1,613 | $ 1,613 | $ 1,613 | $ 1,613 |

## 7. Equity Method Investments

The Company's equity method investments consist principally of minority ownership interests in rehabilitation businesses. Equity method investments of $316.0 million and $320.9 million are presented as part of other assets in the consolidated balance sheets as of December 31, 2023 and 2024, respectively. At December 31, 2024, these businesses primarily consist of the following ownership interests:

| | |
|---|---|
| BIR JV, LLP | 49.0 % |
| OHRH, LLC | 49.0 % |
| GlobalRehab—Scottsdale, LLC | 49.0 % |
| ES Rehabilitation, LLC | 49.0 % |
| BHSM Rehabilitation, LLC | 49.0 % |
| RSH Property Ventures, LLC | 50.0 % |

The Company provides contracted services, principally employee leasing services, and charges management fees to related parties affiliated through its equity method investments. Revenue generated from contracted services provided and management fees charged to related parties affiliated through the Company's equity method investments was $374.1 million, $402.8 million, and $430.3 million for the years ended December 31, 2022, 2023, and 2024, respectively.

## 7. Equity Method Investments (Continued)

The Company had receivables from related parties affiliated through its equity method investments of $18.2 million and $4.5 million, which are included as part of other current assets and other assets in the consolidated balance sheet, respectively, as of December 31, 2023. The Company had receivables from related parties of $17.8 million and $2.2 million, which are included as part of other current assets and other assets in the consolidated balance sheet, respectively, as of December 31, 2024.

The Company had liabilities for the operating cash it holds on behalf of certain rehabilitation businesses in which it has an equity method investment. These liabilities were $66.3 million and $59.0 million as of December 31, 2023 and 2024, respectively, and are included as part of accrued other in the consolidated balance sheets.

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

| | December 31, | |
|---|---|---|
| | 2023 | 2024 |
| | (in thousands) | |
| Current assets | $ 229,920 | $ 250,619 |
| Non-current assets | 523,762 | 522,412 |
| Total assets | $ 753,682 | $ 773,031 |
| Current liabilities | $ 91,614 | $ 100,721 |
| Non-current liabilities | 225,209 | 213,345 |
| Equity | 436,859 | 458,965 |
| Total liabilities and equity | $ 753,682 | $ 773,031 |

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Revenues | $ 624,348 | $ 702,040 | $ 766,197 |
| Cost of services and other operating expenses | 566,014 | 621,107 | 664,172 |
| Net income | 57,811 | 81,122 | 99,386 |

## 8. Insurance Risk Programs

Under a number of the Company’s insurance programs, which include the Company’s employee health insurance, workers’ compensation, and professional malpractice liability insurance programs, the Company is liable for a portion of its losses before it can attempt to recover from the applicable insurance carrier. The Company accrues for losses under an occurrence-based approach whereby the Company estimates the losses that will be incurred in a respective accounting period and accrues that estimated liability using actuarial methods. At December 31, 2023 and 2024, provisions for losses for professional liability risks retained by the Company have been discounted at 3%.

The Company recorded a liability of $132.1 million and $141.6 million related to these programs at December 31, 2023 and 2024, respectively. If the Company did not discount the provisions for losses for professional liability risks, the aggregate liability for all of the insurance risk programs would be approximately $135.6 million and $145.4 million at December 31, 2023 and 2024, respectively. At December 31, 2023 and 2024, the Company recorded insurance proceeds receivable of $8.1 million and $8.5 million, respectively, for liabilities which exceeded its deductibles and self-insured retention limits and are recoverable through its insurance policies.

## 9. Accrued and other liabilities

The following table sets forth the components of accrued and other liabilities on the Consolidated Balance Sheets:

| | December 31, 2023 | December 31, 2024 |
|---|---|---|
| | (in thousands) | |
| Accrued payroll | $ 175,944 | $ 183,045 |
| Accrued vacation | 116,260 | 122,376 |
| Accrued interest | 32,049 | 9,075 |
| Accrued other | 226,332 | 288,681 |
| Income taxes payable | 1,099 | 6,644 |
| Accrued and other liabilities | $ 551,684 | $ 609,821 |

## 10. Interest Rate Cap

The Company had an interest rate derivative to mitigate its market risk exposure arising from changes in interest rates on its term loan, which bears interest at a rate that is indexed to one-month Term SOFR. The interest rate cap limited the Company's exposure to increases in the variable rate index to 1.0% on $2.0 billion of principal outstanding under the term loan. The interest rate cap was effective for the monthly periods from and including April 30, 2021 through September 30, 2024.

The interest rate cap was designated as a cash flow hedge and changes in the fair value of the interest rate cap, net of tax, were recognized in other comprehensive income and were reclassified out of accumulated other comprehensive income or loss and into interest expense when the hedged interest obligations affected earnings.

The following table outlines the changes in accumulated other comprehensive income, net of tax, during the periods presented:

| | For the Year Ended December 31, 2022 | 2023 | 2024 |
|---|---|---|---|
| | | (in thousands) | |
| Balance as of January 1 | $ 12,282 | $ 88,602 | $ 42,907 |
| Gain on interest rate cap contract | 90,730 | 15,783 | 5,723 |
| Amounts reclassified from accumulated other comprehensive income | (14,410) | (61,478) | (48,630) |
| Balance as of December 31 | $ 88,602 | $ 42,907 | $ — |

The effects on net income of amounts reclassified from accumulated other comprehensive income are as follows:

| Statement of Operations | For the Year Ended December 31, 2022 | 2023 | 2024 |
|---|---|---|---|
| | | (in thousands) | |
| Gains included in interest expense | $ 19,086 | $ 80,766 | $ 63,987 |
| Income tax expense | (4,676) | (19,288) | (15,357) |
| Amounts reclassified from accumulated other comprehensive income | $ 14,410 | $ 61,478 | $ 48,630 |

Refer to Note 11 – Fair Value of Financial Instruments for information on the fair value of the Company's interest rate cap contract and its balance sheet classification.

## 11. Fair Value of Financial Instruments

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

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

The Company's interest rate cap contract was recorded at its fair value in the consolidated balance sheets on a recurring basis. The fair value of the interest rate cap contract was based upon a model-derived valuation using observable market inputs, such as interest rates and interest rate volatility, and the strike price (Level 2).

The Company does not measure its indebtedness at fair value in its consolidated balance sheets. The fair value of the credit facilities is based on quoted market prices for this debt in the syndicated loan market. The fair value of the senior notes is based on quoted market prices. The carrying value of the Company's other debt, as disclosed in Note 12 – Long-Term Debt and Notes Payable, approximates fair value.

| | | December 31, 2023 | | December 31, 2024 | |
|---|---|---|---|---|---|
| **Financial Instrument** | **Level** | **Carrying Value** | **Fair Value** | **Carrying Value** | **Fair Value** |
| | | (in thousands) | | | |
| 6.250% senior notes due 2026 | Level 2 | $ 1,232,596 | $ 1,228,063 | $ — | $ — |
| 6.250% senior notes due 2032 | Level 2 | — | — | 539,363 | 528,000 |
| Credit facilities: | | | | | |
| Revolving facility | Level 2 | 280,000 | 278,600 | 105,000 | 102,900 |
| Term loan | Level 2 | 2,077,216 | 2,092,485 | 1,041,661 | 1,051,313 |

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

## 12. Long-Term Debt and Notes Payable

As of December 31, 2024, the Company's long-term debt and notes payable are as follows:

| | Principal Outstanding | Unamortized Premium (Discount) | Unamortized Issuance Costs | Carrying Value | Fair Value |
|---|---|---|---|---|---|
| | (in thousands) | | | | |
| 6.250% senior notes due 2032 | $ 550,000 | $ — | $ (10,637) | $ 539,363 | $ 528,000 |
| Credit facilities: | | | | | |
| Revolving facility | 105,000 | — | — | 105,000 | 102,900 |
| Term loan | 1,050,000 | (2,693) | (5,646) | 1,041,661 | 1,051,313 |
| Other debt, including finance leases | 26,282 | — | (491) | 25,791 | 25,791 |
| Total debt | $ 1,731,282 | $ (2,693) | $ (16,774) | $ 1,711,815 | $ 1,708,004 |

## 12. Long-Term Debt and Notes Payable (Continued)

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

| | 2025 | 2026 | 2027 | 2028 | 2029 | Thereafter | Total |
|---|---|---|---|---|---|---|---|
| | | | | (in thousands) | | | |
| 6.250% senior notes due 2032 | $ — | $ — | $ — | $ — | $ — | $ 550,000 | $ 550,000 |
| Credit facilities: | | | | | | | |
| Revolving facility | — | — | — | — | 105,000 | — | 105,000 |
| Term loan | 10,500 | 10,500 | 10,500 | 10,500 | 10,500 | 997,500 | 1,050,000 |
| Other debt, including finance leases | 9,769 | 2,186 | 1,637 | 54 | 58 | 12,578 | 26,282 |
| Total debt | $ 20,269 | $ 12,686 | $ 12,137 | $ 10,554 | $ 115,558 | $ 1,560,078 | $ 1,731,282 |

As of December 31, 2023, the Company's long-term debt and notes payable are as follows:

| | Principal Outstanding | Unamortized Premium (Discount) | Unamortized Issuance Costs | Carrying Value | Fair Value |
|---|---|---|---|---|---|
| | | | (in thousands) | | |
| 6.250% senior notes due 2026 | $ 1,225,000 | $ 15,533 | $ (7,937) | $ 1,232,596 | $ 1,228,063 |
| Credit facilities: | | | | | |
| Revolving facility | 280,000 | — | — | 280,000 | 278,600 |
| Term loan | 2,092,485 | (12,040) | (3,229) | 2,077,216 | 2,092,485 |
| Other debt, including finance leases | 63,509 | — | (63) | 63,446 | 63,446 |
| Total debt | $ 3,660,994 | $ 3,493 | $ (11,229) | $ 3,653,258 | $ 3,662,594 |

### *Credit Facilities*

On March 6, 2017, Select entered into a senior secured credit agreement (the "credit agreement"). On July 26, 2024, the Company entered into Amendment No. 10 to the credit agreement. Amendment No. 10 reduced the revolving credit facility commitments available under the credit agreement from $770.0 million to $550.0 million. Select also made a voluntary prepayment of $1,640.4 million on its term loan and a $300.0 million repayment on its revolving credit facility using the proceeds derived from the Concentra IPO, as described in Note 2, *Acquisitions and Dispositions*, as well as proceeds from Concentra's issuance of debt in connection with the IPO.

On December 3, 2024, the Company entered into Amendment No. 11 to the credit agreement. Amendment No. 11 established a new incremental term loan in the aggregate amount of $1,050.0 million to replace the existing term loans. The maturity date of the term loan is December 3, 2031. In addition, Amendment No. 11 extended the maturity date of the revolving credit facility to December 3, 2029 and increased the revolving credit facility commitments from $550.0 million to $600.0 million.

At December 31, 2024, Select had $453.3 million of availability under the revolving facility after giving effect to $105.0 million of outstanding borrowings and $41.7 million of outstanding letters of credit.

The interest rate on the term loan is equal to Term SOFR plus 2.00%, or the Alternative Base Rate (as defined in the credit agreement) plus 1.00%. The interest rate on the revolving facility is equal to Adjusted Term SOFR plus a percentage ranging from 2.25% to 2.50%, or the Alternative Base Rate (as defined in the credit agreement) plus a percentage ranging from 1.25% to 1.50%, in each case subject to a specified leverage ratio. As of December 31, 2024, the term loan borrowings bear interest at a rate that is indexed to one-month Term SOFR plus 2.00%. As of December 31, 2024, the revolving facility borrowings bear interest either at a rate indexed to one-month Adjusted Term SOFR plus 2.25% or the Alternative Base Rate plus 1.25%.

The revolving facility requires Select to maintain a leverage ratio, as specified in the credit agreement, not to exceed 7.00 to 1.00. As of December 31, 2024, Select's leverage ratio was 3.18 to 1.00.

## 12. Long-Term Debt and Notes Payable (Continued)

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

*Prepayment of Borrowings*

Select will be required to prepay borrowings under the credit facilities with (i) the net cash proceeds received from non-ordinary course asset sales or other dispositions, or as a result of a casualty or condemnation, subject to reinvestment provisions and other customary carveouts and, to the extent required, the payment of certain indebtedness secured by liens having priority over the debt under the credit facilities or subject to a first lien intercreditor agreement, (ii) the net cash proceeds received from the issuance of debt obligations other than certain permitted debt obligations, and (iii) a percentage of excess cash flow (as defined in the credit agreement) based on Select's leverage ratio, as specified in the credit agreement.

During the year ended December 31, 2024, Select made a voluntary prepayment on its term loan and revolving credit facility as described above under *Credit Facilities*.

***Select 6.250% Senior Notes due 2032***

On December 3, 2024, Select issued and sold $550.0 million aggregate principal amount of 6.250% senior notes due December 1, 2032. Select used the net proceeds of the 6.250% senior notes due 2032, together with the proceeds from the incremental term loan borrowings (as described above) and cash on hand, to redeem in full the $1,225.0 million senior notes due 2026 at a redemption price of 101.0%, and pay related fees and expenses associated with the financing.

Interest on the 2032 senior notes accrues at the rate of 6.250% per annum and is payable semi-annually in arrears on June 1 and December 1 of each year, beginning on June 1, 2025.

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

Select may redeem some or all of the notes prior to December 1, 2027 by paying a "make-whole" premium. Select may redeem some or all of he notes on or after December 1, 2027 at specified redemption prices. The prices which would be paid if redeemed during the twelve-month period beginning on December 1 of the years indicated below are as follows:

| Year | Percentage |
|---|---|
| 2027 | 103.125 % |
| 2028 | 101.563 % |
| 2029 and thereafter | 100.000 % |

Select is obligated to offer to repurchase the senior notes at a price of 101% of their principal amount plus accrued and unpaid interest, if any, as a result of certain change of control events. These restrictions and prohibitions are subject to certain qualifications and exceptions.

***Loss on Early Retirement of Debt***

During the year ended December 31, 2024, the Company repaid the term loan, refinanced the Select credit facilities and the senior notes which resulted in a loss on early retirement of debt of $28.8 million.

During the year ended December 31, 2023, the Company refinanced the Select credit facilities which resulted in a loss on early retirement of debt of $14.7 million.

## 13. Redeemable Non-Controlling Interests

The Company's redeemable non-controlling interests are comprised of common shares held by equity holders other than the Company in less than wholly owned subsidiaries. These shares are subject to redemption rights.

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | | (in thousands) | |
| Balance as of January 1 | $ 39,033 | $ 34,043 | $ 26,297 |
| Net income attributable to redeemable non-controlling interests | 7,572 | 8,087 | 9,402 |
| Distributions to and purchases of redeemable non-controlling interests | (5,443) | (8,217) | (9,725) |
| Redemption value adjustment on redeemable non-controlling interests | (3,385) | (1,527) | 1,947 |
| Purchase of membership interests of Concentra Group Holdings Parent | (5,876) | (6,268) | — |
| Concentra Separation and Distribution | — | — | (17,754) |
| Other | 2,142 | 179 | — |
| Balance as of December 31 | $ 34,043 | $ 26,297 | $ 10,167 |

## 14. Stock Repurchase Program

Holdings' Board of Directors has authorized a common stock repurchase program to repurchase up to $1.0 billion worth of shares of its common stock. The program is in effect until December 31, 2025, unless extended or earlier terminated by the Board of Directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate. Holdings is funding this program with cash on hand and borrowings under the revolving facility. The common stock repurchase program has available capacity of $ 399.7 million as of December 31, 2024. On August 16, 2022, Congress passed the Inflation Reduction Act of 2022, which enacted a 1% excise tax on stock repurchases that exceed $1.0 million, effective January 1, 2023. Holdings was not subject to this excise tax during the years ended December 31, 2023 and 2024.

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Shares repurchased | 7,883,195 | — | — |
| Cost of shares repurchased (in thousands) | $ 185,119 | $ — | $ — |

## 15. Segment Information

The Company identifies its segments according to how the chief operating decision maker evaluates financial performance and allocates resources. The Company's reportable segments consist of the critical illness recovery hospital segment, rehabilitation hospital segment, and outpatient rehabilitation segment. The accounting policies of the segments are the same as those described in the summary of significant accounting policies. Other activities include the Company's corporate shared services, certain investments, and employee leasing services provided to related parties affiliated through the Company's equity method investments.

## 15. Segment Information (Continued)

The Company's chief operating decision maker is its Executive Chairman. The chief operating decision maker uses Adjusted EBITDA in the annual budgeting and forecasting process. The chief operating decision maker considers budget-to-actual variances when making decisions about the allocation of operating and capital resources to each segment. The chief operating decision maker also uses segment Adjusted EBITDA to assess the performance of each segment by comparing the results of each segment to one another and to each segment's budget. Adjusted EBITDA is defined as earnings from continuing operations excluding interest, income taxes, depreciation and amortization, gain (loss) on early retirement of debt, stock compensation expense, gain (loss) on sale of businesses, and equity in earnings (losses) of unconsolidated subsidiaries. The Company has provided additional information regarding its reportable segments, such as total assets, which contributes to the understanding of the Company and provides useful information to the users of the consolidated financial statements.

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

| | For the Year Ended December 31, 2022 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Revenue | $ 2,234,132 | $ 916,763 | $ 1,125,282 | $ 333,002 | $ 4,609,179 |
| Personnel expense | 1,427,515 | 530,159 | 774,144 | | |
| Other segment items [1] | 695,273 | 188,570 | 249,278 | | |
| Adjusted EBITDA | 111,344 | 198,034 | 101,860 | | |
| Total assets | 2,484,542 | 1,200,767 | 1,371,123 | 327,214 | 5,383,646 |
| Capital expenditures | 79,524 | 14,426 | 40,677 | 9,762 | 144,389 |

| | For the Year Ended December 31, 2023 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Revenue | $ 2,299,773 | $ 979,585 | $ 1,188,914 | $ 357,705 | $ 4,825,977 |
| Personnel expense | 1,326,448 | 554,899 | 825,907 | | |
| Other segment items [1] | 727,310 | 202,811 | 251,139 | | |
| Adjusted EBITDA | 246,015 | 221,875 | 111,868 | | |
| Total assets | 2,496,886 | 1,233,888 | 1,380,447 | 248,204 | 5,359,425 |
| Capital expenditures | 93,036 | 21,922 | 38,776 | 6,126 | 159,860 |

| | For the Year Ended December 31, 2024 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospitals | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Revenue | $ 2,444,196 | $ 1,110,592 | $ 1,250,294 | $ 382,023 | $ 5,187,105 |
| Personnel Expense | 1,376,917 | 629,149 | 888,290 | | |
| Other segment items [1] | 765,645 | 235,695 | 253,427 | | |
| Adjusted EBITDA | 301,634 | 245,748 | 108,577 | | |
| Total assets | 2,654,474 | 1,366,922 | 1,404,379 | 182,176 | 5,607,951 |
| Capital expenditures | 65,861 | 53,620 | 36,142 | 3,285 | 158,908 |

(1) Other segment items consist of facilities expense, other operating expenses, and other operating income.

## 15. Segment Information (Continued)

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Adjusted EBITDA - Critical Illness Recovery Hospital Segment | $ 111,344 | $ 246,015 | $ 301,634 |
| Adjusted EBITDA - Rehabilitation Hospital Segment | 198,034 | 221,875 | 245,748 |
| Adjusted EBITDA - Outpatient Rehabilitation Segment | 101,860 | 111,868 | 108,577 |
| Other revenue | 333,002 | 357,705 | 382,023 |
| Other cost of services [(1)] | (333,002) | (357,705) | (382,023) |
| Other general and administrative expenses [(1)] | (122,480) | (134,153) | (145,939) |
| Other operating income | 23,768 | 486 | 375 |
| Depreciation and amortization | (132,158) | (135,691) | (142,866) |
| Stock compensation expense | (35,614) | (43,158) | (99,214) |
| Loss on early retirement of debt | — | (14,692) | (28,845) |
| Equity in earnings of unconsolidated subsidiaries | 27,984 | 41,339 | 63,904 |
| Interest expense | (137,470) | (154,165) | (128,605) |
| Income from continuing operations before income taxes | $ 35,268 | $ 139,724 | $ 174,769 |

(1) Exclusive of depreciation, amortization and stock compensation expense.

## 16. Revenue from Contracts with Customers

The following tables disaggregate the Company's revenue:

| | For the Year Ended December 31, 2022 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Patient service revenue: | | | | | |
| Medicare | $ 848,706 | $ 423,739 | $ 175,252 | $ — | $ 1,447,697 |
| Non-Medicare | 1,376,269 | 448,467 | 878,979 | — | 2,703,715 |
| Total patient services revenue | 2,224,975 | 872,206 | 1,054,231 | — | 4,151,412 |
| Other revenue | 9,157 | 44,557 | 71,051 | 333,002 | 457,767 |
| Total revenue | $ 2,234,132 | $ 916,763 | $ 1,125,282 | $ 333,002 | $ 4,609,179 |

| | For the Year Ended December 31, 2023 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Patient service revenue: | | | | | |
| Medicare | $ 840,187 | $ 462,476 | $ 182,346 | $ — | $ 1,485,009 |
| Non-Medicare | 1,455,772 | 468,439 | 931,124 | — | 2,855,335 |
| Total patient services revenue | 2,295,959 | 930,915 | 1,113,470 | — | 4,340,344 |
| Other revenue | 3,814 | 48,670 | 75,444 | 357,705 | 485,633 |
| Total revenue | $ 2,299,773 | $ 979,585 | $ 1,188,914 | $ 357,705 | $ 4,825,977 |

| | For the Year Ended December 31, 2024 | | | | |
|---|---|---|---|---|---|
| | Critical Illness Recovery Hospital | Rehabilitation Hospital | Outpatient Rehabilitation | Other | Total |
| | (in thousands) | | | | |
| Patient service revenue: | | | | | |
| Medicare | $ 798,439 | $ 503,126 | $ 190,271 | $ — | $ 1,491,836 |
| Non-Medicare | 1,642,115 | 556,640 | 984,945 | — | 3,183,700 |
| Total patient services revenue | 2,440,554 | 1,059,766 | 1,175,216 | — | 4,675,536 |
| Other revenue | 3,642 | 50,826 | 75,078 | 382,023 | 511,569 |
| Total revenue | $ 2,444,196 | $ 1,110,592 | $ 1,250,294 | $ 382,023 | $ 5,187,105 |

## 17. Stock-based Compensation

Holdings' equity incentive plan provides for the issuance of various stock-based awards. Under its current plan, Holdings has issued restricted stock awards. The equity plan currently allows for the issuance of 5,995,000 awards, as adjusted for cancelled or forfeited awards through December 31, 2024. As of December 31, 2024, Holdings has capacity to issue 4,266,900 stock-based awards under its equity plan. The equity plan allows for authorized but previously unissued shares or shares previously issued and outstanding and reacquired by Holdings to satisfy these awards.

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

## 17. Stock-based Compensation (Continued)

Transactions related to restricted stock awards are as follows:

| | Shares | Weighted Average Grant Date Fair Value |
|---|---|---|
| | (share amounts in thousands) | |
| Unvested balance, January 1, 2024 | 4,511 | $ 30.71 |
| Granted | 1,728 | 28.38 |
| Vested | (3,567) | 30.90 |
| Forfeited | (70) | 28.87 |
| Unvested balance, December 31, 2024 | 2,602 | $ 28.94 |

For the years ended December 31, 2022, 2023, and 2024, the weighted average grant date fair values of restricted stock awards granted were $28.41, $29.06, and $28.38, respectively. For the years ended December 31, 2022, 2023, and 2024, the fair values of restricted stock awards vested were $24.6 million, $33.9 million, and $110.2 million, respectively.

In connection with the Company's spin-off of Concentra, employees of the Company holding any unvested restricted shares of the Company's common stock on November 4, 2024 received accelerated vesting with respect to one-third of their unvested awards, applied ratably to each unvested tranche of such awards. This accelerated vesting was approved by the Human Capital and Compensation Committee of the Company in advance of the distribution as a part of the planning intended to ensure the tax-free nature of the distribution of Concentra common stock in respect of the Company's vested stock. This had the effect of accelerating $23.6 million of stock compensation expense into the quarter ended December 31, 2024.

In connection with the distribution of Concentra common stock on November 25, 2024, holders of unvested restricted shares of the Company's common stock received 0.806971 unrestricted and fully vested shares of Concentra common stock for each unvested restricted share of the Company's common stock they held. The distribution of unrestricted Concentra shares is considered an award modification that did not result in incremental fair value and therefore, incremental compensation expense was not recognized. The unrecognized service cost attributed to the Concentra shares of the modified restricted stock award was recognized as stock compensation expense at the distribution date since the Concentra shares were distributed without restrictions. The distribution of vested Concentra shares to Select's restricted stock holders had the effect of accelerating $22.3 million of stock compensation expense into the quarter ended December 31, 2024.

Stock compensation expense recognized by the Company is as follows:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Stock compensation expense: | | | |
| Included in general and administrative | $ 30,555 | $ 36,041 | $ 79,931 |
| Included in cost of services | 5,059 | 7,117 | 19,283 |
| Total | $ 35,614 | $ 43,158 | $ 99,214 |

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

| | 2025 | 2026 | 2027 | 2028 |
|---|---|---|---|---|
| | (in thousands) | | | |
| Stock compensation expense | $ 13,205 | $ 8,240 | $ 2,707 | $ 411 |

## 18. Income Taxes

The components of the Company's income tax expense for the years ended December 31, 2022, 2023, and 2024, are as follows:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Current income tax expense (benefit): | | | |
| Federal | $ (7,022) | $ 24,766 | $ 50,372 |
| State and local | 7,584 | 14,317 | 25,280 |
| Total current income tax expense | 562 | 39,083 | 75,652 |
| Deferred income tax expense (benefit) | 16,161 | (9,830) | (30,870) |
| Total income tax expense | $ 16,723 | $ 29,253 | $ 44,782 |

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

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2022 | 2023 | 2024 |
| Federal income tax at statutory rate | 21.0 % | 21.0 % | 21.0 % |
| State and local income taxes, less federal income tax benefit | 313.9 | 11.8 | 6.5 |
| Permanent differences | 74.1 | 1.8 | 1.7 |
| Deferred income taxes — state income tax rate adjustment | 227.3 | (3.0) | 0.0 |
| Deferred income taxes - covered employee adjustment | — | — | 0.9 |
| Valuation allowance | 216.7 | (1.8) | 1.5 |
| Limitation on officers' compensation | 251.8 | 7.4 | 15.8 |
| Tax credits | (135.5) | (2.7) | (1.6) |
| Stock-based compensation | (41.6) | (1.2) | (5.4) |
| Non-controlling interest | (899.9) | (12.2) | (15.0) |
| Other | 19.6 | (0.2) | 0.2 |
| Effective income tax rate | 47.4 % | 20.9 % | 25.6 % |

Our tax rate for the year ended December 31, 2022 was higher due to our lower income from continuing operations, the mix of states in which the income was earned, valuation allowances recorded as a result of an inability to recognize net operating losses in future periods and the effect of permanent tax differences.

## 18. Income Taxes (Continued)

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

| | December 31, 2023 | December 31, 2024 |
|---|---|---|
| | (in thousands) | |
| Deferred tax assets | | |
| Implicit discounts and adjustments | $ 4,446 | $ 6,169 |
| Compensation and benefit-related accruals | 41,460 | 44,651 |
| Professional malpractice liability insurance | 13,835 | 14,081 |
| Federal and state net operating loss and state tax credit carryforwards | 25,476 | 22,611 |
| Interest limitation carryforward | 17,683 | 47,905 |
| Stock awards | 7,003 | 2,314 |
| Equity investments | 4,724 | 1,235 |
| Operating lease liabilities | 151,710 | 174,165 |
| Research and experimental expenditures | 13,349 | 20,478 |
| Excess capital loss | — | 4,941 |
| Other | 361 | 384 |
| Deferred tax assets | 280,047 | 338,934 |
| Valuation allowance | (14,493) | (15,230) |
| Deferred tax assets, net of valuation allowance | 265,554 | 323,704 |
| Deferred tax liabilities | | |
| Investment in unconsolidated affiliates | $ (16,788) | $ (20,228) |
| Investment in consolidated affiliates | — | (3,511) |
| Depreciation and amortization | (190,153) | (190,355) |
| Deferred financing costs | (1,483) | (494) |
| Operating lease right-of-use assets | (141,030) | (162,171) |
| Derivatives | (14,151) | — |
| Other | (801) | (1,378) |
| Deferred tax liabilities | (364,406) | (378,137) |
| Deferred tax liabilities, net of deferred tax assets | $ (98,852) | $ (54,433) |

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

| | December 31, 2023 | December 31, 2024 |
|---|---|---|
| | (in thousands) | |
| Other assets | $ 21,090 | $ 27,064 |
| Non-current deferred tax liability | (119,942) | (81,497) |
| | $ (98,852) | $ (54,433) |

As of December 31, 2023 and 2024, the Company’s valuation allowance is primarily attributable to the uncertainty regarding the realization of state net operating losses and other net deferred tax assets of loss entities.

For the year ended December 31, 2023, the Company recorded a net valuation allowance decrease of $2.4 million. These changes resulted from net changes in state net operating losses. For the year ended December 31, 2024, the Company recorded a net valuation allowance increase of $0.7 million. The changes in the Company’s valuation allowance were recognized as a result of management’s reassessment of the amount of its deferred tax assets that are more likely than not to be realized.

## 18. Income Taxes (Continued)

At December 31, 2023 and 2024, the Company's net deferred tax liabilities of approximately $98.9 million and $54.4 million, respectively, consist of items which have been recognized for tax reporting purposes, but which will increase tax on returns to be filed in the future. The Company has performed an assessment of positive and negative evidence regarding the realization of the net deferred tax assets. This assessment included a review of legal entities with three years of cumulative losses, estimates of projected future taxable income, the effect on future taxable income resulting from the reversal of existing deferred tax liabilities in future periods, and the impact of tax planning strategies that management would and could implement in order to keep deferred tax assets from expiring unused. Although realization is not assured, based on the Company's assessment, it has concluded that it is more likely than not that such assets, net of the determined valuation allowance, will be realized.

The total state net operating losses are approximately $518.1 million. State net operating loss carryforwards expire and are subject to valuation allowances as follows:

| | State Net Operating Losses | Gross Valuation Allowance |
|---|---|---|
| | (in thousands) | |
| 2025 | $ 45,964 | $ 45,276 |
| 2026 | 24,622 | 23,300 |
| 2027 | 39,137 | 38,102 |
| 2028 | 45,246 | 42,951 |
| Thereafter through 2042 | 363,092 | 293,147 |

## 19. Earnings per Share

The following table sets forth the income attributable to the Company from continuing operations, net of tax, and the Company's common shares outstanding, and its participating securities outstanding. There were no contractual dividends paid for the years ended December 31, 2022, 2023, and 2024.

| | Basic and Diluted EPS | | |
|---|---|---|---|
| | For the Year Ended December 31, | | |
| | 2022 | 2023 | 2024 |
| | (in thousands) | | |
| Income from continuing operations, net of tax | $ 18,545 | $ 110,471 | $ 129,987 |
| Less: net income attributable to non-controlling interests | 33,516 | 51,444 | 64,514 |
| Income from continuing operations, net of tax, attributable to Select Medical's common stockholders | (14,971) | 59,027 | 65,473 |
| Less: distributed and undistributed net income attributable to participating securities | (528) | 2,127 | 2,319 |
| Distributed and undistributed income from continuing operations, net of tax, attributable to common shares | $ (14,443) | $ 56,900 | $ 63,154 |

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

| | For the Year Ended December 31, 2022 | | |
|---|---|---|---|
| | Income from Continuing Operations, Net of Tax, Allocation | Shares(1) | Basic and Diluted EPS |
| | (in thousands, except for per share amounts) | | |
| Common shares | $ (14,443) | 124,628 | $ (0.12) |
| Participating securities | (528) | 4,557 | (0.12) |
| Total Company | $ (14,971) | | |

| | For the Year Ended December 31, 2023 | | |
|---|---|---|---|
| | Income from Continuing Operations, Net of Tax, Allocation | Shares(1) | Basic and Diluted EPS |
| | (in thousands, except for per share amounts) | | |
| Common shares | $ 56,900 | 123,105 | $ 0.46 |
| Participating securities | 2,127 | 4,601 | 0.46 |
| Total Company | $ 59,027 | | |

| | For the Year Ended December 31, 2024 | | |
|---|---|---|---|
| | Income from Continuing Operations, Net of Tax, Allocation | Shares(1) | Basic EPS |
| | (in thousands, except for per share amounts) | | |
| Common shares | $ 63,154 | 124,614 | $ 0.51 |
| Participating securities | 2,319 | 4,576 | $ 0.51 |
| Total Company | $ 65,473 | | |

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

## 20. Commitments and Contingencies

***Construction Commitments***

At December 31, 2024, the Company had outstanding commitments under construction contracts related to new construction, improvements, and renovations totaling approximately $158.0 million.

***Litigation***

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

To address claims arising out of the Company's operations, the Company maintains professional malpractice liability insurance and general liability insurance coverages through a number of different programs that are dependent upon such factors as the state where the Company is operating and whether the operations are wholly owned or are operated through a joint venture. For the Company's wholly owned hospital and outpatient clinic operations, the Company currently maintains insurance coverages under a combination of policies with a total annual aggregate limit of up to $42.0 million for professional malpractice liability insurance and $45.0 million for general liability insurance. The Company's insurance for the professional liability coverage is written on a "claims-made" basis, and its commercial general liability coverage is maintained on an "occurrence" basis. These coverages apply after a self-insured retention limit is exceeded. For the Company's joint venture operations, the Company has designed a separate insurance program that responds to the risks of specific joint ventures. Most of the Company's joint ventures are insured under a master program with an annual aggregate limit of up to $80.0 million, subject to a sublimit aggregate ranging from $23.0 million to $33.0 million for most joint ventures. The policies are generally written on a "claims-made" basis. Each of these programs has either a deductible or self-insured retention limit. The Company also maintains additional types of liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by the applicable professional malpractice and general liability insurance policies, including workers compensation, property and casualty, directors and officers, cyber liability insurance, and employment practices liability insurance coverages. Our insurance policies generally are silent with respect to punitive damages so coverage is available to the extent insurable under the law of any applicable jurisdiction, and are subject to various deductibles and policy limits. The Company reviews its insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. Significant legal actions, as well as the cost and possible lack of available insurance, could subject the Company to substantial uninsured liabilities. In the Company's opinion, the outcome of these actions, individually or in the aggregate, will not have a material adverse effect on its financial position, results of operations, or cash flows.

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

*Oklahoma City Investigation.* On August 24, 2020, the Company and Select Specialty Hospital – Oklahoma City, Inc. ("SSH–Oklahoma City") received civil investigative demands ("CIDs") from the U.S. Attorney's Office for the Western District of Oklahoma seeking responses to interrogatories and the production of various documents principally relating to the documentation, billing and reviews of medical services furnished to patients at SSH-Oklahoma City. The Company understands that the investigation arose from a qui tam lawsuit alleging billing fraud related to charges for respiratory therapy services at SSH–Oklahoma City and Select Specialty Hospital – Wichita, Inc. The Company has produced documents in response to the CIDs and is fully cooperating with this investigation. At this time, the Company is unable to predict the timing and outcome of this matter.

## 20. Commitments and Contingencies (Continued)

*Physical Therapy Billing.* On October 7, 2021, the Company received a letter from a Trial Attorney at the U.S. Department of Justice, Civil Division, Commercial Litigation Branch, Fraud Section ("DOJ") stating that the DOJ, in conjunction with the U.S. Department of Health and Human Services ("HHS"), is investigating the Company in connection with potential violations of the False Claims Act, 31 U.S.C. § 3729, *et seq.* The letter specified that the investigation relates to the Company's billing for physical therapy services, and indicated that the DOJ would be requesting certain records from the Company. In October and December 2021, the DOJ requested, and the Company furnished, records relating to six of the Company's outpatient therapy clinics in Florida. In 2022 and 2023, the DOJ requested certain data relating to all of the Company's outpatient therapy clinics nationwide, and sought information about the Company's ability to produce additional data relating to the physical therapy services furnished by the Company's outpatient therapy clinics and Concentra. The Company has produced data and other documents requested by the DOJ and is fully cooperating on this investigation. In May 2024, by order of the U.S. District Court for the Middle District of Florida, a qui tam lawsuit that is related to the DOJ's investigation was unsealed after the U.S. filed a notice declining to intervene in the case, but stating that its investigation is continuing and reserving its right to intervene at a later date. The lawsuit, filed in May 2021 and amended in October 2021 and July 2024, was brought by Kathleen Kane, a physical therapist formerly employed in the Company's outpatient division, against Select Medical Corporation, Select Physical Therapy Holdings, Inc. and Select Employment Services, Inc. The amended complaint alleges that the defendants billed Federally funded health programs for one-on-one therapy services when group therapy was performed or overbilled for one-on-one therapy services, and billed for unreimbursable unskilled physical therapy services. In September 2024, the Company filed a motion to dismiss the amended complaint on multiple grounds. At this time, the Company is unable to predict the timing and outcome of this matter.

## 21. Subsequent Events

On February 13, 2025, the Company's Board of Directors declared a cash dividend of $0.0625 per share. The dividend will be payable on or about March 13, 2025, to stockholders of record as of the close of business on March 3, 2025.

## 22. Selected Quarterly Financial Data (Unaudited)

The tables below sets forth selected unaudited financial data for each quarter of the last two years.

| | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| | (in thousands, except per share amounts) | | | |
| For the year ended December 31, 2023 | | | | |
| Revenue | $ 1,208,682 | $ 1,207,449 | $ 1,191,730 | $ 1,218,116 |
| Cost of services, exclusive of depreciation and amortization | 1,056,091 | 1,056,764 | 1,067,452 | 1,074,062 |
| Depreciation and amortization | 34,115 | 31,656 | 34,435 | 35,485 |
| Income from continuing operations before income taxes | 47,845 | 50,081 | 6,929 | 34,869 |
| Income from continuing operations, net of tax | 36,657 | 35,000 | 8,563 | 30,251 |
| Income from discontinued operations, net of tax | 48,600 | 56,860 | 52,253 | 31,547 |
| Net income | 85,257 | 91,860 | 60,816 | 61,798 |
| Net income attributable to Select Medical Holdings Corporation | 70,805 | 78,237 | 48,180 | 46,269 |
| Earnings (loss) from continuing operations per common share: | | | | |
| Basic and diluted | $ 0.18 | $ 0.18 | $ (0.02) | $ 0.12 |

| | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| | (in thousands, except per share amounts) | | | |
| For the year ended December 31, 2024 | | | | |
| Revenue | $ 1,321,211 | $ 1,281,748 | $ 1,271,582 | $ 1,312,564 |
| Cost of services, exclusive of depreciation and amortization | 1,120,711 | 1,121,943 | 1,135,708 | 1,175,099 |
| Depreciation and amortization | 35,584 | 36,069 | 34,930 | 36,283 |
| Income (loss) from continuing operations before income taxes | 88,209 | 55,853 | 45,650 | (14,943) |
| Income (loss) from continuing operations, net of tax | 61,529 | 37,638 | 41,276 | (10,456) |
| Income from discontinued operations, net of tax | 55,638 | 57,128 | 39,739 | 14,212 |
| Net income | 117,167 | 94,766 | 81,015 | 3,756 |
| Net income (loss) attributable to Select Medical Holdings Corporation | 96,897 | 77,563 | 55,628 | (16,050) |
| Earnings (loss) from continuing operations per common share:[1] | | | | |
| Basic | $ 0.33 | $ 0.17 | $ 0.19 | $ (0.18) |
| Diluted | $ 0.33 | $ 0.17 | $ 0.19 | $ (0.19) |

(1) Due to rounding, the summation of quarterly earnings per common share balances may not equal year to date equivalents.

The following Financial Statement Schedule along with the report thereon of PricewaterhouseCoopers LLP dated February 20, 2025, should be read in conjunction with the consolidated financial statements. Financial Statement Schedules not included in this filing have been omitted because they are not applicable or the required information is shown in the consolidated financial statements or notes thereto.

**Schedule II—Valuation and Qualifying Accounts**

| | Balance at Beginning of Year | Charged to Cost and Expenses | Acquisitions[1] | Deductions[2] | Balance at End of Year |
|---|---|---|---|---|---|
| | | | (in thousands) | | |
| **Income Tax Valuation Allowance** | | | | | |
| Year ended December 31, 2024 | $ 14,493 | $ 737 | $ — | $ — | $ 15,230 |
| Year ended December 31, 2023 | $ 16,858 | $ (2,365) | $ — | $ — | $ 14,493 |
| Year ended December 31, 2022 | $ 13,688 | $ 3,170 | $ — | $ — | $ 16,858 |

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

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

# SELECT MEDICAL HOLDINGS CORPORATION
# SELECT MEDICAL CORPORATION

AMENDED AND RESTATED

STATEMENT OF

TRADING POLICIES

ADOPTED: August 12, 2009
LAST AMENDED: February 13, 2025

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## I. SUMMARY OF THE COMPANY'S TRADING POLICIES

This Statement of Trading Policies (this "Statement") covers a fundamental principle which each employee and director of Select Medical Holdings Corporation, Select Medical Corporation or any of their current or future subsidiaries (collectively, the "Company") must follow: It is the Company's policy that it will without exception comply with the securities laws of the United States. Each employee and each director is expected to abide by this policy. When carrying out Company business, employees and directors must avoid any activity that violates applicable state and federal securities laws or regulations.

The foregoing principle is described in more detail below. A description of certain applicable securities laws and related policies is set forth in Sections II and III of this Statement. This Statement does not describe every securities law or regulation which will affect the Company and its business, but attempts to familiarize employees and directors with the securities laws which they must pay particular attention to in an effort to assure the Company's compliance. Of course, employees and directors are expected to comply with all applicable laws.

In meeting the standards set out in this Statement, it is essential that each employee and director conduct the Company's business with honesty and integrity. Each employee and each director contributes to the Company's overall reputation. Therefore, each employee and each director must accept individual responsibility for ensuring that these standards are implemented.

## II. THE USE OF INSIDE INFORMATION IN CONNECTION WITH THE TRADING OF SECURITIES

### A. General Rule.

The U.S. securities laws regulate the sale and purchase of securities in the interest of protecting the investing public. U.S. securities laws give the Company, its officers and directors, and other employees the responsibility to ensure that information about the Company is not used unlawfully in the purchase and sale of securities.

All employees and directors should pay particularly close attention to the laws against trading on "inside" information. These laws are based upon the belief that all persons trading in a company's securities should have equal access to all "material" information about that company. For example, if an employee or a director of a company knows material nonpublic financial information, that employee or director is prohibited from buying or selling securities of a company until the information has been disclosed to the public. This is because the employee or director knows information that will probably cause the price of those securities to change, and it would be unfair for the employee or director to have an advantage (knowledge of the price change) that the rest of the investing public does not have. In fact, it is more than unfair. It is considered to be fraudulent and illegal. Civil and criminal penalties for this kind of activity are severe.

*The general rule* can be stated as follows: It is a violation of the federal securities laws for any person to buy or sell securities if he or she is in possession of material inside information. Information is *material* if it could affect a person's decision whether to buy, sell or hold the securities. It is *inside* information if it has not been publicly disclosed. Furthermore, it is illegal for any person in possession of material inside information to provide other people with such information or to recommend that they buy or sell the securities. (This is called "tipping".) In that case, they may both be held liable. While it is not possible to identify all information that would be deemed "material," the following types of information ordinarily may be considered material:

- Financial performance, especially quarterly and year-end results of operations, and significant changes in financial performance, conditions or liquidity.
- Company projections and strategic plans.
- Potential mergers and acquisitions or the sale of Company assets or subsidiaries.
- New major contracts, collaborations, orders, suppliers, customers, or finance sources, or the loss thereof.
- Significant changes or developments in products or product lines.
- Significant changes or developments in supplies or inventory, including significant product defects, recalls or product returns. Significant pricing changes.
- Stock splits, public or private securities/debt offerings, or changes in Company dividend policies or amounts.
- Plans to repurchase a material amount of the Company's securities.
- Significant changes in senior management. Significant labor disputes or negotiations.
- Actual or threatened major litigation, or the resolution of such litigation.

The rule applies to any and all transactions in the Company's securities, including its common stock and options and warrants to purchase common stock (other than the exercise of employee stock options or warrants, but including the sale of shares acquired upon the exercise of employee stock options or warrants), and any other type of securities that the Company may issue, such as notes (including without limitation, Select Medical Corporation's 6.250% Senior Notes Due 2032), preferred stock, convertible debentures, warrants and exchange-traded options or other derivative securities.

This Statement continues to apply to your transactions in Company securities even after you have terminated employment or are no longer serving the Company as a director or consultant. If you are in possession of material nonpublic information when your employment or your service as a director or consultant terminates, you may not trade in Company securities until that information has become public or is no longer material. In all other respects, the procedures set forth in this Statement will cease to apply to your transactions in Company securities upon the expiration of any "blackout period" that is applicable to your transactions at the time of your termination of service.

The U.S. Securities and Exchange Commission (the "SEC"), the securities exchanges and plaintiffs' lawyers focus on uncovering insider trading. A breach of the insider trading laws could expose the insider to criminal fines up to $5 million (up to $25 million for a person other than a natural person) and imprisonment of up to twenty years, in addition to civil penalties (up to three times the profits earned), and injunctive actions. In addition, punitive damages may be imposed under applicable state laws. Securities laws also subject controlling persons to civil penalties for illegal insider trading by employees, including employees located outside the United States. Controlling persons include directors, officers, and supervisors. These persons may be subject to fines up to the greater of $1,000,000 or three times the profit realized or loss avoided by the insider trader. Inside information does not belong to the individual directors, officers or other employees who may handle it or otherwise become knowledgeable about it. It is an asset of the Company. For any person to use such information for personal benefit or to disclose it to others outside the Company violates the Company's interests. More particularly, in connection with trading in the Company securities, it is a fraud against members of the investing public and against the Company. However, trading may be permitted while in possession of, but not on the basis of, material inside information, pursuant to a validly created and approved 10b5-1 Plan (described in Section II.E.6 below) adopted in compliance with Rule 10b5-1 of the Securities Exchange Act of 1934 ("Rule 10b5-1") and this Statement.

B. Who Does the Policy Apply To?

The prohibition against trading on inside information applies to directors, officers and all other employees, and to other people who gain access to that information. Because of their access to confidential information on a regular basis, Company policy subjects its directors, certain employees and related parties (the "Window Group" as defined below) to additional restrictions on trading in the Company securities. The restrictions for the Window Group are discussed in Section II.E.5 below. In addition, directors and certain employees with inside knowledge of material information may be subject to ad hoc restrictions on trading from time to time.

Additionally, the Company has designated those persons listed on *Exhibit A* attached hereto ("Section 16 Individuals") as the directors and officers who are subject to the reporting provisions and trading restrictions of Section 16 of the Securities Exchange Act of 1934 (the "Exchange Act"). Except for those trades made pursuant to a validly created and approved 10b5-1 Plan, Section 16 Individuals must obtain prior approval of all trades in Company securities from the Compliance Officer (as defined in Section II.F below) or other such person designated by the Board of Directors in accordance with the procedures set forth in Section II.G below. The Company will amend *Exhibit A* from time to time as necessary to reflect the addition, resignation or departure of Section 16 Individuals.

The Company has designated those persons listed on *Exhibit B* attached hereto as "Key Employees" because of their position as officers of the Company and/or their access to material nonpublic information. Except for those trades made pursuant to a validly created and approved 10b5-1 Plan, Key Employees must obtain the prior approval of all trades in Company securities from the Compliance Officer in accordance with the procedures set forth in Section II.G below. The Company will amend *Exhibit B* from time to time as necessary to reflect the addition, resignation or departure of Key Employees.

The Window Group consists of (i) the Section 16 Individuals listed on *Exhibit A* attached hereto, (ii) the Key Employees listed on *Exhibit B* attached hereto and (iii) such other persons as may be designated from time to time and informed of such status by the Compliance Officer. All references to members of the Window Group or "related parties" of a person in this

Statement apply also to such persons’ spouses, members of their immediate families sharing the same household and any trust, partnership or other entity the investments of which any of the foregoing have direct or indirect power to control.

C. Other Companies’ Securities.

The same rules against insider trading, and the requirement to clear trades with the Compliance Officer, apply to other companies’ securities. Employees, directors and related parties who learn material information about any third-party, including but not limited to suppliers, customers, or competitors, through their work at the Company should keep it strictly confidential and not buy or sell such companies’ securities until the information becomes public. Employees, directors and related parties should not give tips about those securities. Information that is not material to the Company may nevertheless be material to a third-party company.

D. Margin Accounts and Pledging or Hedging Company Securities.

1. *Margin Accounts and Pledging.* Securities held in a margin account may be sold by the broker without the customer’s consent if the customer fails to meet a margin call. Likewise, securities pledged to a bank or financial institution may be sold without the customer’s consent if the customer fails to repay the obligation secured by the pledge. Because such sales may occur at a time when an employee or a director had material inside information or is otherwise not permitted to trade in Company securities, the Company prohibits employees, directors and related parties from purchasing Company securities on margin, holding Company securities in a margin account or pledging Company securities.

2. *Hedging Transactions.* All employees and directors of the Company are prohibited from purchasing any financial instrument that is designed to hedge or offset any decrease in the market value of the Company’s securities, including, but not limited to, any prepaid forward contracts, options, puts, calls, equity swaps, collars, other derivative instruments or any other similar type of financial transaction entered into for such purpose (a “Hedging Transaction”).

E. Guidelines.

The following guidelines should be followed in order to ensure compliance with applicable antifraud laws and with the Company’s policies:

1. *Nondisclosure.* Material inside information must not be disclosed to anyone, except to persons within the Company whose positions require them to know it. Care should be taken so that material, nonpublic information is kept secure. No one may “tip” or disclose material nonpublic information concerning the Company to any outside person (including, but not limited to family members, analysts, individual investors, and members of the investment community and news media), unless required as part of that person’s regular duties for the Company and authorized by the Compliance Officer and/or the Board of Directors. In any instance in which such information is disclosed to outsiders, the Company will take such steps as are necessary to preserve the confidentiality of the information, including requiring the outsider to agree in writing to comply with the terms of this policy and/or to sign a confidentiality agreement. All inquiries from outsiders regarding material nonpublic information about the Company must be forwarded to the Compliance Officer.

No one may give trading advice of any kind about the Company to anyone while possessing material nonpublic information about the Company, except to advise others not to trade if doing so might violate the law or this policy. The Company strongly discourages all directors, officers and related parties from giving trading advice concerning the Company to third parties even when the director or officer does not possess material nonpublic information about the Company.

2. *Trading in the Company's Securities.* No employee, director or related party should place a purchase or sale order, or recommend that another person place a purchase or sale order in the Company's securities, when he or she has knowledge of material, non-public information concerning the Company. This includes orders for purchases and sales of stock and convertible securities, such as options, puts and calls. The exercise of employee and non-employee director stock options and warrants is not subject to this policy, whether the exercise price is paid in cash, or, pursuant to a contractual right, by either the surrender of securities by the holder of the option or warrant or the withholding by the Company of a portion of the underlying securities. However, securities that were acquired upon exercise of a stock option or warrant will be treated like any other securities, and may not be sold by an employee, director or related party who is in possession of material inside information. Employees, directors or related parties who possess material inside information should wait until after the close of the first trading day after the information has been publicly released before trading. In addition, the Company prohibits directors, employees and related parties from effecting any "short sales" of the Company's securities (see "Prohibition of Short Sales," below), as it is the Company's policy that this type of activity is inherently speculative in nature and it may arouse suspicion in the eyes of the SEC that the person was trading on the basis of inside information, particularly when the trading occurs before a major Company announcement or event. Directors and executive officers of the Company are also prohibited by Section 306 of the Sarbanes-Oxley Act of 2002 from purchasing, selling or otherwise acquiring or transferring the Company's equity securities during any blackout period under any individual account plan maintained by the Company, including the Company's 401(k) plan. However, trading may be permitted while in possession of, but not on the basis of, material inside information, pursuant to a validly created and approved 10b5-1 Plan adopted in compliance with Rule 10b5-1 and this Statement.

3. *Avoid Speculation.* Investing in the Company's securities often provides an opportunity to share in the future growth of the Company. But investment in the Company and sharing in the growth of the Company does not mean short range speculation based on fluctuations in the market. Such activities put the personal gain of the employee or director in conflict with the best interests of the Company and its stockholders. Although this policy does not mean that employees or directors may never sell Company securities, the Company encourages employees, directors and related parties to avoid frequent trading in Company securities. Speculating in Company securities is not part of the Company's culture.

4. *Trading in Another Company's Securities.* No employee, director or related party should place a purchase or sale order, or recommend that another person place a purchase or sale order, in the securities of another company, if the employee or director learns in the course of his or her employment confidential information about the other company that is likely to affect the value of those securities. For example, it would be a violation of the securities laws if an employee or director learned through Company sources that the Company intended to purchase assets from a company, and then bought or sold that other company's securities because of the likely increase or decrease in the value of those securities.

5. *Additional Rules for the Window Group.* Except for trades made pursuant to a validly created and approved 10b5-1 Plan, the Window Group is subject to the following additional restrictions on trading Company securities:

- trading is permitted from the close of the first trading day following an earnings release with respect to the preceding fiscal period until the close of trading on the twenty-second ($22^{nd}$) day of the third ($3^{rd}$) month of the current fiscal quarter (each, a "Window"), subject to the restrictions below;
- for each Company employee, the 10b5-1 Plan may not begin until after the expiration of a 30-day cooling-off period after your adoption of your 10b5-1 Plan;
- a material modification (including any change in the amount, price, or timing of purchases or sales, or changes to the formula or algorithm that affect the amount price, or timing of purchases or sales) to the terms of a 10b5-1 Plan triggers a new cooling off period that will be determined by the Company's Compliance Officer in accordance with SEC rules;
- all trades are subject to prior review;
- clearance for all trades must be obtained from the Company's Compliance Officer;
- no trading in Company securities even during a Window while in the possession of material inside information. Persons possessing such information may trade during a Window only after the close of trading on the first trading day following the Company's widespread public release of such material inside information;
- no trading in Company securities outside of a Window or during any special blackout periods that the Compliance Officer may designate. No one may disclose to any outside third party that a special blackout period has been designated;
- no trading in Company debt securities at any time when the Company is seeking to purchase the same class of debt securities; and
- the Compliance Officer may, on a case-by-case basis, authorize trading in Company securities outside of a Window (but not during special blackout periods) due to financial hardship or other hardships.

6. *Trading Pursuant to a 10b5-1 Plan.* Rule 10b5-1 provides an affirmative defense to directors, officers and employees from insider trading liability under Rule 10b5 for transactions under a previously established contract, plan or instruction to trade in the Company's stock (a "10b5-1 Plan") entered into and operated in good faith for the duration of the 10b5-1 Plan and in accordance with the terms of Rule 10b5-1 and all applicable state laws and will be exempt from the trading restrictions set forth in this Statement. The initiation of, and any modification to, any such 10b5-1 Plan will be deemed to be a transaction in the Company's securities, and such initiation or modification is subject to all limitations and prohibitions relating to transactions in the Company's securities. Each such 10b5-1 Plan, and any modification thereof, must be submitted to and pre-approved by the Company's Compliance Officer who may impose such conditions on the implementation and operation of the 10b5-1 Plan as the Compliance Officer deems necessary or advisable. However, compliance of the 10b5-1 Plan to the terms of Rule 10b5-1 and the execution of transactions pursuant to the 10b5-1 Plan are the sole responsibility of the person initiating the 10b5-1 Plan, not the Company or the Compliance Officer.

**The 10b5-1 Plans do not exempt individuals from complying with Section 16 short-swing profit rules or liability.**

Rule 10b5-1 presents an opportunity for insiders to establish arrangements to sell (or purchase) Company stock without the restrictions of trading windows and black-out periods, even when there is undisclosed material information. A 10b5-1 Plan may also help reduce negative publicity that may result when key executives sell the Company's stock. Rule 10b5-1 only provides an "affirmative defense" in the event there is an insider trading lawsuit. It does not prevent someone from bringing a lawsuit.

A director, officer or employee may enter into a 10b5-1 Plan only when he or she is not in possession of material, non-public information, and only during a trading window period outside of the trading black-out period. Although transactions effected under a 10b5-1 Plan will not require further pre-clearance at the time of the trade, any transaction (including the quantity and price) made pursuant to a 10b5-1 Plan of a Section 16 reporting person must be reported to the Company promptly on the day of each trade to permit the Company's filing coordinator to assist in the preparation and filing of a required Form 4. Such reporting may be oral or in writing (including by e-mail) and should include the identity of the reporting person, the type of transaction, the date of the transaction, the number of shares involved and the purchase or sale price. However, the ultimate responsibility, and liability, for timely filing remains with the Section 16 reporting person.

The Company reserves the right from time to time to suspend, discontinue or otherwise prohibit any transaction in the Company's securities, even pursuant to a previously approved 10b5-1 Plan, if the Compliance Officer or the Board of Directors, in its discretion, determines that such suspension, discontinuation or other prohibition is in the best interests of the Company. Any 10b5-1 Plan submitted for approval hereunder should explicitly acknowledge the Company's right to prohibit transactions in the Company's securities. Failure to discontinue purchases and sales as directed shall constitute a violation of the terms of this Section II.E and result in a loss of the exemption set forth herein.

Officers, directors and employees may adopt 10b5-1 Plans with brokers that outline a pre-set plan for trading of the Company's stock, including the exercise of options. Trades pursuant to a 10b5-1 Plan generally may occur at any time. However, consistent with the requirements of Rule 10b5-1, the Company requires a cooling-off period between the establishment of a 10b5-1 Plan and commencement of any transactions under such plan of at least the later of (i) 90 days, or (ii) two business days following the disclosure in a periodic report of the Company's financial results for the fiscal period in which the 10b5-1 Plan was established. Officers, directors and employees may only have one 10b5-1 Plan in place for purchases and sales during any one period, except in limited circumstances and after specific approval by the Compliance Officer. Further, officers, directors and employees may only enter into one "single-trade" 10b5-1 Plan (i.e., a 10b5-1 Plan designed to effect the purchase or sale of securities under the 10b5-1 Plan in a single transaction rather than in multiple transactions) in any 12-month period.

Please review the following description of how a 10b5-1 Plan works.

Pursuant to Rule 10b5-1, an individual's purchase or sale of securities will not be "on the basis of" material, non-public information if:

- First, before becoming aware of the information, the individual enters into a binding contract to purchase or sell the securities, provides instructions to another person to sell the securities or adopts a written plan for trading the securities (i.e., the 10b5-1 Plan).
- Second, the 10b5-1 Plan must either:
    - specify the amount of securities to be purchased or sold, the price at which the securities are to be purchased or sold and the date on which the securities are to be purchased or sold;
    - include a written formula or computer program for determining the amount, price and date of the transactions; or
    - prohibit the individual from exercising any subsequent influence over the purchase or sale of the Company's stock under the 10b5-1 Plan in question.
- Third, the purchase or sale must occur pursuant to the 10b5-1 Plan and the individual must not enter into a corresponding hedging transaction or alter or deviate from the 10b5-1 Plan.

Any 10b5-1 Plan entered into by an officer, director or employee of the Company must include representations by the person entering into the plan that (i) they are not aware of any material non-public information about the Company or its securities, and (ii) they are adopting the plan in good faith and not as part of a plan or scheme to evade the prohibitions of Rule 10b5. The Compliance Officer or administrator of the Company's stock plans is authorized to notify the broker in such circumstances, thereby insulating the insider in the event of revocation. Any adoption of a 10b5-1 Plan by a director or officer of the Company will be disclosed in the Company's next Form 10-Q or Form 10-K.

a. <u>Revocation of and Amendments to 10b5-1 Plans</u>. Revocation of 10b5-1 Plans should occur only in unusual circumstances. Effectiveness of any revocation or amendment of a 10b5-1 Plan will be subject to the prior review and approval of the Compliance Officer. Revocation is effected upon written notice to the broker. Once a 10b5-1 Plan has been revoked, the participant should wait at least 30 days before trading outside of a 10b5-1 Plan and 180 days before establishing a new 10b5-1 Plan. Any termination of a 10b5-1 Plan by a director or officer of the Company will be disclosed in the Company's next Form 10-Q or Form 10-K. A person acting in good faith may amend a prior 10b5-1 Plan so long as such amendments are made outside of a quarterly trading black-out period and at a time when the 10b5-1 Plan participant does not possess material, non-public information. Plan amendments must not take effect for at least 30 days after the plan amendments are made. Under certain circumstances, a 10b5-1 Plan *must* be revoked. This may include circumstances such as the announcement of a merger or the occurrence of an event that would cause the transaction either to violate the law or to have an adverse effect on the Company. The Compliance Officer or administrator of the Company's stock plans is authorized to notify the broker in such circumstances, thereby insulating the insider in the event of revocation.

b. Discretionary Plans. Although non-discretionary 10b5-1 Plans are preferred, discretionary 10b5-1 Plans, where the discretion or control over trading is transferred to a broker, are permitted if pre-approved by the Compliance Officer. The Compliance Officer of the Company must pre-approve any 10b5-1 Plan, arrangement or trading instructions, etc., involving potential sales or purchases of the Company's stock or option exercises, including but not limited to, blind trusts, discretionary accounts with banks or brokers, or limit orders. The actual transactions effected pursuant to a pre-approved 10b5-1 Plan will not be subject to further pre-clearance for transactions in the Company's stock once the 10b5-1 Plan or other arrangement has been pre-approved.

c. Reporting (if Required). If required, an SEC Form 144 will be filled out and filed by the individual/brokerage firm in accordance with the existing rules regarding Form 144 filings. A footnote at the bottom of the Form 144 should indicate that the trades "are in accordance with a 10b5-1 Plan that complies with Rule 10b5-1 and expires ____." For Section 16 reporting persons, Form 4s should be filed before the end of the second business day following the date that the broker, dealer or plan administrator informs the individual that a transaction was executed, provided that the date of such notification is not later than the third business day following the trade date. A similar footnote should be placed at the bottom of the Form 4 as outlined above.

d. Options. Exercises of options for cash may be executed at any time. Cashless exercise option exercises through a broker are subject to trading windows. However, the Company will permit same day sales under 10b5-1 Plans. If a broker is required to execute a cashless exercise in accordance with a 10b5-1 Plan, then the Company must have exercise forms attached to the 10b5-1 Plan that are signed, undated and with the number of shares to be exercised left blank. Once a broker determines that the time is right to exercise the option and dispose of the shares in accordance with the 10b5-1 Plan, the broker will notify the Company in writing and the administrator of the Company's stock plans will fill in the number of shares and the date of exercise on the previously signed exercise form. The insider should not be involved with this part of the exercise.

e. Trades Outside of a 10b5-1 Plan. During an open trading window, trades differing from 10b5-1 Plan instructions that are already in place are allowed as long as the 10b5-1 Plan continues to be followed.

f. Public Announcement. The Company may make a public announcement that 10b5-1 Plans are being implemented in accordance with Rule 10b5-1. It will consider in each case whether a public announcement of a particular 10b5-1 Plan should be made. It may also make public announcements or respond to inquiries from the media as transactions are made under a 10b5-1 Plan.

g. Prohibited Transactions. The transactions prohibited under Section II.E of this Statement, including among others short sales and hedging transactions, may not be carried out through a 10b5-1 Plan or other arrangement or trading instruction involving potential sales or purchases of the Company's securities.

h. Limitation on Liability. None of the Company, the Compliance Officer, the Compliance Officer or the Company's other employees will have any liability for any delay in reviewing, or refusal of, a 10b5-1 Plan submitted pursuant to this Section II.E of this Statement. Notwithstanding any review of a 10b5-1 Plan or pre-clearance of a transaction pursuant to this Section II.E of this Statement, none of the Company, the Compliance Officer, the Compliance Officer or the Company's other employees assumes any liability for the legality or consequences of such 10b5-1 Plan or transaction to the person engaging in or adopting such 10b5-1 Plan or transaction.

7. *Trading within the 401(k) Plan.* When the Company has a stock account in its 401(k) plan, the following provisions will be applicable. Most transactions under the 401(k) Plan (the "Plan") are not subject to the Section 16(b) short-swing profits rule (described at Section III.E below) or the Section 16(a) reporting requirements (described at Section III.G below). An example of an exempt, non-reportable transaction would be a contribution to the Plan, such as, any employee pre-tax or after-tax contributions and any Company match or profit sharing contributions, even if the participant for whose benefit the contributions are made has the right to direct that some or all of the contributions will be invested in the Plan's Company stock fund. Similarly, cash distributions from the Plan's Company stock fund to a participant by reason of the participant's retirement or other termination of employment would be an exempt, non-reportable transaction.

In contrast, discretionary transactions by a participant in the Plan who is a Section 16 Individual are subject to the Section 16(a) reporting requirements. Discretionary transactions include (1) a participant's election to transfer part or all of the participant's Plan balance into (or out of) the Company stock fund (after such monies are originally contributed to the Plan and invested, when contributed, in the Company stock fund) and (2) any voluntary request by a participant for a cash withdrawal from the Company's stock fund on an occasion other than the participant's retirement or other termination of employment (e.g., a hardship withdrawal request).

Discretionary transactions by a Plan participant who is a Section 16 Individual will be exempt from the Section 16(b) short-swing profits rule only if the participant's election to effect the transaction (e.g., the election to move out of the Company stock fund or the request for a hardship withdrawal) occurs at least six months after the participant's most recent discretionary "opposite-way" purchase or sale election under the Plan. The election by a Plan participant who is a Section 16 Individual to effect a discretionary transaction under the Plan less than six months before or after an opposite-way discretionary transaction under the Plan will be subject to Section 16(b). For instance, if a participant elected to move some of his Plan account balance into the Company stock fund in October after he had elected to move some of his Plan account out of the Company stock fund in August, the transaction would be subject to the Section 16(b) short-swing profits rule as well as to the Section 16(a) reporting requirements. Plan participants who are Section 16 Individuals are urged to consult with the Company's Compliance Officer prior to engaging in any Plan transaction that would be treated as a discretionary transaction.

The general prohibition against trading based on inside information described herein is equally applicable to Plan transactions. Therefore, discretionary transactions, including changes by a participant in the amount invested in the Company stock fund, while the participant is in possession of material inside information are prohibited. Additionally, Window Group members are prohibited from making changes in Plan designations outside of a Window or during any other blackout period, even if the participant is not in possession of material inside information. Plan participants who are Window Group members are urged to consult with the Company's Compliance Officer prior to making any changes in Plan designations outside of a Window.

F. Insider Trading Compliance Officer.

The Company has designated Michael E. Tarvin, as its insider trading Compliance Officer (the "Compliance Officer"). The Compliance Officer will review and either approve or prohibit all proposed trades by members of the Window Group and all proposed trades made on behalf of the Company in accordance with the procedures set forth in Section II.G, II.H or II.I below, as applicable.

In addition to the trading approval duties described in Sections II.G, II.H and II.I below, the duties of the Compliance Officer will include the following:

1. Administering this Statement and monitoring and enforcing compliance with all its provisions and procedures.

2. Responding to all inquiries relating to this Statement and its provisions or procedures.

3. Designating and announcing special trading blackout periods during which no members of the Window Group and no one acting on behalf of the Company may trade in Company securities, except for those trades made pursuant to a validly created and approved 10b5-1 Plan.

4. Providing copies of this Statement and other appropriate materials to all current and new directors, officers and employees, and such other persons who the Compliance Officer determines have access to material nonpublic information concerning the Company.

5. Administering, monitoring and enforcing compliance with all federal and state insider trading laws and regulations, including without limitation Sections 10(b), 16, 20A and 21A of the Exchange Act and the rules and regulations promulgated thereunder, and Rule 144 under the Securities Act of 1933 (the "Securities Act"); and assisting in the preparation and filing of all required SEC reports relating to insider trading in Company securities, including without limitation Forms 3, 4, 5 and 144 and Schedules 13D and 13G.

6. Revising this Statement as necessary to reflect changes in federal or state insider trading laws and regulations.

7. Maintaining as Company records originals or copies of all documents required by the provisions of this policy or the procedures set forth herein, and copies of all required SEC reports relating to insider trading, including without limitation Forms 3, 4, 5 and 144 and Schedules 13D and 13G.

8. Maintaining the accuracy of the list of Section 16 Individuals and Key Employees as set forth on *Exhibits A* and *B* attached hereto.

9. Reviewing and approving 10b5-1 Plans and any amendments thereto that are established by insiders.

The Compliance Officer may designate one or more individuals, which may include outside counsel, who may perform the Compliance Officer's duties.

G. Procedures for Approving Trades by Members of the Window Group.

1. *Trades by Members of the Window Group.* Except for trades made pursuant to a validly created and approved 10b5-1 Plan, no member of the Window Group may trade in Company securities until:

a. the person trading has notified the Compliance Officer in writing of the amount and nature of the proposed trade(s) by delivering a Window Group Trading Notification Form substantially in the form attached hereto as *Exhibit C*,

b. the person trading has certified to the Compliance Officer that (i) he or she is not in possession of material nonpublic information concerning the Company and (ii) he or she has received and read this Statement and had the opportunity to ask the Compliance Officer questions regarding this Statement, and

c. the Compliance Officer has approved the trade(s) after considering all relevant factors, and has certified the approval in writing. Written approval can be by mail, facsimile transmission or email.

2. *No Obligation to Approve Trades.* The existence of the foregoing approval procedures does not in any way obligate the Compliance Officer to approve any trades requested by members of the Window Group. The Compliance Officer may reject any trading requests at his/her sole discretion.

3. *Trades pursuant to a 10b5-1 Plan.* The Compliance Officer must review and approve an insider's 10b5-1 Plan. Once the Plan has received all necessary approvals and has become effective, trades made pursuant to the Plan do not need the Compliance Officer's approval before taking place. The Compliance Officer does, however, need notice of trades made pursuant to the Plan.

4. *Registered Offerings.* The prohibitions on trading and procedures for approving trades by members of the Window Group are not applicable to sales pursuant to an offering registered with the SEC.

H. Procedures for Approving Trades Made by Persons Claiming a Hardship Case.

1. *Trades by Persons Claiming a Hardship Case.* The Compliance Officer may, on a case-by-case basis, authorize trading in Company securities outside of a Window due to financial hardship or other hardships only after:

a. the person trading has notified the Compliance Officer in writing of the circumstances of the hardship and the amount and nature of the proposed trade(s),

b. in addition to any applicable requirements set forth in Section G.1 above, the person trading has certified to the Compliance Officer in writing no earlier than two (2) business days prior to the proposed trades(s) that he or she is not in possession of material nonpublic information concerning the Company, and

c. the Compliance Officer has approved the trade(s) after considering all relevant factors, and has certified the approval in writing. Written approval can be by mail, facsimile transmission or email.

I. Procedures for Approving Trades on Behalf of the Company.

1. *Trades on Behalf of the Company.* No person may initiate, cause or effect any trade in Company securities on behalf of the Company until:

a. the Chief Financial Officer of Select Medical Holdings Corporation has notified the Compliance Officer in writing of the amount and nature of the proposed trade(s) by delivering a Company Trading Notification Form substantially in the form attached hereto as *Exhibit D,*

b. the Chief Financial Officer has certified to the Compliance Officer that (i) to the best of his or her knowledge, the Company is not in possession of material nonpublic information concerning the Company and (ii) he or she has received and read this Statement and had the opportunity to ask the Compliance Officer questions regarding this Statement, and

c. the Compliance Officer has approved the trade(s) after considering all relevant factors, and has certified the approval in writing. Written approval can be by mail, facsimile transmission or email.

2. *No Obligation to Approve Trades.* The existence of the foregoing approval procedures does not in any way obligate the Compliance Officer to approve any trades requested on behalf of the Company. The Compliance Officer may reject any trading requests at his/her sole discretion.

III. OTHER LIMITATIONS ON SECURITIES TRANSACTIONS

A. Public Resales — Rule 144.

The Securities Act requires every person who offers or sells a security to register such transaction with the SEC unless an exemption from registration is available. Rule 144 under the Securities Act is the exemption typically relied upon (i) for public resales by any person of “restricted securities” *(i.e.,* securities acquired in a private offering) and (ii) for public resales by officers, directors and other control persons of a company (known as “affiliates”) of any of the Company’s securities, whether restricted or unrestricted.

Rule 144 contains five conditions, although the applicability of some of these conditions will depend on the circumstances of the sale. The following conditions (other than the Current Public Information condition) do not have to be complied with by holders of restricted securities who have held (and fully paid for in cash) their restricted shares for at least six (6) months and who were not affiliates during the three (3) months preceding the sale under the rule:

a. *Current Public Information.* Current information about the Company must be publicly available at the time of sale. The Company’s periodic reports filed with the SEC ordinarily satisfy this requirement.

b. *Holding Period.* Restricted securities must be held and fully paid for by the seller for a period of six (6) months prior to the sale. The holding period requirement, however, does not apply to securities held by affiliates that were acquired either in the open market or in a public offering of securities registered under the Securities Act. If the seller acquired the securities from someone other than the Company or an affiliate of the Company, the holding period of the person from whom the seller acquired such securities can be “tacked” to the seller’s holding period.

c. *Volume Limitations.* The amount of securities which can be sold during any three (3) month period cannot exceed the greater of one percent (1%) of the outstanding shares of the class or (ii) the average weekly reported trading volume for shares of the class on the New York Stock Exchange during the four calendar weeks preceding the filing of the notice of sale referred to below.

d. *Manner of Sale.* The securities must be sold in unsolicited brokers’ transactions, riskless principal transactions or directly to a market-maker.

e. *Notice of Sale.* The seller must file a notice of the proposed sale with the SEC at the time the order to sell is placed with the broker, unless the amount to be sold neither exceeds 5,000 shares nor involves sale proceeds greater than $50,000. See Section III.G below.

Bona fide gifts are not deemed to involve sales of stock for purposes of Rule 144, so they can be made at any time without limitation on the amount of the gift. Donors who receive restricted securities from an affiliate generally will be subject to the same restrictions under Rule 144 that would have applied to the donor for a period of up to one year following the gift, depending on the circumstances.

B. Private Resales.

Directors and officers also may sell securities in a private transaction without registration. Although there is no statutory provision or SEC rule expressly dealing with private sales, the general view is that such sales can safely be made by affiliates if the party acquiring the securities understands he is acquiring restricted securities that must be held for at least one year before the securities will be eligible for resale to the public under Rule 144. Private resales raise certain documentation and other issues and must be reviewed in advance by the Company’s Compliance Officer.

C. Underwriter Lock-Up Agreements.

Some holders of the Company’s Common Stock outstanding immediately prior to any future underwritten public offering of the Company may be asked to agree not to offer, sell, contract to sell or otherwise dispose of any shares of Common Stock or any securities convertible into or exercisable or exchangeable for Common Stock for an agreed upon period of time from the date of the public offering without the prior written consent of the underwriters of the offering. The terms of any such lock-up agreements vary, and anyone who signs a lock-up agreement will be responsible for complying with its terms.

D. Restrictions on Purchases of Company Securities.

In order to prevent market manipulation, the SEC has adopted Regulation M and Rule 10b-18 under the Exchange Act. Regulation M generally prohibits the Company or any of its affiliates from buying Company stock in the open market during certain periods while a public offering is taking place. Rule 10b-18 sets forth guidelines for purchases of Company stock by the Company or its affiliates while a stock buyback program is occurring. While the guidelines are optional, compliance with them provides immunity from a stock manipulation charge. You should consult with the Company's Compliance Officer if you desire to make purchases of Company stock during any period that the Company is making a public offering or buying stock from the public.

E. Disgorgement of Profits on Short-Swing Transactions — Section 16(b).

Section 16 of the Exchange Act applies to directors and officers of the Company and to any person who is the beneficial owner of more than ten percent (10%) of any registered class of the Company's equity securities. The section is intended to deter such persons (collectively referred to below as "insiders") from misusing confidential information about their companies for personal trading gain. Section 16(a) requires insiders to publicly disclose any changes in their beneficial ownership of the Company's equity securities (See Section III.G below). Section 16(b) requires insiders to disgorge to the Company any "profit" resulting from "short-swing" trades, as discussed more fully below. Section 16(c) effectively prohibits insiders from engaging in short sales (See Section III.F below).

For all purposes other than determining status as a greater than ten percent (10%) beneficial owner, a person is deemed the beneficial owner of securities for purposes of Section 16 if such person, directly or indirectly, through any contract, arrangement, understanding, relationship or otherwise, has or shares a direct or indirect pecuniary interest in the subject securities. Pecuniary interest in the subject securities means the opportunity, directly or indirectly, to profit or share in any profit derived from a transaction in such securities.

Under Section 16(b), any profit realized by an insider on a "short-swing" transaction *(i.e.,* a purchase and sale, or sale and purchase, of the Company's equity securities within a period of less than six (6) months) must be disgorged to the Company upon demand by the Company or a stockholder acting on its behalf. By law, the Company cannot waive or release any claim it may have under Section 16(b), or enter into an enforceable agreement to provide indemnification for amounts recovered under the section.

Liability under Section 16(b) is imposed in a mechanical fashion without regard to whether the insider intended to violate the section. Good faith, therefore, is not a defense. All that is necessary for a successful claim is to show that the insider realized "profits" on a short-swing transaction; however, profit, for this purpose, is calculated as the difference between the sale price and the purchase price in the matching transactions, and may be unrelated to the actual gain on the shares sold. When computing recoverable profits on multiple purchases and sales within a six month period, the courts maximize the recovery by matching the lowest purchase price with the highest sale price, the next lowest purchase price with the next highest sale price, and so on. The use of this method makes it possible for an insider to sustain a net loss on a series of transactions while having recoverable profits. The terms "purchase" and "sale" are construed under Section 16(b) to cover a broad range of transactions, including acquisitions and dispositions in tender offers and certain corporate reorganizations. Moreover, purchases and sales by an insider may be matched with transactions by any person (such as certain family members) whose securities are deemed to be beneficially owned by the insider.

The Section 16 rules are complicated and present ample opportunity for inadvertent error. To avoid unnecessary costs and potential embarrassment for insiders and the Company, officers and directors are strongly urged to consult with the Company's Compliance Officer prior to engaging in any transaction or other transfer of Company equity securities regarding the potential applicability of Section 16(b).

F. Prohibition of Short Sales.

Under Section 16(c), insiders are prohibited from effecting "short sales" of the Company's equity securities. A "short sale" is one involving securities which the seller does not own at the time of sale, or, if owned, are not delivered within twenty (20) days after the sale or deposited in the mail or other usual channels of transportation within five (5) days after the sale. No member of the Window Group should engage in any short sales of the Company's equity securities. Wholly apart from Section 16(c), the Company prohibits directors, employees and related parties from selling the Company's stock short. This type of activity is inherently speculative in nature and it may arouse suspicion in the eyes of the SEC that the person was trading on the basis of inside information, particularly when the trading occurs before a major Company announcement or event.

G. Filing Requirements.

1. *Forms 3, 4 and 5.* Under Section 16(a) of the Exchange Act, insiders must file with the SEC public reports disclosing their holdings of and transactions involving the Company's equity securities. Copies of these reports must also be submitted to the Company. An initial report on Form 3 must be filed by every insider within ten (10) days after election or appointment disclosing all equity securities of the Company beneficially owned by the reporting person on the date he became an insider. Even if no securities were owned on that date, the insider must file a report. Any subsequent change in the nature or amount of beneficial ownership by the insider (including changes due to sales under 10b5-1 plans) must be reported on Form 4 and filed before the end of the second (2$^{nd}$) business day following the day on which the transaction causing such change is executed, as such date of execution is determined by Rule 16a-3 under the Exchange Act. Certain exempt transactions may be reported on Form 5 within forty five (45) days after the end of the fiscal year. The fact that no securities were owned after the transactions were completed does not provide a basis for failing to report. All changes in the amount or the form *(i.e.,* direct or indirect) of beneficial ownership (not just purchases and sales) must be reported. Thus, such transactions as gifts and stock dividends ordinarily are reportable. Moreover, an officer or director who has ceased to be an officer or director must report any transactions after termination which occurred within six (6) months of a transaction that occurred while the person was an insider. The Compliance Officer will retain on file copies of each of Forms 3, 4 and 5, respectively.

The reports under Section 16(a) are intended to cover all securities beneficially owned either directly by the insider or indirectly through others. An insider is considered the direct owner of all Company equity securities held in his or her own name or held jointly with others. An insider is considered the indirect owner of any securities from which he obtains benefits substantially equivalent to those of ownership. Thus, equity securities of the Company beneficially owned through partnerships, corporations, trusts, estates, and by family members generally are subject to reporting. Absent countervailing facts, an insider is presumed to be the beneficial owner of securities held by his or her spouse and other family members sharing the same home. But an insider is free to disclaim beneficial ownership of these or any other securities being reported if the insider believes there is a reasonable basis for doing so.

It is important that reports under Section 16(a) be prepared properly and filed on a timely basis. The reports must be received at the SEC by the filing deadline. There is no provision for an extension of the filing deadlines, and the SEC can take enforcement action against insiders who do not comply fully with the filing requirements. In addition, the Company is required to disclose in its annual proxy statement the names of insiders who failed to file Section 16(a) reports properly during the fiscal year, along with the particulars of such instances of noncompliance. Accordingly, the Company strongly urges all directors and officers to notify the Company's Compliance Officer prior to any transactions or changes in their or their family members' beneficial ownership involving Company stock, and to avail themselves of the assistance available from Dechert LLP, the Company's outside counsel, or their own counsel in satisfying the reporting requirements.

2. *Schedule 13D and 13G.* Section 13(d) of the Exchange Act requires the filing of a statement on Schedule 13D or 13G by any person or group which acquires beneficial ownership of more than five percent (5%) of a class of equity securities registered under the Exchange Act. The threshold for reporting is met if the stock owned, when coupled with the amount of stock subject to options exercisable within sixty (60) days, exceeds the five percent (5%) limit.

Initial reports on Schedule 13D and 13G are required in most cases to be filed with the SEC and submitted to the Company within five (5) business days after the reporting threshold is reached. If a material change occurs in the facts set forth in the Schedule 13D, such as an increase or decrease of one percent (1%) or more in the percentage of stock beneficially owned, an amendment disclosing the change must be filed within two (2) business days. If a material change occurs in the facts set forth in a Schedule 13G filing, the filing must be amended within 45 days after the end of the calendar quarter in which any material change occurred.

A person is deemed the beneficial owner of securities for purposes of Section 13(d) if such person has or shares voting power *(i.e.,* the power to vote or direct the voting of the securities) or dispositive power *(i.e.,* the power to sell or direct the sale of the securities). As is true under Section 16(a) of the Exchange Act, a person filing a Schedule 13D or 13G may disclaim beneficial ownership of any securities attributed to him or her if he or she believes there is a reasonable basis for doing so. The Compliance Officer will retain on file copies of each of Schedule 13D and Schedule 13G, respectively.

3. *Form 144.* As described above under the discussion of Rule 144, a seller relying on Rule 144 must file a notice of proposed sale with the SEC at the time the order to sell is placed with the broker unless (x) the amount to be sold neither exceeds 5,000 shares nor involves sale proceeds greater than $50,000 or (y) the seller is not at the time of the sale, and has

not been for the three months preceding such date, an affiliate of the Company and, if the securities to be sold are restricted securities, such restricted securities have been held (and fully paid for) for at least six (6) months. The Compliance Officer will retain on file copies of the form of notice of proposed sale under Rule 144.

## IV. INTERPRETATION, AMENDMENT AND IMPLEMENTATION OF THIS STATEMENT

The Compliance Officer shall have the authority to interpret and update this Statement and all related policies and procedures. In particular, such interpretations and updates of this Statement, as authorized by the Compliance Officer, may include amendments to or departures from the terms of this Statement, to the extent consistent with the general purpose of this Statement and applicable securities laws. Any material amendment to this Statement must be approved by the Board of Directors of the Company.

Actions taken by the Company, the Compliance Officer, or any other Company personnel do not constitute legal advice, nor do they insulate you from the consequences of noncompliance with this Statement or with securities laws.

**EXHIBIT A**

Individuals subject to reporting provisions and trading restrictions of Section 16 of the Securities Exchange Act of 1934, as amended:

*Directors of the Company*

[List Retained by the Company’s Compliance Officer]

*Officers of the Company*

[List Retained by the Company’s Compliance Officer]

## **EXHIBIT B**

Key Employees who must obtain prior approval from the Compliance Officer of all trades in Company securities:

*Key Employees of the Company*

[List Retained by the Company’s Compliance Officer]

**EXHIBIT C**

**SELECT MEDICAL HOLDINGS CORPORATION**
**SELECT MEDICAL CORPORATION**

**Window Group Trading Notification Form**

Please provide the following information:

Name: ___
(Last) (Middle) (First)

Residence address: ___

Position/title: ___

Number and type of securities intended to be acquired / disposed (circle one) of:

___
Aggregate amount of such securities beneficially owned by you (prior to acquisition/disposition)

Name of brokerage firm, if any, through which the securities will be acquired/disposed of:

___

The undersigned acknowledges that he/she has received a copy of the Company's Statement of Trading Policies, dated February 13, 2025, and further acknowledges that he/she has read and understands such Statement.

The undersigned represents and warrants to the Company that he/she is not in the possession of any material, non-public information, whether positive or negative, that if publicly disclosed might have an effect on the market for any of the Company's securities generally or that an investor might consider important in deciding whether to buy, sell or hold any of the Company's securities.

The undersigned represents and warrants that the foregoing information, representations and warranties are true and complete as of the date hereof, and will immediately advise the Company if, prior to the completion of the above-described securities transactions, any of such information, representations or warranties are no longer true and complete.

Date: Signature

___ ___

Printed Name

___

**********************************************************

The above-proposed securities transaction is approved.

Date: Name:

Title: Compliance Officer

## EXHIBIT D

## SELECT MEDICAL HOLDINGS CORPORATION
## SELECT MEDICAL CORPORATION

### Company Trading Notification Form

Please provide the following information:
Name:
(Last) (Middle) (First)

Position/title: Chief Financial Officer

Number and type of securities intended to be acquired / disposed (circle one) of on behalf of the Company:

Aggregate amount of such securities beneficially owned by the Company (prior to acquisition/disposition)

Name of brokerage firm, if any, through whom the securities will be acquired/disposed of:

The undersigned acknowledges that he/she has received a copy of the Company's Statement of Trading Policies, dated February 13, 2025, and further acknowledges that he/she has read and understands such Statement.

The undersigned represents and warrants to the that, to the best of his/her knowledge, the Company is not in the possession of any material, non-public information, whether positive or negative, that if publicly disclosed might have an effect on the market for any of the Company's securities generally or that an investor might consider important in deciding whether to buy, sell or hold any of the Company's securities.

The undersigned represents and warrants that the foregoing information, representations and warranties are true and complete as of the date hereof, and will immediately advise the Company if, prior to the completion of the above-described securities transactions, any of such information, representations or warranties are no longer true and complete.

Date: Name:

Title: Chief Financial Officer,
Select Medical Holdings Corporation

Date: Name:

Title: Chief Financial Officer,
Select Medical Holdings Corporation

***********************************************************

The above-proposed securities transaction is approved.

Date:

Name:
Title: Compliance Officer

**ACKNOWLEDGMENT OF RECEIPT**

I have received a copy of the Statement of Trading Policies of Select Medical Holdings Corporation, Select Medical Corporation and each of their subsidiaries. As an employee / officer / director (circle as applicable), I understand and agree that it is my responsibility to read, familiarize myself with and adhere to the policies and procedures related to this matter.

Date Signature

Printed Name

**Exhibit 21.1**

**SUBSIDIARIES OF SELECT MEDICAL HOLDINGS CORPORATION**
**As of December 31, 2024**

| NAME | Jurisdiction of Organization |
|---|---|
| Actra Rehabilitation Associates, Inc. | Wisconsin |
| Acuity General Partner, LLC | Texas |
| Acuity Healthcare Holdings, Inc. | Delaware |
| Acuity Healthcare Management, LLC | Louisiana |
| Acuity Healthcare of Ohio, L.L.C. | Ohio |
| Acuity Healthcare, LP | Louisiana |
| Acuity Holdings, LLC | North Carolina |
| Acuity Hospital of New Jersey, L.L.C. | New Jersey |
| Acuity Specialty Hospital, LLC | New Jersey |
| Acuity Specialty Hospital—Ohio Valley, LP | Ohio |
| Advantage Rehabilitation Clinics, Inc. | Massachusetts |
| Alexandria Sports, Inc. | New York |
| Allevant Solutions, LLC | Delaware |
| American Transitional Hospitals, LLC | Delaware |
| Archer Rehabilitation, LLC | Delaware |
| Argosy Health, LLC | Delaware |
| Benchmark Acquisition Corp. | Delaware |
| Benchmark Medical Management Company | Delaware |
| Benchmark O&P Holdings, Inc. | Delaware |
| Benchmark Orthotics & Prosthetics, Inc. | Delaware |
| BHSM ES, Inc. | Delaware |
| BHSM Rehabilitation, LLC | Delaware |
| BIR JV, LLP | Texas |
| BIR Pinnacle GP, LLC | Texas |
| Blue Hen Physical Therapy, Inc. | Delaware |
| California Rehab Institute Medical Group | California |
| California Rehabilitation Institute, LLC | Delaware |
| Cape Prosthetics-Orthotics, Inc. | Missouri |
| Caritas Rehab Services, LLC | Kentucky |
| Carrollton Physical Therapy Clinic, Inc. | Texas |
| Central Iowa Physio, LLC | Iowa |
| Champion Sports Medicine Birmingham, LLC | Delaware |
| Cleveland Clinic Rehabilitation Hospitals, LLC | Delaware |
| CMC Ozarks Rehabilitation, LLC | Delaware |
| Coastal Virginia Rehabilitation, LLC | Virginia |
| CRI ES, Inc. | Delaware |
| Crowley Physical Therapy Clinic, Inc. | Louisiana |
| Dade Prosthetics & Orthotics, Inc. | Florida |
| DG Physical Therapy, P.C. | Massachusetts |
| Dignity Select Nevada, LLC | Delaware |
| Douglas Avery & Associates, Ltd. | Virginia |
| Duval Rehabilitation, LLC | Delaware |
| Eagle Rehab Corporation | Delaware |
| Eden Sports, Inc. | New York |

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| **ES LTACH, LLC** | **Georgia** |
| **ES Rehabilitation, LLC** | **Georgia** |
| **ESOP Rehabilitation, LLC** | **Georgia** |
| **FC Select, LLC** | **Delaware** |
| **Fine, Bryant & Wah, Inc.** | **Maryland** |
| **Frederick Orthopedic Rehabilitation, Inc.** | **Maryland** |
| **Freedom Management Services, LLC** | **Pennsylvania** |
| **GH General, LLC** | **Texas** |
| **GH General-San Antonio, LLC** | **Texas** |
| **GlobalRehab — Fort Worth, LP** | **Texas** |
| **GlobalRehab — Scottsdale, LLC** | **Arizona** |
| **GlobalRehab, LP** | **Texas** |
| **GP Therapy, L.L.C.** | **Georgia** |
| **GR General-Scottsdale, LLC** | **Texas** |
| **Great Lakes Specialty Hospital—Hackley, LLC** | **Delaware** |
| **Great Lakes Specialty Hospital—Oak, LLC** | **Delaware** |
| **GRSH ES, Inc.** | **Delaware** |
| **Gulf Breeze Physical Therapy, Inc.** | **Florida** |
| **HealthWorks ES, Inc.** | **Delaware** |
| **Hospital Holdings Corporation** | **Delaware** |
| **Indiana Rehabilitation Services, LLC** | **Delaware** |
| **Indianapolis Physical Therapy and Sports Medicine, Inc.** | **Indiana** |
| **Integrity Physical Therapy, Inc.** | **Delaware** |
| **Intensiva Healthcare Corporation** | **Delaware** |
| **Intensiva Hospital of Greater St. Louis, Inc.** | **Missouri** |
| **ISH Northern Virginia, LLC** | **Delaware** |
| **Island Tree Physical Therapy, P.C.** | **Rhode Island** |
| **Jeffersontown Physical Therapy, LLC** | **Kentucky** |
| **Johnson Physical Therapy, Inc.** | **Ohio** |
| **Joyner Sportsmedicine Institute, Inc.** | **Pennsylvania** |
| **Kentucky Orthopedic Rehabilitation, LLC** | **Delaware** |
| **Kentucky Rehabilitation Services, Inc.** | **Kentucky** |
| **Kessler Hudson County Rehabilitation, LLC** | **Delaware** |
| **Kessler Institute for Rehabilitation, Inc.** | **New Jersey** |
| **Kessler Orthotic & Prosthetic Services, Inc.** | **Delaware** |
| **Kessler Pediatric Therapy, Inc.** | **Delaware** |
| **Kessler Professional Services, LLC** | **Delaware** |
| **Kessler Rehab Centers, Inc.** | **Delaware** |
| **Kessler Rehabilitation Corporation** | **Delaware** |
| **Kessler Rehabilitation Services, Inc.** | **New Jersey** |
| **Keystone Rehabilitation Systems of McMurray** | **Pennsylvania** |
| **Keystone Rehabilitation Systems, Inc.** | **Pennsylvania** |
| **KORT Kentuckiana, LLC** | **Delaware** |
| **KORT Rehabilitation at Home, LLC** | **Delaware** |

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| Leesburg Sports, Inc. | New York |
| LifeBridge Sports Medicine and Rehabilitation, LLC | Maryland |
| LifeSigns Management, Inc. | Michigan |
| Long-Term Acute Care Hospital of Northern Virginia, LLC | Virginia |
| LTACH @ Riverside, LLC | Virginia |
| LTACH Morgantown, LLC | West Virginia |
| Madison Rehabilitation Center, Inc. | Connecticut |
| Matrix Healthcare Services, LLC | Delaware |
| Matrix Rehabilitation, Inc. | Delaware |
| Matrix Rehabilitation-Delaware, Inc. | Delaware |
| Matrix Rehabilitation-Georgia, Inc. | Delaware |
| Matrix Rehabilitation-Ohio, Inc. | Delaware |
| Matrix Rehabilitation-South Carolina, Inc. | Delaware |
| Matrix Rehabilitation-Texas, Inc. | Delaware |
| Metro Rehabilitation Services, Inc. | Michigan |
| Morris Area Rehabilitation Association, Inc. | New Jersey |
| North Dallas Physical Therapy Associates, Inc. | Texas |
| Northstar Health Service, Inc. | Delaware |
| NovaCare Occupational Health Services, Inc. | Delaware |
| NovaCare Outpatient Rehabilitation East, Inc. | Delaware |
| NovaCare Outpatient Rehabilitation, Inc. | Kansas |
| NovaCare Rehabilitation of Ohio, Inc. | Ohio |
| NSR ES, Inc. | Delaware |
| OHRH ES, Inc. | Delaware |
| OHRH Select, Inc. | Delaware |
| OHRH Subsidiaries, LLC | Delaware |
| OHRH, LLC | Ohio |
| OKC Rehabilitation, LLC | Delaware |
| Osprey Rehabilitation, LLC | Delaware |
| Osprey Urban Renewal, LLC | Delaware |
| OSR Louisiana, LLC | Delaware |
| OSR Property Ventures, LLC | Delaware |
| P&O Services, Inc. | Michigan |
| Pacific Rehabilitation & Sports Medicine, Inc. | Delaware |
| Penn State Hershey Rehabilitation, LLC | Delaware |
| PHS Physical Therapy, LLC | Delaware |
| PhysioKids, Inc. | Delaware |
| PhysioLink Corporation | Delaware |
| Physiotherapy Associates Holdings, Inc. | Delaware |
| Physiotherapy Associates NRH Rehab, LLC | Maryland |
| Physiotherapy Associates Union Rehab, LLC | Maryland |
| Physiotherapy Associates, Inc. | Michigan |
| Physiotherapy Corporation | Delaware |
| Physiotherapy-BMHI Holdings, Inc. | Delaware |

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| **Pinnacle Health Select Rehabilitation, LLC** | **Delaware** |
| **PR Acquisition Corporation** | **California** |
| **Pro Active Therapy of North Carolina, Inc.** | **North Carolina** |
| **Pro Active Therapy of South Carolina, Inc.** | **South Carolina** |
| **Pro Active Therapy of Virginia, Inc.** | **Virginia** |
| **Pro Active Therapy, Inc.** | **North Carolina** |
| **Professional Rehab Associates, Inc.** | **Pennsylvania** |
| **Professional Therapeutic Services, Inc.** | **Ohio** |
| **Progressive Therapy, Services, Inc.** | **Ohio** |
| **PSHR Physical Therapy, LLC** | **Delaware** |
| **PTSMA, Inc.** | **Connecticut** |
| **R.S. Network, Inc.** | **Illinois** |
| **RCI (Michigan), Inc.** | **Delaware** |
| **RCI (WRS), LLC** | **Delaware** |
| **Regency Hospital Company of Macon, LLC** | **Delaware** |
| **Regency Hospital Company of Meridian, L.L.C.** | **Delaware** |
| **Regency Hospital Company of South Carolina, L.L.C.** | **Delaware** |
| **Regency Hospital Company, L.L.C.** | **Delaware** |
| **Regency Hospital of Atlanta, LLC** | **Delaware** |
| **Regency Hospital of Columbus, LLC** | **Delaware** |
| **Regency Hospital of Greenville, LLC** | **Delaware** |
| **Regency Hospital of Jackson, LLC** | **Delaware** |
| **Regency Hospital of Kansas City, LLC** | **Delaware** |
| **Regency Hospital of Minneapolis, LLC** | **Delaware** |
| **Regency Hospital of North Central Ohio, LLC** | **Delaware** |
| **Regency Hospital of Northwest Arkansas, LLC** | **Delaware** |
| **Regency Hospital of Northwest Indiana, LLC** | **Delaware** |
| **Regency Hospital of Rhode Island, LLC** | **Delaware** |
| **Regency Hospital of Rockford, LLC** | **Delaware** |
| **Regency Hospital of Southern Mississippi, LLC** | **Delaware** |
| **Regency Hospital of Toledo, LLC** | **Delaware** |
| **Regency Hospitals, LLC** | **Delaware** |
| **Regency Management Company, Inc.** | **Delaware** |
| **Rehab Associates of Jackson Hospital, LLC** | **Alabama** |
| **Rehab Associates, L.L.C.** | **Alabama** |
| **Rehab Colorado, LLC** | **Alabama** |
| **Rehab Hospital of Fort Wayne, LLC** | **Delaware** |
| **Rehab Missouri, LLC** | **Alabama** |
| **Rehab Provider Network of Colorado, Inc.** | **Colorado** |
| **Rehab Provider Network of New Mexico, Inc.** | **New Mexico** |
| **Rehab Provider Network of North Carolina, Inc.** | **North Carolina** |
| **Rehab Provider Network of South Carolina, Inc.** | **Delaware** |
| **Rehab Provider Network of Virginia, Inc.** | **Virginia** |
| **Rehab Provider Network—East I, Inc.** | **Delaware** |

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| Rehab Provider Network—Indiana, Inc. | Indiana |
| Rehab Provider Network—Ohio, Inc. | Ohio |
| Rehab Provider Network—Pennsylvania, Inc. | Pennsylvania |
| Rehab Xcel, LLC | Alabama |
| RehabClinics (PTA), Inc. | Delaware |
| RehabClinics (SPT), Inc. | Delaware |
| RehabClinics, Inc. | Delaware |
| Rehabilitation Center of Washington, D.C., Inc. | Delaware |
| Rehabilitation Consultants, Inc. | Delaware |
| Rehabilitation Hospital of Vancouver, LLC | Delaware |
| Rehabilitation Institute of Denton, LLC | Delaware |
| RPN of NC, Inc. | Delaware |
| RSH Property Ventures, LLC | Delaware |
| Rush Specialty Hospital, LLC | Delaware |
| Rush-Select Holdings, LLC | Delaware |
| S.T.A.R.T., Inc. | Massachusetts |
| Saco Bay Orthopedic and Sports Physical Therapy, Inc. | Maine |
| SCRI, LLC | Delaware |
| Select Cleveland Hospitals, LLC | Delaware |
| Select Employment Services, Inc. | Delaware |
| Select Hospital Investors, LP | Delaware |
| Select Illinois Holdings, Inc. | Delaware |
| Select Kentuckiana, Inc. | Delaware |
| Select LifeCare Western Michigan, LLC | Delaware |
| Select Medical Corporation | Delaware |
| Select Medical International (US), Inc. | Delaware |
| Select Medical International Limited | Cyprus |
| Select Medical of Kentucky, Inc. | Delaware |
| Select Medical of Maryland, Inc. | Delaware |
| Select Medical of New York, Inc. | Delaware |
| Select Medical Patient Safety and Quality Institute, LLC | Delaware |
| Select Medical Property Ventures, LLC | Delaware |
| Select Medical Rehabilitation Clinics, Inc. | Delaware |
| Select NovaCare—PBG, Inc. | New York |
| Select NovaCare—PIT, Inc. | Arizona |
| Select Physical Therapy Holdings, Inc. | Delaware |
| Select Physical Therapy Network Services, Inc. | Delaware |
| Select Physical Therapy of Albuquerque, Ltd. | Alabama |
| Select Physical Therapy of Blue Springs Limited Partnership | Alabama |
| Select Physical Therapy of Colorado Springs Limited Partnership | Alabama |
| Select Physical Therapy of Connecticut Limited Partnership | Alabama |
| Select Physical Therapy of Denver, Ltd. | Alabama |
| Select Physical Therapy of Kendall, Ltd. | Alabama |
| Select Physical Therapy of St. Louis Limited Partnership | Alabama |

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| **Select Physical Therapy of West Denver Limited Partnership** | **Alabama** |
| **Select Physical Therapy Orthopedic Services, Inc.** | **Delaware** |
| **Select Physical Therapy Texas Limited Partnership** | **Alabama** |
| **Select Rehabilitation Hospital—Hershey, Inc.** | **Delaware** |
| **Select San Diego Physical Therapy, P.C.** | **California** |
| **Select Software Ventures, LLC** | **Delaware** |
| **Select Specialty Hospitals, Inc.** | **Delaware** |
| **Select Specialty Hospital—Akron, LLC** | **Delaware** |
| **Select Specialty Hospital—Ann Arbor, Inc.** | **Missouri** |
| **Select Specialty Hospital—Arizona, Inc.** | **Delaware** |
| **Select Specialty Hospital—Augusta, Inc.** | **Delaware** |
| **Select Specialty Hospital—Beech Grove, Inc.** | **Missouri** |
| **Select Specialty Hospital—Belhaven, LLC** | **Delaware** |
| **Select Specialty Hospital—Boardman, Inc.** | **Delaware** |
| **Select Specialty Hospital—Broward, Inc.** | **Delaware** |
| **Select Specialty Hospital—Central Pennsylvania, L.P.** | **Delaware** |
| **Select Specialty Hospital—Charleston, Inc.** | **Delaware** |
| **Select Specialty Hospital—Cincinnati, Inc.** | **Missouri** |
| **Select Specialty Hospital—Cleveland, LLC** | **Delaware** |
| **Select Specialty Hospital—Colorado Springs, Inc.** | **Delaware** |
| **Select Specialty Hospital—Columbus, Inc.** | **Delaware** |
| **Select Specialty Hospital—Dallas, Inc.** | **Delaware** |
| **Select Specialty Hospital—Danville, Inc.** | **Delaware** |
| **Select Specialty Hospital—Daytona Beach, Inc.** | **Delaware** |
| **Select Specialty Hospital—Denver, Inc.** | **Delaware** |
| **Select Specialty Hospital—Des Moines, Inc.** | **Delaware** |
| **Select Specialty Hospital—Durham, Inc.** | **Delaware** |
| **Select Specialty Hospital—Erie, Inc.** | **Delaware** |
| **Select Specialty Hospital—Evansville, LLC** | **Delaware** |
| **Select Specialty Hospital—Evansville, Inc.** | **Missouri** |
| **Select Specialty Hospital—Flint, Inc.** | **Missouri** |
| **Select Specialty Hospital—Fort Myers, Inc.** | **Delaware** |
| **Select Specialty Hospital—Fort Smith, Inc.** | **Missouri** |
| **Select Specialty Hospital—Gainesville, LLC** | **Delaware** |
| **Select Specialty Hospital—Greensboro, Inc.** | **Delaware** |
| **Select Specialty Hospital—Gulf Coast, Inc.** | **Missouri** |
| **Select Specialty Hospital—Jackson, Inc.** | **Delaware** |
| **Select Specialty Hospital—Johnstown, Inc.** | **Missouri** |
| **Select Specialty Hospital—Kalamazoo, Inc.** | **Delaware** |
| **Select Specialty Hospital—Kansas City, Inc.** | **Missouri** |
| **Select Specialty Hospital—Laurel Highlands, Inc.** | **Delaware** |
| **Select Specialty Hospital—Lexington, Inc.** | **Delaware** |
| **Select Specialty Hospital—Lincoln, Inc.** | **Delaware** |
| **Select Specialty Hospital—Little Rock, Inc.** | **Delaware** |
| **Select Specialty Hospital—Longview, Inc.** | **Delaware** |
| **Select Specialty Hospital—Macomb County, Inc.** | **Missouri** |
| **Select Specialty Hospital—Madison, Inc.** | **Delaware** |
| **Select Specialty Hospital—McKeesport, Inc.** | **Delaware** |

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| Select Specialty Hospital—Memphis, Inc. | Delaware |
| Select Specialty Hospital—Miami Lakes, Inc. | Delaware |
| Select Specialty Hospital—Midtown Atlanta, LLC | Delaware |
| Select Specialty Hospital—Milwaukee, Inc. | Delaware |
| Select Specialty Hospital—Nashville, LLC | Delaware |
| Select Specialty Hospital—North Atlanta, Inc. | Delaware |
| Select Specialty Hospital—North Knoxville, Inc. | Missouri |
| Select Specialty Hospital—Northeast New Jersey, Inc. | Delaware |
| Select Specialty Hospital—Northeast Ohio, Inc. | Missouri |
| Select Specialty Hospital—Northern Kentucky, LLC | Delaware |
| Select Specialty Hospital—Oklahoma City, Inc. | Delaware |
| Select Specialty Hospital—Omaha, Inc. | Missouri |
| Select Specialty Hospital—Orlando, Inc. | Delaware |
| Select Specialty Hospital—Palm Beach, Inc. | Delaware |
| Select Specialty Hospital—Panama City, Inc. | Delaware |
| Select Specialty Hospital—Pensacola, Inc. | Delaware |
| Select Specialty Hospital—Phoenix, Inc. | Delaware |
| Select Specialty Hospital—Pittsburgh/UPMC, Inc. | Delaware |
| Select Specialty Hospital—Quad Cities, Inc. | Delaware |
| Select Specialty Hospital—Richmond, Inc. | Delaware |
| Select Specialty Hospital—Saginaw, Inc. | Delaware |
| Select Specialty Hospital—San Antonio, Inc. | Delaware |
| Select Specialty Hospital—Savannah, Inc. | Delaware |
| Select Specialty Hospital—Sioux Falls, Inc. | Missouri |
| Select Specialty Hospital—South Dallas, Inc. | Delaware |
| Select Specialty Hospital—Springfield, Inc. | Delaware |
| Select Specialty Hospital—Tallahassee, Inc. | Delaware |
| Select Specialty Hospital—The Villages, Inc. | Delaware |
| Select Specialty Hospital—TriCities, Inc. | Delaware |
| Select Specialty Hospital—Tucson, LLC | Delaware |
| Select Specialty Hospital—Tulsa, Inc. | Delaware |
| Select Specialty Hospital—Tulsa/Midtown, LLC | Delaware |
| Select Specialty Hospital—West Tennessee, LLC | Delaware |
| Select Specialty Hospital—Western Michigan, Inc. | Missouri |
| Select Specialty Hospital—Wichita, Inc. | Missouri |
| Select Specialty Hospital—Wilmington, Inc. | Missouri |
| Select Specialty Hospital—Winston-Salem, Inc. | Delaware |
| Select Specialty Hospital—Youngstown, Inc. | Missouri |
| Select Specialty Hospital—Zanesville, Inc. | Delaware |
| Select Specialty—Downriver, LLC | Delaware |
| Select Subsidiaries, Inc. | Pennsylvania |
| Select Synergos, Inc. | Delaware |
| Select Transport, Inc. | Delaware |
| Select Tucson Holdings, LLC | Delaware |
| Select Unit Management, Inc. | Delaware |

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| **SelectMark, Inc.** | **Delaware** |
| **SemperCare, Inc.** | **Delaware** |
| **SLMC Finance Corporation** | **Delaware** |
| **SMCS Holdings, Inc.** | **Delaware** |
| **SMCS Management, LLC** | **Delaware** |
| **SMR Banyan Tree, Inc.** | **New York** |
| **SMR Temple, LLC** | **Delaware** |
| **SMR Tucson, LLC** | **Delaware** |
| **SN Kentuckiana Rehab, LLC** | **Delaware** |
| **Special Care Hospital, LLC** | **Delaware** |
| **Sports Orthopedic Rehabilitation Services, Inc.** | **Florida** |
| **SSM Select Rehab St. Louis, LLC** | **Delaware** |
| **Susquehanna Physical Therapy Associates, Inc.** | **Pennsylvania** |
| **Swanson Orthotic and Prosthetic Center, Inc.** | **Ohio** |
| **The Rehab Center** | **Pennsylvania** |
| **Theraphysics Partners of Colorado, Inc.** | **Delaware** |
| **Theraphysics Partners of Texas, Inc.** | **Delaware** |
| **Therapy Associates of Martinsville, Inc.** | **Virginia** |
| **TheraWorks, Inc.** | **Texas** |
| **TriHealth Rehabilitation, LLC** | **Delaware** |
| **Trumbull P.T. Corp.** | **Connecticut** |
| **VHSD ES, Inc.** | **Delaware** |
| **Vibra Hospital of San Diego, LLC** | **Delaware** |
| **Victoria Healthcare, Inc.** | **Florida** |
| **West Gables Rehabilitation Hospital, LLC** | **Delaware** |
| **Wisconsin Prosthetics & Orthotics, Inc.** | **Wisconsin** |
| **WWLTACH, LLC** | **Delaware** |

EX-23 4 sem-1231202410kex23.htm EX-23

**Exhibit 23**

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 333-162407, 333-174393, 333-211776, 333-238231) of Select Medical Holdings Corporation of our report dated February 20, 2025, relating to the financial statements, financial statement schedule and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 20, 2025

**EXHIBIT 31.1**

**SELECT MEDICAL HOLDINGS CORPORATION**
**CERTIFICATIONS PURSUANT TO SECTION 302 OF**
**THE SARBANES-OXLEY ACT OF 2002**
**CERTIFICATION**

I, David S. Chernow, certify that:

1. I have reviewed this annual report on Form 10-K of Select Medical Holdings Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2025

/s/ David S. Chernow
David S. Chernow
*Chief Executive Officer*

**EXHIBIT 31.2**

**SELECT MEDICAL HOLDINGS CORPORATION**
**CERTIFICATIONS PURSUANT TO SECTION 302 OF**
**THE SARBANES-OXLEY ACT OF 2002**
**CERTIFICATION**

I, Michael F. Malatesta, certify that:

1. I have reviewed this annual report on Form 10-K of Select Medical Holdings Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant’s other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Date: February 20, 2025

/s/ Michael F. Malatesta
Michael F. Malatesta
*Executive Vice President and Chief Financial Officer*

**EXHIBIT 32.1**

**CERTIFICATION PURSUANT TO**
**18 U.S.C. SECTION 1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report on Form 10-K of Select Medical Holdings Corporation (the “Company”) for the period ended December 31, 2024 as filed with the Securities and Exchange Commission on the date hereof (the “Report”), we, David S. Chernow and Michael F. Malatesta, Chief Executive Officer and Chief Financial Officer, respectively, of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to our knowledge:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company as of the dates and for the periods expressed in the Report.

February 20, 2025

/s/ David S. Chernow
David S. Chernow
*Chief Executive Officer*

/s/ Michael F. Malatesta
Michael F. Malatesta
*Executive Vice President and Chief Financial Officer*